Not safe for us yet

The experiences and views of older lesbians, gay men and bisexuals using mental health services in London.

A scoping study.

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A project funded by the City Bridge Trust
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Terminology

(Adapted from from the Department of Health ‘Core training standards for sexual orientation’)

In the study we generally use the familiar terms lesbian, gay and bisexual even though these may not be the terms preferred by every participant. We use these terms to describe a sexual orientation characterized by lasting aesthetic attraction, romantic love or sexual desire exclusively for others of the same gender, or for both genders. While ‘homosexuality’ may still be used in academic work there is considerable debate within the lesbian and gay communities about the label of homosexual. It is considered by many that the term is too clinical and dehumanizing, a sentiment that derives from the fact that homosexuality was defined as a mental illness. (It was as late as 1990 that the World Health Organisation said that homosexuality was no longer a disease). In addition it is argued that the term “homosexual” over-emphasizes and tends to define people only in terms of their sexual behaviour ignoring other aspects of being lesbian, gay or bisexual such as those related to culture, politics and community.
General Glossary
(Drawn from Department of Health ‘Core training standards for sexual orientation’)

**Diversity:** Diversity is about the recognition and valuing of difference in the broadest sense. It is about creating a working culture and practices that recognize, respect, value and harness difference for the benefit of the organisation and individuals.

**Equality:** Is about creating a fairer society where everyone can participate and has the opportunity to fulfil their potential. It is backed by legislation designed to address unfair discrimination based on membership of a particular group.

**Heteronormativity** is a term describing the marginalization of non-heterosexual lifestyles and the view that heterosexuality is the normal sexual orientation. Instances of this include the idea that people fall into two distinct and complementary categories (male and female), that sexual and marital relations are normal only when between people of different sexes, and that each sex has certain natural roles in life. (From Wikipedia on ‘heteronormativity’).

**Heterosexism:** Is a belief, argument and/or belief system based on an assumption of innate superiority that male-female sexuality is the only natural, normal and moral code of sexual behaviour. It is also used to refer to the effects of that cultural ideology. Heterosexism may be institutionalized.

**Homophobia:** Homophobia is an extreme and irrational aversion to homosexuality and homosexuals. It can also mean hatred or disparagement of LGB people, their lifestyle, their sexual behaviour or culture and is used to assert bigotry. Opposition to same gender attraction on religious, moral or political grounds is also generally referred to as homophobic.

**Internalised Homophobia:** Internalised homophobia usually refers to homophobia as a prejudice carried by homosexuals against themselves and others like them. It includes a discomfort with or disapproval of one's own sexual orientation.
Executive Summary

1) Introduction and Background

i) Previous community work undertaken by Polari involving consultation of older lesbian, gay and bisexual people found access to and negative experiences within mental health services to be an area of concern.

ii) The mental health professions have been associated with the pathologisation of LGB sexuality since the beginning of the 20th century. Aggressive treatments aimed at changing sexual orientation peaked during the 60s and early 70s, a time when many of today’s older LGB population would have been entering adulthood. The effect of this may be an increased suspicion and lack of access of services and increased stigma attached to their use.

iii) Previous research commissioned by the voluntary sector and within academia has shown that often professionals within statutory services have continued to pathologise and discriminate against LGB service users up until recent times, again contributing to the sense that mental health services do not provide a ‘safe’ support for LGB people who need them.

iv) Older LGB people may be at increased risk of mental distress due to increased historical exposure to stigma and life stressors as well as reduced access to LGB social networks (which can act as an ameliorating factor).

2. Developments in Mental Health Services

i) The National Service Framework for mental health, published by the Department of Health in 1999, sets out the agenda for improvement in the provision of mental health services for working age adults (18-65) only. Subsequent funding was directed at implementing such improvements. The mental health care of older people was covered as part of the generic National Service Framework for older adults in 2001. However, no further funding was attached to this. The Mental Health in Later Life Inquiry carried out by Age Concern presents substantial evidence to suggest that the current mental health system is failing those over 65. (Age Concern, 2007)

ii) There is a current drive within the NHS to utilise a ‘stepped care’ model of treatment and prevention of mental health conditions, part of which is provision of brief and intensive psychological therapies at the point of presentation within primary care. Such an approach has been deemed to be cost effective in terms of keeping people in work. Older people often have limited access to such services, possibly because their perceived value to the economy is less.
iii) The NHS is increasingly aiming to move towards incorporation of a user-derived model or process of recovery. However, concerns about safety within the community have prevented older LGB people from becoming engaged in user groups. Service user involvement initiatives have been seen as valuable, but have sometimes ceased due to lack of ongoing funding.

iv) Increased social inclusion for those living with mental health conditions is listed as a target by the NSF, leading to the development of a National Social Inclusion Implementation Team co-ordinated by the National Institute of Mental Health in England. Many of the issues raised by this team are particularly pertinent to older LGBs: reduced access to social communities or events due to stigma or feared persecution; negative attitudes around mental health within the community; lack of safety within housing and difficulties securing and sustaining employment which respects LGB identity.

v) The Mental Capacity Act (2005) has made it possible for individuals to wield more choice in who cares for and makes decisions for them should they become unable to do so themselves. Theoretically this allows for greater recognition of LGB partners and carers, although it is felt by one user in this study that the Act needs further explicit contextualisation.

3. Method

i) An advisory group made up of older LGB service users and mental health professionals was convened in order to inform the design and implementation of the project.

ii) 49 older LGB service users completed a questionnaire on their experiences of mental health services within the last five years in Greater London. Of these, 10 took part in further in-depth qualitative interviews. Additionally two carers of LGB mental health service users were interviewed. A small focus group was also held.

iii) Additionally, several LGB mental health support groups were visited. A small survey of 36 mental health day services for adults across London was conducted as part of this scoping research. Managers were contacted by telephone and asked a short series of questions. Some contact with staff working in older peoples’ mental health, adult mental health and voluntary sector older peoples’ and LGB-specific services took place also.

iv) Participants were recruited via existing links in the community, LGB websites, community events, community and social venues, voluntary sector organisations and some NHS and local authority services. Snowball sampling technique was utilised.
4. Quantitative Findings

i) The sample was fairly balanced in terms of gender and disability, although bisexuals, people with black or minority ethnicity and those over 60 (compared to those 50-60) were under-represented. A majority of participants were single home-owners but people on low income and in social housing were also included.

ii) Just over a third of gay men and lesbians weren’t ‘out’ to anybody. 38% of gay men and 41% of lesbians were ‘out’ to health professionals; similar numbers were ‘out’ to most of their family.

iii) We compared some findings with statistics available at the time of the study: 22% of men were found to be drinking at levels over the recommended weekly allowance, of which 8% reported consuming amounts considered to be hazardous to health. This was lower than the national average for adult men (Office of National Statistics). The percentage of gay male smokers was almost exactly the same as that reported in previous research, and rates of drug use were lower than previously recorded in a similar sample.

iv) The majority of respondents were current users of statutory mental health services. Those who were not had either used them in the past, or were currently using voluntary / private services.

v) Most individuals who were aware of having a current diagnosis were using statutory mental health services, though a small minority were only accessing voluntary services and a slightly larger minority were using both. More respondents were currently using and had previously used voluntary sector counselling than statutory sector.

vi) Amongst those participants who had wanted to access statutory services but couldn’t / decided against it, the most commonly cited reason was difficulty with disabled access. This was followed by long waiting times, concern about being given unwanted treatment and concern about being told they had a disorder.

vii) Views of mental health services within this sample were found to be diverse. As a general trend, more current- and ex-service users had negative views of statutory services (for example that professionals would pathologise their sexual orientation or make negative assumptions about them) than those who had never used them. However, few expected overt discrimination or mistreatment.

* Since this time Stonewall’s ‘Prescription for Health’ (2008) has provided statistics on lesbians and bisexual women.
viii) Most respondents (current and non-users) said they would be more likely to access mental health services and/or talk about their issues if the professional they were seeing was openly gay or gay-friendly. However, similar agreement was found with respect to professionals who had received training on working with LGB people. Both those who have never used and those who previously used services believe that, if LGB people were represented more prominently in publicity, they would be more inclined to access services.

ix) 92% of respondents were able to be ‘out’ within the context of services, and almost half reported that they were pleased with the way in which professionals treated them when they had been open about their sexual orientation. 41% believed that if there was greater LGB visibility in publicity material they would feel more comfortable to be open about their sexual orientation to all staff. However, over a third of respondents felt that the behaviour of mental health professionals towards them on account of their sexual orientation had made their problems worse. In addition 41% reported being subjected to homophobic remarks from professionals and discriminatory behaviour, with a slightly smaller percentage noting mockery and verbal abuse and disclosure of sexual orientation without permission. Although there was consensus from respondents that they would not keep quiet in such instances, only 38% would know how to make a complaint and 50% do not believe it would be taken seriously even if they were to.

x) There was some consensus between all groups that there are some mental health services that they don’t use because of anxiety about experiencing homophobia from other service users there, and user groups are not excluded from this. Even amongst those who felt comfortable in most instances being open about their sexual orientation to mental health professionals (n=17), just over half (n=9) felt as comfortable when it came to other service users.

xi) About two thirds of respondents worry that openness would result in service users revealing their sexual orientation to others without their permission, and about half would be concerned for their safety in the area in which they live. 60% had witnessed other service users talking negatively about LGB people in general, and 45% had witnessed discriminatory or negative behaviour towards another. 77% reported experiencing discriminatory behaviour, 66% verbal abuse and 44% violence from other service users on account of their sexual orientation. There was no clear consensus on whether mental health professionals had taken clear steps to prevent or stop such instances.

xii) There was strong consensus that being in an LGB-specific environment would make it easier to be open about sexual orientation. Once again, there was little consensus on whether complaints would be taken seriously.

xiii) In summary there was no evidence to suggest that older LGBs had worse experiences of mental health services than younger peers. Nonetheless there
had been little evident change in attitudes and experiences since previous research had been carried out five years previously, although sample size in our study was much smaller. Results seemed to suggest that negative expectations about services with regards to their treatment of LGB people do not represent the primary barrier to engagement for those who have never used them. However, it is possible that expectation of poor practice constituted more of a barrier to continued engagement amongst those who had previously used statutory services; such a group may have more reason to expect bad practice, having previously experienced it themselves.

5. Qualitative Findings

i) Many of the participants discussed (unprompted) topics which highlighted the many ways in which issues surrounding their sexual orientations and indeed their age had been integral to or had affected their mental health, in particular the impact of dealing with homophobia. Some support was lent for the view that LGB people may be at particular risk of developing mental health issues as a result of the effect on self-esteem of being frequently presented with a negative characterisation of LGB identity. Individuals appeared to demonstrate a need to receive support that is non-judgmental and (for them) safe, given their experiences of hostility and stigmatisation in the wider world.

ii) Unfortunately, despite this need the majority of participants could count mental health professionals amongst their persecutors at some time in their lives. There was some belief that services had generally changed for the better over time. However, most service user participants reported some recent instances of perceived homophobic or discriminatory behaviour from staff within a service context, leading to anger and frustration and other adverse effects. Most commonly, participants described the vulnerability they felt when confronted with staff in a hospital setting who openly discussed their religious beliefs. Others described feeling that they were being subjected to indirect discrimination through professionals’ lack of recognition of the validity of their sexual identities.

iii) Perhaps unsurprisingly, experiences such as the above tended to result in participants becoming very cynical about the ability of statutory professionals to provide a suitable service for them and indeed a general lack of trust. In some instances, this cynicism about the ability of services to provide suitable provision was reinforced by NHS staff themselves who we talked to. Subsequently for some this has meant avoiding statutory services altogether, although the need to access them was there.

iv) Experiences of reactions from other service users were mixed. A couple of individuals with more limited experience within the mental health system reported generally positive responses. For the majority of others, discrimination and attack from other service users was of at least equal or sometimes greater concern than the negative behaviour of staff. Despite the above, not one individual reported an instance in which members of staff had
tackled homophobic behaviour on the part of service users. Most individuals had not seen making a complaint as a viable option.

v) Participants in most instances were keen to discuss their concern, frustration and in some cases alarm at what was perceived to be poor standards of care currently offered by the NHS. The general picture painted of the hospital environment in many instances was often one of inadequately trained, unmotivated staff making mistakes with regards to practice which (in one instance) had especially serious consequences. Several participants complained of being unable to access services that were supposedly present, despite efforts to the contrary – particularly counselling, despite current initiatives to increase access to talking therapies. This feeling – of being left isolated and without support outside of hospital – was often repeated in some form, and ‘outreach’ was generally criticised as offering inadequate care.

vi) Related to the final points above, several participants felt very strongly about the current programme of day centre closure, and there was considerable discussion of this issue at the focus group. Contrary to the suggestions of the Department of Health paper mentioned in section 3, they felt that closures had been a) detrimental to user empowerment since users had campaigned fruitlessly to keep their centres open where they had in fact been consulted at all and b) detrimental to the social inclusion of individuals with chronic mental health needs since the majority of these had (subsequent to closures) ended up back in hospital, or simply wandering the streets. The combination of lack of consultation in service closures and perceived doublespeak in terms of user empowerment resulted in the general perception that saving money was considered to be of greater importance than the wellbeing of service users.

vii) Experiences of staff within the NHS were not universally negative. Nearly every participant spoke positively of at least some individuals, most frequently (though not exclusively) CPNs. However, it was felt by one individual that good staff in the NHS are burnt out or marginalised. A non-judgmental and respectful attitude seemed to be the key trait of staff who were judged to have been helpful. Awareness of LGB resources was also seen as being of benefit, but contact with actual LGB members of staff was not deemed strictly necessary for good service. Several participants spoke highly of attempts to develop service-user involvement initiatives within services, although in one instance funding for this had ceased.

viii) The two carers interviewed (and included in the focus group) had particular issues to raise about their own experiences of participating in the care of friends or partners experiencing mental distress. Lack of support from both the voluntary and statutory sectors was mentioned as a problem and corroborated by service users talking about their own carers. A wider issue discussed was general lack of recognition and exclusion from the care of LGB loved ones.
This issue was raised by those who were concerned about the care of LGB friends and also by a disabled carer whose perception was that disabled people (seen as ‘needing care’) were seldom recognised in their roles as carers.

ix) Several of the participants were one-time or current users of voluntary sector services, and tended to speak highly of them. Speaking to members of an LGB mental health support group tended to confirm the increased sense of safety experienced by users in this environment, and the consequent benefits for their mental wellbeing. Several participants had themselves initiated or volunteered for support organisations, and had found this to be a positive experience. Nonetheless for several people there were various concerns about access, given the relatively small number of LGB-specific services available, and also recognition that as such they tended to be overstretched. Some women (and indeed men) recognised that existing groups had difficulty attracting enough lesbians regularly, which in turn made it intimidating for new women to join. There were also concerns about changes to services occurring as a result of funding cuts, especially around the provision of HIV support and prevention. Finally, one user (who had been refused a statutory assessment and who could not afford to seek out private services) expressed concern about the fact that voluntary organisations often can only really afford to employ trainees in therapeutic roles.

x) In addition to feeling isolated from society at large, most of the participants felt to some degree discriminated against within or excluded from the LGB community due to stigma attached to and lack of consideration for age, mental health issues or disability. Concerns about the future and hopelessness concerning the possibility of finding meaningful relationships seemed to contribute significantly to several people’s distress.

xi) The issue of sexual orientation monitoring was raised in particular to investigate whether fears that asking about this as part of wider service user monitoring would be perceived as offensive or an invasion of privacy. The consensus tended to be that the question was useful, but that it had to be asked sensitively. It must be noted that here participants were, in the main, ‘out’ to services, which may have affected their responses.

xii) As suggested by the recovery model, suitable housing was seen as being integral to mental wellbeing by several service users who felt that such concerns played a large part in the story of their mental health difficulties. The high cost of housing and other financial concerns had in one instance prevented a service user’s partner from being able to offer the level of care that she wished to. In every instance, individuals felt disempowered and without representation when confronted by these situations.
xiii) Ideas for improving accessibility and practice within statutory services were offered freely. Adequate, mandatory diversity training for staff on sexual orientation issues was mentioned most frequently. A related issue is that individuals experiencing crisis or mental health issues need to feel safe in the environment in which they access services, and the guarantee of protection against homophobia (or even acknowledgement that LGB people exist) can be an important way of ensuring this. Others have described a need for LGB-specific services, and indeed a less symptom-based and more holistic approach to the treatment of mental health needs.

xiv) Some participants who were registered disabled also called for greater physical accessibility of services. In terms of wider support and (potentially) voluntary sector initiatives, almost everyone felt that a peer support network of some form would be massively beneficial.

6. Findings from Staff

i) The overall perception of older LGB people amongst staff (particularly those not offering an LGB-specific service) was that they tended to be very isolated from their peers and the rest of the community. Voluntary sector staff (especially those providing LGB-specific services) tended to report instances of non-engagement with statutory services amongst users.

ii) Only two of the mental health resource centres surveyed provided LGB-specific groups. Perceived need for such groups amongst staff was slightly higher at 14%. A commonly reported reason for lack of specific groups was difficulty in generating sustained interest. A few were open to the idea of developing LGB-specific services, but had concerns about doing so. Others described being constrained by the priorities identified by their service level agreements. A substantial proportion of managers felt that LGB issues were more appropriately tackled in one-to-one work. Amongst CMHTs there was some consensus that a peer support network of some kind would prove useful for isolated clients, and wished that the researcher could develop such a service since they were not in a position to be able to do so.

iii) Polari recognises that many services may not attract sufficient numbers of LGB people to justify running a separate group, or may not have the resources or confidence to attempt to do so. However displaying publicity and signposting to LGB specific services at least caters for those who may not feel able to be open about their sexual orientation to their keyworker and fulfils the commissioning framework’s inclusivity requirement. Nonetheless under 20% of centres surveyed actually had any publicity and only a further 28% said they would consider having any.
iv) Only 56% of services surveyed allowed users to continue to use the service once they reached 65 and only 28% received new referrals for individuals who had reached this age. When asked why this was, no single service mentioned any particular difficulty anticipated (in terms of levels of support or staff required) in catering for or including older people; rather, referral criteria were said to be determined by NHS or local authority policy. Nonetheless, this age cut-off was not universally observed, and many service providers described a level of flexibility in their policy for accepting new referrals.

ev) Many of the NHS staff reported a climate of homophobia within the organisation, often taking place as part of a general expression of religious attitudes within the workplace. Some reported recognising these problems, but experiencing a sense of powerlessness to change anything. However there was also some recognition of a gradual process of change within the organisation, although current training on equalities was seen in some instances as inadequate.

vi) The issue of monitoring for sexual orientation on the Count Me in Census was raised with older peoples’ CMHTs and NHS day service staff contacted. The primary issue expressed was that people felt uncomfortable asking what they perceived to be a very personal question of users.

7. Problems and Limitations

i) Significant delays to the project were incurred through difficulties in negotiating local protocols around research governance. The small sample size in this study was seen as a problem with regards to the representativeness of the findings. Tightness of inclusion criteria and flaws in the recruitment strategy were supposed to have contributed to this.

**Recommendation:** Future work would benefit from taking place within statutory services and from being more widely publicised.

ii) Difficulty in reaching LGB mental health service users over 60 was encountered. The sample was under-representative of bisexuals, people from poorer socioeconomic backgrounds and people from BME communities.

**Recommendation:** Future work should perhaps aim to focus on qualitative accounts garnered through long term outreach work with particular voluntary or statutory mental health support projects, perhaps undertaken by older LGBs themselves.

iii) The use of a quantitative tool in this research was not deemed to have been particularly successful: it produced data that was too broad to make any specific recommendations, contributed to biasing the sample towards certain
populations and was generally not received well by participants. Demand characteristics and the fairly directive nature of the questionnaire may also have had a role in shaping responses.

**Recommendation:** Future research would be better served by concentrating on gathering good quality qualitative material from a wider, more representative base (again possibly through work within statutory services).

iv) The exploratory design of the study prevented any reliable claims being made about the measured need of older LGB people for mental health services, or relative need compared to other groups.

**Recommendation:** Future research would benefit from the incorporation of a more objective measure of mental wellbeing (for example tools such as CIS-R, GHQ 12). A possible protocol would be to compare use of mental health services by older heterosexual and older LGB people as well as providing a comparative correlation between mental wellbeing and use of services.

8. Current initiatives aimed at improving services for older LGBs

i) A range of voluntary sector services (related to mental health or older LGB people in some way) are presented in appendix C of the full report.

ii) The Department of Health paper ‘Core training standards for sexual orientation: Making National Health Services inclusive for LGB People’ states categorically that training is needed for all NHS staff to make services inclusive for LGB people. Current training is perceived by some staff as being insufficient in content with regards to sexual orientation.

iii) Several of the organisational bodies which inform and design policy within health services now have LGBT advisory groups of some form. At the Department of Health the Sexual Orientation and Gender Identity Advisory Group (including members from both the voluntary sector and the NHS) has been currently assisting with the development and delivery of a programme of work with the aim of improving service accessibility for LGBT users. In terms of staff representation, many borough councils, PCTs, and mental health trusts and professional bodies across London host LGBT staff forums which can be contacted through equality and diversity officers.

iv) Monitoring for sexual orientation is currently taking place across mental health trusts as part of the annual Count Me In census of psychiatric inpatients. This is an important move since monitoring can provide information about health inequalities between minorities, identify potential barriers to services and
identify areas where discriminatory practices might be occurring and subsequently address these problems. Nonetheless, 144 out of 238 providers in 2006 and 127 out of 257 in 2007 refused to collect information around sexual orientation; many of these were in the London area. In a 2006 report ‘Monitoring sexual orientation in the health sector.’ LGB rights group Stonewall concluded that, despite clear benefits associated with doing so, the NHS will not be ready to monitor for sexual orientation until it takes significant steps to demonstrate inclusion and indicates that it is supportive of LGB people.

v) The Equality Act (Sexual Orientation) Regulations came into force in April 2007. This legislation makes it illegal to discriminate in the provision of goods, facilities, services, education and public functions on the basis of sexual orientation. The law now provides a new powerful protection but individuals are not always in a position to contest their rights and resources to assist them to do so are limited or inaccessible.

vi) With regards to health service provision, the Department of Health is working with 18 NHS Trusts to develop single equality schemes. The learning derived will be used to provide case studies and tools to assist other NHS Trusts to incorporate practices which will enable them better to respond to the needs of their local communities.

9. Recommendations

i) Training

Training was considered as most important both by questionnaire respondents and during discussion in the focus group. The Department of Health document ‘Core training standards for sexual orientation’ recommends training on this strand of equalities should a) not be subsumed into a hierarchy of equalities where it is dealt as a sub-issue and should b) be mandatory for NHS and social care staff at all levels (within the first three years of appointment) and tied to the key skills framework. This training should also incorporate the views and experiences of older gay men, lesbians and bisexuals, and ideally (in the spirit of social inclusion) should be delivered by or in conjunction with LGB service users and/or ‘survivors.’ The training package developed by the Royal College of Psychiatrists is inclusive of older LGB issues, and further work should aim to promote and/or incorporate this into plans to deliver training in the future.

ii) Implementation of existing policies

It is also proposed that the NHS needs to go to greater lengths to promote itself as taking a hard line against homophobic attitudes. Upon appointment of
staff, there needs to be (as part of induction) training on all equalities strands, accompanied by a clear statement that discriminatory behaviour of any form towards any minority (and specifically mentioning sexual orientation) will result in a defined disciplinary procedure. This should then be actively followed through as standard in instances where complaints are made or issues arise.

iii) **Information about LGB Services**

Information about LGB services should be provided as standard within venues providing mental health services, which if possible should allow service users from all minorities to signpost themselves to relevant resources if they desire to do so. Doing so empowers service users by maximising choice. It partly fulfils the requirement of the service to consider the specific needs of minority users (where the service is unable to cater for them itself). It also helps the organisation to develop a reputation for taking minority issues seriously (with the subsequent benefits for staff and service users described elsewhere in this report).

iv) **Information and support to make complaints**

This was highlighted as a need. Provision of information about advocacy services and/or referral to these services where necessary must be standard practice, especially within inpatient settings. Service-user-run patient counsellor or outreach posts as well as user-led audits have been popular. Making such projects common practice across every MHT would provide a useful check of good practice and service effectiveness. Given the findings of this study, it would be useful for audits such as these to take into account LGB issues and for LGB service user volunteers to be actively recruited.

v) **LGB-specialist counsellors and/or therapists**

These currently exist in both voluntary and private sectors. Nonetheless, in the case of private provision, participants reported being deterred from accessing these due to prohibitive cost. With regards to the voluntary sector, respondents worried about long waiting times for sessions with insufficiently experienced trainees.

Given funding restrictions and high demand, voluntary sector organisations currently often rely on trainees or volunteers due to an inability to meet the costs of employing fully trained counsellors. Hopefully demand will ease as primary care counselling continues to develop in the future. Possibly an equally useful way of utilising volunteers (as suggested during the focus group conducted as part of this research) would be to assign advocacy- or counselling-trained LGB ‘liaison’ officers to psychiatric wards on a part-time and/or rotating basis in order to provide a visible point of contact for LGB
patients who feel under threat in that environment. Considerable thought would have to be given as to how such contact could take place in a confidential fashion.

vi) LGB Service Users’ Forum

The possibility of setting up a LGB Service Users’ Forum was a key topic of discussion of the focus group, with users keen to see something develop because current similar services were either inaccessible to lesbians, or too geographically dispersed to be feasibly reachable. It was felt that such a group would provide much needed peer support during times of crisis or following discharge from hospital, and indeed that peer support was particularly valuable due to the benefits wrought by shared experiences and insight as service users. It was also felt that it could serve as a non-judgmental, accepting social outlet for older LGB people who feel isolated. The issue of geographical dispersion and access would have to be considered. Polari is also aware that Transgender and Transsexual people have very specific issues with mental health services: the reason they were not included in this scoping study which focused on sexual orientation. However we would recommend consideration and consultation as to whether an LGBT Services Users forum is needed, including support for trans people using the same mental health services.

vii) LGB volunteering and awareness raising

This may help to counteract the perceived non-inclusiveness of the LGB community in general to those with mental health needs, those who are disabled and to older people. A drive to improve disabled access in LGB community venues would be beneficial.

Cross-generational contact has been identified here as potentially beneficial for both older and younger LGB people. A befriending scheme which maximises recruitment from younger age groups could have an impact on the quality of LGB lives. Increasing awareness of opportunities to volunteer as well as emphasising the benefits of doing so to young people (for example, skill sharing, training and experience) would be important in attempting to make such an approach a success. LGB community events (for example Pride, the London LGBT film festival, LGBT history month) could be more inclusive of marginalised groups by giving space to or hosting mental health service user projects and presentations or mental health charities. Funding arts projects for these groups could give them a means of making their experiences known within such forums.

Some participants reported feeling that their sexuality had been marginalised or ignored. A campaign that aims to raise awareness of the potential that
positive sexual identity and indeed activity has for improving mental wellbeing both across statutory and voluntary sectors could help to reverse this situation.

viii) Access for older people to primary care mental health support

This could be improved; trial periods of inclusiveness (to Advice and Brief Intervention teams) could be implemented and treatment outcomes / cost effectiveness audited in order to assess whether (as the literature suggests) early treatment may shorten subsequent periods of intensive care and improve quality of life for this population.

ix) Inclusive Review of Mental Capacity legislation review

Any review of the current Mental Capacity legislation should aim to incorporate consultation with LGB service users with regards to the success of the Act in providing clear and acceptable guidance and protocol for individual cases where LGB carers or partners have been involved.

x) Monitoring for sexual orientation

In the context of this study, users have felt that it was more important to monitor for sexual orientation than not, despite recognition of the fact that some may find such a process offensive or intrusive. It may be the case that (as Stonewall’s 2006 report suggested) the NHS must still make efforts to represent itself successfully as an organisation which values diversity before such monitoring can successfully be carried out. Nonetheless, whilst Count Me In continues to take place annually, it is important to remember to give sufficient information in a manner that is clearly comprehensible concerning the use and storage of data given and the potential usefulness of such data in terms of service commissioning. Participants should be given the means of submitting their responses anonymously, even though this may present some challenges for those with some kinds of impairments.
1. Introduction

Polari is a voluntary organisation which works for better services for older lesbians, gay men and bisexuals. It was founded in 1993 in order to address concerns about the unmet housing needs of an ageing lesbian, gay and bisexual (LGB) population. Since then its work has diversified, encompassing:

a) policy and strategy work with local and national Government departments to promote older LGBT needs
b) research and consultation aimed at investigating the needs and experience of older LGBT people
c) advising older LGBT people’s groups how to get their views and needs heard,
d) a consultancy carrying out research, and training related to older LGBTs
e) an information service for older LGBT people and those who support them.

In 2002, Polari began a three year project ‘Polari in Partnership’. Working across the London boroughs of Hackney, Kingston and Westminster, groups of lesbians and gay men aged 55 and over were formed to discuss their needs and their views of local services. The overall focus was mainly on the areas of housing, health care, social care and community safety. The aim was to involve participants in the decisions made by their service providers.‡

Further to these groups, several conferences were held and an information service was run which allowed older lesbians, gay men and bisexuals (OLGBs), their carers and the professionals who work with them to give voice to their experiences. These individuals represented a much larger area than just the three boroughs mentioned above, yet common themes of concern emerged. Conspicuous amongst these were worries about the provision of effective and appropriate mental health services.

To give some examples, there was considerable concern reported about the lack of choice of suitable therapists as well as anecdotal evidence of inappropriate comments made by staff. One participant mentioned recent experiences where they felt that their sexual orientation was seen to be a problem by professionals within mental health services. Others were anxious for their safety in terms of the homophobic behaviour of other patients, and lacked confidence in the ability and the inclination of staff to respond to this appropriately.

City Bridge Trust awarded funding to carry out a one year scoping project looking at the needs of older lesbian, gay and bisexual users of mental health services with a view to deciding whether further policy, research or service development work was required and/or feasible in this instance.

‡ For an evaluation of this project, and its outcomes please see ‘Being Taken Seriously’ on Polari’s website www.polari.org where it is listed under ‘Documents’
2. Background

This section aims to:

- explore some of the historical issues surrounding lesbian, gay and bisexual use of mental health services

- briefly review contemporary research in the UK and abroad around LGB people and mental health

- discuss issues related to ageing and its consequences for mental wellbeing

- provide a rationale and context for this particular project

2.1 LGB people and the mental health professions: an historical perspective

Lesbian, gay and bisexual people over 50 (the subjects of this study) came of age in the sixties and seventies when a discourse of homosexuality and mental disorder had been current for over half a century. The treatment of homosexual behaviour as a mental disorder dates back to the late 1800s, emerging as part of a growing ‘sexology’ movement that aimed scientifically to examine human sexual practices. Familiar discussions with regards to the relative roles of congenital and environmental factors in the development of same-sex attraction were already being undertaken by sexologists such as Richard von Krafft-Ebing ('Psychopathia Sexualis' 1886) and Havelock Ellis ('Sexual Inversion' 1897). Consensus was by no means unanimous – Ellis for instance was to conclude on the basis of case studies that homosexuality was an inherited variation but not a harmful disease or a moral aberration. Nonetheless, the prevailing zeitgeist tended to select the view that the behaviour constituted a ‘deviance’ or ‘parasthaesia’ to be explained with a view to curing it.

The term 'homosexual' was also extended to include women in the 20th century and although legislation against sexual activity between women existed in many European countries (Crompton 1980/81), no such legislation existed in Britain. Ellis and Symonds (1897) had suggested that there was a pathological association between women's social and political emancipation and same-sex love, criminality and insanity. An attempt to prohibit sexual acts between women in British law for the first time was rejected in parliament in 1921 on the grounds that merely putting such ideas in the public domain would corrupt (Doan 2001).

In the late 1800s, Freud had begun to publish his unique views on personality and psychopathology. These were of course to remain hugely influential for almost a hundred years (and to a lesser extent for longer than this), both within the public consciousness but also as the basis of and inspiration for many areas of clinical research and practice. Although frequently characterised as having
proposed an overtly negative view of homosexuals and homosexuality, this is often unreflective of the actual content of his writings. In ‘Three Essays on the Theory of Sexuality’ he states that ‘it is... found in people whose efficiency is unimpaired, and who are indeed distinguished by specially high intellectual development and ethical culture,’ (p138). He also resisted using the value-laden term ‘perversion’ to describe gay sexual practice, preferring the term ‘inversion.’

Importantly, however, Freud disagreed with Ellis that homosexuality was in any way innate or congenital. He claims (based on infamously limited evidence) that ‘all human beings are capable of making a homosexual object choice and have in fact made one in their unconscious,’ (p145) and furthermore that (in the case of individuals exhibiting same-sex attraction) ‘it is possible to show that very early in their lives a sexual impression occurred which left a permanent after-effect in the shape of a tendency to homosexuality,’ (p140). Also widely accredited to Freud is the popularisation of an approach to mental illness that sought to cure through treatment as opposed to shutting away. Taken in a particular way, these claims – that homosexuals have simply made a wrong decision somewhere along the line, or have been made the way they are because of some (possibly pathological) experience in their youth – can be and are still used as grounds for the persecution of LGB people and for attempts to control and repress their sexuality. It seems more fair to state of Freud that, in this manner, his views often provided a loose justification for the continuing cultural stigmatisation of both mental illness and homosexuality, which itself led to the conflation of the two. Likewise, they provided some basis for an attempt to cure functional LGB people. Rudledge (2003) claims that (following Freud) there was a significant increase in the number of individuals placed in hospitals and prisons.

It seems that, despite the increasing emphasis on therapy as opposed to incarceration, the mental health professions were in fact continuing in their historical role as the implicit proponents and indeed enforcers of a particular set of (non-scientific) cultural values. These values not only determined what was to be considered pathological, but they directed research and decided who could and couldn’t carry out diagnoses themselves (as the exclusion of homosexuals from psychoanalytic training until the 1990s shows). Treatments developed since the 1940s had already moved beyond Freudian analysis to include castration, brain surgery, and breast amputation (Rudledge 2003). The rise of the behaviourist school of psychology in the 60s and 70s did little to improve the situation. The typical position is thus outlined by McCulloch and Feldman (1970) - "the restoration of heterosexual interest is as important as the reduction, and hopefully, elimination of homosexual interest; indeed the two go together.” By far the most commonly prescribed practice within the NHS for achieving this goal was aversion therapy. This aimed to eliminate same sex desire by producing an association between homosexually-arousing material and unpleasant or painful experiences (frequently electric shock or sickness). Of the hundreds of people who were subjected to this approach, relatively little is known. However, the accounts that have emerged tend to be harrowing, including this from an article for the BBC:
“The psychiatrist who made the tape … gave him a pile of ‘dirty’ books containing images of nude men and a crate of Guinness to drink.

"They then injected [him] with something that made [him] violently sick for about an hour and they left [him] there …. The doctors refused to give him a basin and insisted he vomit over himself.

For 72 hours [he] lay in [his] own excrement and dirt, scared out of [his] wits … He begged to be let out of the hospital after the psychiatrist told him the next stage of the treatment involved attaching electrodes to his penis."

*From an article for the BBC ‘When Gays Were Cured’ – Brian Wheeler (www.bbc.co.uk)*

Even at the time there was little evidence to suggest that this approach represented a useful intervention for patients, and systematic outcome audit was fairly rare. A feasibility study of 10 men treated by Bancroft (1969) noted that one developed phobic anxiety to attractive men and attempted suicide; one became aggressive, attempted suicide and was anorgasmic in homosexual relationships; one became hostile and dropped out; one developed severe depression after rejection by women; one became psychotically depressed and wandered in the street removing his clothes; one became disillusioned with the homosexual world and could no longer obtain emotionally rewarding relationships. Bancroft did not consider any of these men 'worse off.'

Smith, Bartlett and King (2004) have conducted an investigation into the experiences of professionals who administered, and patients who received, these treatments. They describe how individuals disclosing their sexual orientation to GPs were told that the way they were was ‘wrong,’ ‘perverse’ and that they were suffering a ‘sickness.’ Even within this fairly small sample (n=29), one participant claimed that a male doctor he consulted for help with his homosexuality abused him several times at the age of 14, another that several doctors physically assaulted him during his treatment and a third that his name had been given to police and family members by mental health professionals. The brother of another participant died in hospital due to the side effects of apomorphine (a drug used to induce sickness as part of the aversion process). Several of those who took part reported that they had been unable to participate in sexual relationships following treatment. Nonetheless, in some instances a minority of professionals report successful interventions, despite the lack of a standardised outcomes framework – for example, one instance in which a gay man was ‘cured,’ married a lesbian who then also sought treatment and who subsequently had children.

Gay men were frequently choosing therapy over prison in the early 60s. Even after the partial decriminalisation of homosexuality (of consenting adults over 21 in private) in 1967, treatments to change homosexuals into heterosexuals
remained common until the mid 70s. The Greater London Council called for an end to shock, drug or behavioural therapies to cure lesbianism in 1986, which may demonstrate that such interventions were still used as recently as 20 years ago. Some individuals were referred to psychiatrists after confiding in teachers or other professionals during these decades (Smith et al 2004).

In 1994 the World Health Organisation finally replaced its categorization of homosexuality as a mental illness with the diagnosis of ego-dystonic homosexuality on the International Classification of Diseases, the diagnostic tool sanctioned by the Department of Health, where it remains to this day. This disorder is defined as either the lack of arousal in wanted heterosexual relationships, or distress from unwanted homosexual arousal. It seems to be assumed that a parallel ego dystonic heterosexuality in people happily identified as homosexual does not exist.

If anything is to be learned from history in this respect, it is that changes in legislation and diagnostic categories rarely bring immediate changes in attitude. With regards to the psychiatrists and psychologists who had originally administered invasive treatments such as aversion therapy, some had shown concern and sympathy for their patients at the time, many questioned the efficacy of the treatment and several have since spoken of their guilt at its use. Smith et al (2004) conclude that professionals had “realised with hindsight that they lacked understanding of sexual behaviour within its social context” (p3). However, a minority involved in this research still claimed that same sex attraction is a mental illness requiring treatment, or is associated with psychopathology. In the words of one psychologist, ‘I thought they [homosexuals] were people who were disordered and needed treatment and psychiatric help. And I still do”’ (p3). Another advocates the use of treatment for those who feel uncomfortable with ‘the whole gay scene,’ suggesting a lack of understanding of the diverse social options available for LGB people to express themselves in the present day or that they see same sex sexual orientation as problematic.

In conclusion, it is worth bearing two things in mind. Firstly, whilst it is generally and reasonably taken for granted that society and its institutions have become massively more accepting of LGB people in recent years, covert discriminations and assumptions inherent in particular approaches remain much more difficult to detect than overt abuses. Take for example the continued use of ego-dystonic homosexuality as a diagnostic category, or the vigour with which potential causes for same sex attraction was sought in the 90s (with a good deal of publicity centring on the so-called ‘gay gene’). It could be argued that the latter continued to place homosexuality in the same bracket as mental disorders for which we also attempt to find an aetiology - there is after all no equivalent search for the cause of heterosexuality. This ‘heteronormativity’ may contribute to the feelings of isolation and separation from society that (as will be discussed later) can be predictors of mental illness.

Secondly, Coyle and Kitzinger (2002) propose that declassification of homosexuality as a disorder was only achieved as a result of intense lobbying from lesbian, gay and bisexual political organizations such as the Gay Liberation
Front, whose 1971 Manifesto listed gay people’s oppressors as including ‘psychiatry.’ Many older LGBs have been active in these movements, and many are likely to believe that institutional developments came about as a result of pressure from outside as opposed to genuine changes of attitude from within psychology and psychiatry. There may therefore be some degree of reconciliation and ‘rebranding’ of mental health services still to do in order to reach people within this age bracket, many of whom will avoid mental health services in spite of worsening psychological wellbeing. Within this study we have heard that psychiatrists were seen as the enemy within the gay community, and that therefore those who sought their help were seen as misguided or even traitors.

2.2 Contemporary experiences of mental health services

Although undoubtedly treatment of LGB people by mental health services has improved significantly in the UK in recent years, contemporary studies on the topic have not painted a reassuring picture. In 1997 Mind commissioned the report ‘WithOut Prejudice’ (Golding 1997). 84% of a sample of 55 LGB services users (recruited from a Mind database) feared prejudice, discrimination or pathologisation which adversely affected their willingness to use mental health services. Of those who had used services (either voluntarily or non-voluntarily through having been sectioned under the Mental Health Act), 51% said that mental health workers had inappropriately used their lesbian, gay or bisexual identity in order to explain the cause of mental distress. 60% of the sample denied their sexual identities within healthcare settings (or allowed the assumption that they were heterosexual to go unchallenged), and 78% would not consider revealing their sexual orientation to other service users. This led Golding to suggest that there is a ‘climate of fear’ (p17) in mental health services for lesbian, gay and bisexual people - hardly surprising since 73% of the sample had experienced some form of prejudice, discrimination, or in some cases violence within services either by professionals or other users.

A year later P.A.C.E (an organisation devoted to the mental health of the LGB community) undertook qualitative research in the London area, interviewing both service providers (n=35) and LGB service users (n=35). Once again, negative experiences of mental health services and professionals tended to be more commonplace than positive. Participants reported experiencing physical abuse, verbal abuse and ridicule, ignorance and lack of awareness, being silenced, stereotyping, voyeurism and inappropriate questioning, and judgmental attitudes as well as having their sexual orientation pathologised, denied, discouraged, devalued and ignored and their relationships trivialized. Respondents also cited instances of breaches of confidentiality, anti-gay jokes and, in women, attempts to encourage femininity. Breaches of confidentiality included discussing and ‘outing’ the service user to their families without prior permission. Interaction with other service users were typified by fears about physical safety, experiences of sexual harassment, verbal abuse, isolation (with effects on use of services) non-
intervention and collusion from staff which compounded fear about coming out and feelings about lack of safety. The service user movement was perceived as not taking lesbian, gay and bisexual issues on board.

McFarlane and Golding agree that many lesbian, gay and bisexual people anticipate negative reactions from healthcare professionals which is in itself stressful for these service users. The former also argues that healthcare organisations do little to change this perception as they seldom routinely provide positive images of lesbian, gay and bisexual people or specific information leaflets. There is a similar lack of visibility within policies and practice models.

Other studies have highlighted LGB service user’s anticipation of homophobic comments and attitudes (Mugglestone 1999; Scherzer 2000) and the encouragement of heterosexually defined femininity in women (Annesley and Coyle 1998). Koffman (1997) has claimed that experiences of isolation as a lesbian, gay man or bisexual person within mainstream mental health services renders these services inaccessible to some lesbian, gay and bisexual people. Nonetheless, McFarlane’s study did note some positive responses from mental health professionals, where users’ sexual orientation was recognised and accepted, individuals were given appropriate help and information (including referral to appropriate services), and information was passed on to LGB friends / partners as requested.

Most recently, King, McKeown et al (2003) interviewed a small sample of gay men (n=9) and lesbian women (n=14) with experience of mental distress. The participants spoke of some incidents of homophobia from mental health professionals, although these did not typify the respondent’s experiences of mental health workers. More common experiences involved assumptions of heterosexuality, and a lack of knowledge about issues that relate to lesbian, gay and bisexual lifestyles and experiences. Some who had come out found their sexual identities were ignored and avoided by healthcare professionals. Others found that their sexual identity was seen as a part of their difficulties and problems. Respondents differed in their approaches to coming out in this context, with a variety of positive and negative responses experienced to doing so. Some respondents did not come out because, like the participants in Golding’s and MacFarlane’s studies, they feared prejudicial or negative responses to disclosure of their sexual orientation.

Finally, a recent study carried out in Leeds also reflected a gradual improvement in perception of services. 75.5% of males and 72.7% of females in a group of LGB participants (n=76) reported that they would feel comfortable in letting mental health service providers know their sexual orientation (Noret, Rivers and Richards 2007). 13.4% of the sample had experienced some form of discrimination when visiting a mental health service which, although unacceptable, is a considerable improvement on the situation described by Golding’s study ten years earlier. Instances seemingly had become less explicit, with participants mostly describing general lack of awareness of LGB lifestyles or (in one instance) inappropriate citing of sexual orientation as an element of
mental distress. Interestingly though, whilst 91.2% of local service providers surveyed believed they acknowledged the specific needs of the LGB community, only 22% of participants reported that they felt that these needs were sufficiently acknowledged.

If services are indeed failing LGB people it is a matter for some concern, since there is evidence to suggest that this group are at greater risk of experiencing mental distress.

2.3 LGB People and Mental Health: Research up to the Present Day

Since the 1950s, there had been considerable evidence published to suggest that individuals attracted to members of the same sex were not in and of themselves ‘psychologically pathological.’ Hooker (1957) asked experts to rate the psychological adjustment of gay men ‘functioning normally in society,’ as well as that of heterosexual men, without prior knowledge of sexual orientation. No significant differences were found. Comparable results were found when lesbian women were compared with their heterosexual peers (Freedman 1971). In a review of published studies comparing homosexual and heterosexual samples on psychological tests, Gonsiorek (1982) found that, although some differences have been observed in test results between homosexuals and heterosexuals, both groups consistently score within the normal range and that "homosexuals as a group are not more psychologically disturbed on account of their homosexuality” (p74). In all, a substantial body of evidence led the American Psychological Association to declare conclusively in 1999 that ‘homosexuality is not associated with psychopathology in any way.’

However, there is also a significant body of evidence to suggest that LGB people are at greater risk of experiencing poor mental health than their heterosexual peers, although the majority of studies to date have been carried out in the United States, where samples of gay men there have been found to experience higher rates of bipolar disorder (Pillard 1998) and major depression (Cochran and Mays 2000). Atkinson et al (1998) report a higher incidence of most mental disorders in men who have sex with men. Lesbians have been shown to be almost twice as likely to have attempted suicide as heterosexual women (Hughes, Pollinger-Haas et al 2000).

Similar findings have emerged from elsewhere in the world. LGB people in New Zealand reported higher rates of major depression, generalised anxiety disorder and conduct disorder (Fergusson et al 1999). Having surveyed 2987 LGB individuals of various ages in Norway, Hegna et al (1999) found a much higher risk of mental health issues than in the general population. Research from the Netherlands (Sandfort et al 2001) and Australia (Jorm et al 2002) point to comparable trends.

Recent research in the UK has tended to focus on rates of attempted suicide within LGB populations, which have been consistently high. Of five studies
reviewed\textsuperscript{4}, the percentages of gay men claiming to have attempted suicide at least once range from 27% (Hutchison et al 2003) to 54% of the largest sample (n=656) (King et al 2003). For lesbians, the figures have been slightly higher – 30% (Carolan and Redmond 2003) to 59% (John and Patrick 1999). Kessler, Borges and Walters (2000) found that rates of lifetime suicidal ideation within a general sample of 8580 women and men were 17 and 13% respectively.

There have been two large-scale studies in the UK detailing the incidence of mental ill health within the LGB population. King and McKeown (2003) found that gay men (n=656), lesbians (n=430) and bisexuals (n=198) scored significantly differently to heterosexuals across two measures of psychological wellbeing and quality of life, indicating greater levels of psychological distress. 44% of gay men scored above the threshold for common mental disorder on the CIS-R scale, as compared to 36% of heterosexual men. The figures for women were 44% for lesbians and 34% for heterosexuals. 50% of the sample in total had self-harmed at some point in their lives. Gay men and lesbians were also more likely than heterosexuals to have ever consulted a mental health professional in the past, even after current mental health had been controlled for. In Noret et al’s (2007) study, 51.4% of gay men and 68.8% of lesbians surveyed reported having accessed a mental health service in Leeds.

Warner, Mckeown et al (2004) conducted a questionnaire survey of 1249 LGB people. They found high levels of planned and actual self-harm as well as high rates of psychiatric morbidity (as defined by the CIS-R). 42% of the gay men scored significantly highly on this test, along with 43% of lesbians and 49% of bisexuals. Typical reported prevalence rates of mental disorder amongst heterosexuals (as scored on the same test) are approximately 12% in men and 20% in women (Meltzer et al 1995; Singleton et al 2000\textsuperscript{3}). 39.7% of Noret et al’s sample reported having been diagnosed with a mental health problem.

2.4 Elements increasing susceptibility to poor mental health

The popular diathesis-stress model of mental illness suggests that a genetic vulnerability or predisposition (diathesis) interacts with the environment and life events (stressors) to trigger psychological disorders. Greater underlying vulnerabilities require less stress to trigger the disorder and vice versa. Given the data described above, it is possible that LGB people are more prone to certain stressors, in turn making them more susceptible to mental ill health. The prevalence of HIV amongst gay men, for example, may represent an added stressor that may push individuals into crisis (in terms of both direct effects on the individual and vicarious or social effects through loss of significant others). At least one research study has confirmed a link between the disease and depression (Fulk et al 2003).

\textsuperscript{4} King et al 2003; Hutchinson et al 2003; Carolan and Redmond 2002; the Count Me In census 2001; John and Patrick 1999
\textsuperscript{3} Psychiatric Morbidity Surveys – Department of Health www.dh.gov.uk
Substance misuse is another good candidate for such a connection. Pillard (1998) found higher rates of alcohol and drug dependence amongst lesbians than heterosexual women. Bradford et al (1994) and McKirnan and Peterson (1989) also report high rates of alcohol consumption among lesbians, and both found that rates do not decline with age as they do among heterosexual women. The 2005 UK Gay Men’s Sex Survey of 16,500 gay men found relatively high rates of alcohol and illegal drug use amongst the population. The link between substance misuse and poor mental health is well documented (e.g. Evans and Willey 2000). One commonly held reason for increased substance use amongst LGB people is the idea that the community has historically met and socialised in an underground bar and club scene where alcohol and drugs were rife, and that this has simply continued in a more commercialised and exaggerated form. Some researchers have suggested that internalised homophobia is to blame (e.g. Davis and Neal 1996; Glaus 1988; Finnegam and Cook 1984).

Moss (1973), one proponent of social interactionist theories of identity development, suggests that interactions with society provide the individual with information on the construction of the world. Cooley’s (1902/22) ‘looking glass self’ idea proposes that (predictably) negative regard from others leads to negative regard for self. Lazarus and Folkman (1984) unify these positions by claiming that conflict or mismatch between an individual and his/her experience of society leads to stress and compromises health.

From these ideas, the concept of ‘minority stress’ has arisen – this is defined as a state resulting from "...culturally sanctioned, categorically ascribed inferior status, social prejudice and discrimination, the impact of these environmental forces on psychological wellbeing, and consequent readjustment or adaptation." (Brooks 1981 p107). Meyer (1995) notes that "minority stress arises not only from negative events but from the totality of the minority person's experience in dominant society. At the centre of this experience is the incongruence between the minority person's culture, needs and experience and societal structures" (p39).

In summary, LGB peoples’ experiences of homophobic abuse, attack, negative reaction from others, ignorance of or sidelining of their issues and indeed heterosexism within ‘mainstream’ culture all represent psychological stressors that contribute to increased likelihood of mental illness. LGB people, Meyer claims, suffer a unique form of minority stress in that gay men and lesbians may not have a readily available alternative positive cultural identity outside of the mainstream. ‘Gay-related stress’ (measured by a specific tool designed by Meyer) is found to be consistently associated with psychological distress (DiPlacido 1998; Lewis et al 2002; Meyer and Dean 1998). 50% of LGBT people (n=110) surveyed in Edinburgh in 2001 claimed that their mental health had been adversely affected by homophobic discrimination.

It is not only actual experience of homophobia or stigmatisation that can contribute to stress – expectation of it is as important, if not more so. An
interesting illumination of this effect is provided by the concept of ‘stigma consciousness,’ where a chronically persecuted or minority-stressed individual displays an increased expectation of being stereotyped by others and as such is more likely to perceive discrimination directed towards them. Pinel (1999) amongst others has found stigma consciousness to be a significant mediator of the relationship between gay-related stress and psychological distress.

Finally, as the ‘looking glass self’ idea would suggest, years of exposure to negative attitudes towards LGB sexuality can often result in internalised negative views of the self and low self-esteem which themselves predict poor mental wellbeing. Some research suggests most gay men and lesbians adopt negative attitudes towards homosexuality early in their developmental histories (e.g. Davies, 1996) leading to a ‘gay person's direction of negative social attitudes towards the self, leading to a devaluation of the self and resultant internal conflicts,' Meyer and Dean (1998 p 161). John and Patrick (1999) report that, of a group of 137 LGB people in Glasgow who had experienced depression, 71% connected their mental difficulties to their own or others’ feelings towards their sexual orientation. Bennett (2001) found higher levels of internalised homophobia in lesbians and bisexual women who self-harmed. In the King and McKeown (2003) study cited above, 62% of gay men who had considered seeking help to change their sexual orientation scored above the threshold of the CIS-R™ for mental illness as opposed to 39% of those who had not.

Clark (1999) notes that positive coping strategies for such stress are common amongst minority groups and are associated with resources such as group solidarity and cohesiveness. LGB people counteract minority stress by establishing alternative structures and values that enhance their group (Crocker and Major 1989; D'Emilio 1983). For example, amongst LGB adolescents family support and self-acceptance was found to ameliorate the negative effect of anti-gay abuse on mental health outcomes (Hershberger and D'Augelli 1995). Members of stigmatised groups who have a strong sense of community cohesiveness evaluate themselves in comparison with others who are like themselves rather than members of the dominant culture. Such a process also allows stigmatised individuals to experience environments in which they are not stigmatised by others and access support for negative evaluation (Jones et al 1984). Identification with the minority group may also bring stress (because of perception of self as stigmatised and devalued minority) – this may explain why there is no clear relationship documented between openness about sexual orientation and depression, (e.g. Ayala and Coleman 2000; McGregor et al 2001; Oetjen and Rothblum 2000).

Given all of this, there are several points to be made which are of direct relevance to this study:

1. Negative historical societal attitudes towards homosexuality may have resulted in a greater degree of negative internalisation and has possibly resulted in some older LGB people having had less opportunity to develop

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™ A standardised tool for measuring mental wellbeing
positive self-identities, leading to increased risk of developing mental illness as a result.

2. Negative experiences of homophobia within mental health services (from professionals or other users), even if in the past, may serve to increase expectation of stigmatisation. This in itself may contribute to stress and mental illness, particularly where individuals are isolated and have limited contact with others outside of a service context.

3. Stigmatisation results in stress and increased likelihood of mental ill health. Older LGB people may be subject to triple stigma around age, sexual orientation and mental health: being stigmatised for being old or having mental health issues where their sexual orientation is accepted, for their sexual orientation in older or mental health contexts, or stigmatised for all three in some situations.

4. Coping strategies available to manage minority- and stigmatisation-based stress through community cohesion are potentially not as widely accessible to older LGB people. This is because of a) ageist attitudes within the mainstream LGB social scene, b) other access issues and c) lack of availability of social opportunities specifically for older LGB people or LGB people experiencing mental health difficulties.

2.5 Older LGB People, Mental Health and Aging

The Mental Health in Later Life Inquiry conducted by Age Concern in 2007 notes that mental health needs are a common but not inevitable feature of ageing. The report states that one in seven people aged 65 and over has “major” depression which is severe and persistent and disrupts day-to-day functioning, and that this rises to one in four if we include all depressions which are severe enough to impair quality of life. Men aged 75 and over have the second highest rates of suicide amongst men (18.4 per 100,000 population). Women aged 75 and over, and women aged 45-74, have the highest and second highest rates amongst women (7.0 and 6.9 per 100,000 population). Between 71 and 95 per cent of older people who die by suicide have a diagnosable mental health problem at time of death. In addition five per cent of people aged 65 and over have dementia, rising to 20 per cent of people aged 80 and over and 33 per cent of people aged 95 and over. The Inquiry also reports that evidence has consistently suggested that knowledge of mental health issues is low amongst older people, and attitudes often negative.

Like other older people, LGB individuals may also be subject to added stressors (more common amongst their age group) which are theoretically likely to increase likelihood of developing mental illness. Poverty for example is more common amongst older adults and this may be particularly relevant to LGB communities: Heaphy, Yip and Thompson (2003) report that only half of a sample of 106 lesbians over 50 reported feeling financially secure. This is supported by
anecdotal evidence from Polari (e.g. in projects documented in River 2006 and Davies and River 2006). Older lesbians who have had children often experience financial exclusion because of diminished chances of accumulating financial security through adequate pension and savings, and the lower likelihood of being benefited by a male partner’s pension. Illness, loss of partners, isolation as a result of illness and role loss (through retirement or children leaving) may affect the psychological wellbeing of both heterosexual and homosexual elders. For some older LGB people, especially for older gay men, the loss of friends and community as a result of the HIV epidemic has increased their vulnerability. Perceived negativity towards LGB sexuality and expectation of stigmatisation are (as described) important stressors - 35% of Heaphy et al’s total sample of 266 lesbians and gay men felt vulnerable to homophobic violence and yet only 35% believed health professionals to be positive towards non-heterosexual clients, with 16% trusting them to be generally knowledgeable about LGB lifestyles. Perhaps this is why Department of Health guidance documentation on ‘Working with LGBT people’ describes older LGBs as 5 times less likely to access services.

Strangely however, despite all of the potential contributory factors outlined above, there has been little direct evidence as yet to suggest that older LGB people are at greater risk of mental ill health than their younger peers. Very little research has been done specifically with this sample. Yet, in both the King and McKeown (2003) and Warner, McKeown et al (2004) studies it was noted that older LGBs scored better on tests of psychological wellbeing than those younger. In a questionnaire survey of 266 lesbians and gay men of 50 and over, 29% of women and 27% of men felt that being non-heterosexual had had a negative consequence on their personal feelings of well-being (Heaphy, Yip and Thompson 2006). This is a significant number, but perhaps lower than might be expected from previous discussion. Grossman et al (2000), in a study of 416 gay men 60 and over in the US, found that 37% reported overall mental health as excellent, 47% good, 14% fair, 2% poor, 1% very poor. Most reported fairly high levels of self-esteem and low personal homonegativity (or internalised homophobia) - 80% were glad to be LGB and 17% wished to be heterosexual. Loneliness was experienced by many, but the mean level was exactly same as that found by Mullins et al (1987) for 62+ adults of all sexual orientations. 91% indicated they belonged to at least one LGB organisation.

Even earlier studies (taking place during a more overtly homophobic time) tended to show equal or greater adjustment amongst older gay men at least. Weinberg and Williams (1974) noted that, amongst 1117 gay men, those 45 and over did not differ from younger men in most aspects of psychological adjustment, worried less about exposure of homosexuality, were less likely to desire psychiatric treatment, and had more stable self-concepts. Berger (1980) reports that most homosexual men over 40 in his research were well adjusted and, in comparison to younger peers, reported less depression and fewer psychosomatic symptoms.
What must be noted from the above, however, is the manner in which participants have been recruited to such studies. Primarily this has taken place through adverts in the gay press or via LGB community organisations, and has tended to attract individuals who are already ‘out’ (95% in both the Heaphy et al and Grossman et al studies). As such, findings mainly reflect the experiences of people who are comfortable with their sexual orientation and who have found the kind of community support described as essential in negating the effects of stigmatisation. It is possible that these surveys are not reaching or reflecting a substantial number of isolated LGB people with mental health needs.

What is likely to be the predictive factor in mental wellbeing in these instances (given the social evaluation theories mentioned earlier) is welcoming and inclusive community or social networks. It is possible that some older people may have had more time and inclination to surround themselves with such groups, which in turn has helped them to become more positive about their own sexual identities. The evidence seems largely to support this view. 96% of women and 93.3% of men in Heaphy at al’s (2003) study consider friendships as important or very important – sometimes they were described as the most important people in their lives. The lack of such friendships may be presumed to have negative effects: 70% of lesbians who said they were isolated in Bridget’s 1993 study (cited in Bridget 1995) had attempted suicide. Furthermore, Grossman et al (2000) found that, of 416 LGBs of 60 and over, the only significant predictor of satisfaction with support networks was whether others knew of their sexual orientation – this in turn correlated with better emotional and mental status. This may be the reason for a reported higher participation of older LGBs in LGB rather than older networks: more than half (of 80) LGBs of 50 and over reported having participated in an LGB social group in one report from the US (Quam and Whitford, 1992). This contrasted with the 9% who had participated in a local senior club or centre. Another study found older LGBs evaluated social and support resources within local LGB communities more positively than non-LGB-specific services (Jacobs, Ramussen and Hohman, 1999).

Stigma (surrounding age or mental health issues) may prevent some individuals from accessing this kind of community. One significant finding in Heaphy et al’s study was that many older gay men noted the non-heterosexual media and commercial scenes were youth-orientated and indicated that being gay had made them more conscious of the ageing process. 54% said that they felt excluded from these arenas. The researchers note that other studies have confirmed this finding (e.g. Kimmel and Sang (1995); Berger (1996); Pugh (2002)). Older (admittedly non-UK) studies interestingly produced different results. Kelly (1976) noted that most gay men over 65 interviewed reported satisfactory social and sex lives, and Minnigerode (1976) also found no evidence that homosexual men perceived themselves as ageing sooner. Privileging of youth was found to be less of an issue in lesbian communities both now and in the past, though Polari has found anecdotally that older lesbians are now increasingly reporting ageism in lesbian venues and media. Ironically it seems possible that an atmosphere of supposed greater tolerance (compared to, say, the 1970s) has led to a commercialisation of LGB identities in place of previously self-organised
community groups. The commercialisation process has often resulted in greater exclusion for some LGB people who are older and/or disabled.

2.6 Summary
The aim of this section of the report was to present a body of evidence to justify that research into the needs of older lesbians, gay men and bisexuals is important and currently needed. Lack of prior research on the topic coupled with the identification of multiple risk factors within this population that could contribute to greater incidence of mental distress suggest that it is. Indeed whether or not older LGB people are at greater risk or in greater potential need, there is theoretical reason to believe that those who do experience isolation from a peer group or community are amongst those service users who are at greatest risk of continuing distress and/or relapse. As it seems likely that older LGB people have had negative views of statutory services as a result of history or fear of homophobia (as indicated by the DH suggestion that they are five times less likely to engage), there is an equal opportunities issue at stake. There is also a public health issue: certain disorders (for example Alzheimers-type dementia) carry with them much improved prognosis if intervention is early.

Also Herdt and Beeler (1998) note that increasing numbers of people are disclosing their sexual orientation for the first time in later life. Whilst there may be no conclusive evidence to suggest that doing so is inherently conducive to better mental health, it is likely that services must be prepared to encounter greater numbers of self-identified older LGB people as time goes on. The primary function of this report is to investigate whether all of these issues are currently pertinent, and to explore methods of addressing them identified primarily by users of services.

Nonetheless, it must be noted that there are problems inherent in presenting evidence such as that given above. Reducing the association between mental distress and LGB sexual orientation to historical patterns of minority oppression simplifies the issue. In fact pathologisation of LGB sexuality is seemingly tied up with ingrained societal perspectives on what constitutes mental or general wellbeing, for example the formation of traditional networks such as the family unit and procreative heterosexual relationships. As one participant notes in Rivers (2006), a qualitative study of LGB mental health service users and professionals, even well disposed workers may have sympathy for LGB people because they are thought to be unable to have children, or to have lives that are inherently more difficult. Such assumptions may inform their practice. In fact, this implicitly labels non-heterosexual orientations as impairments and doesn’t recognise that it is society that is disabling LGB people with its assumption of a single model of a life well-lived. Furthermore, the foundation of the medical model rests on the observation, pathologisation and management of difference (in so far as it impedes quality of life). The ‘out of the ordinary’ tends to be the standard explanation for ‘abnormal’ suffering. This puts the cart before the horse in this instance (as with the diagnosis of ‘ego-dystonic homosexuality’ retained on the WHO’s ICD-10). For example, ‘not coming to terms with your sexual orientation’
was (in Rivers’ research) one response from professionals to a service user who reported that her distress was nothing at all to do with this. It is not likely that living with an LGB identity inherently makes one unhappy, but rather that doing so in a society which does not widely accept an individual’s same sex desires, and choice to live with this identity, does.

Recognising stressors that put LGB people at risk of mental ill health is important, but there is an inherent risk of re-pathologising LGB sexuality in doing so. There is also the possibility that new stereotypes will be formed that will then contribute to a picture of LGB people as having ‘high-risk’ lifestyles – that there is greater risk of HIV, drug and alcohol use, suicidality, multiple partners and so on for every LGB person. Another participant in Rivers’ research noted comparable problems because professionals seemed to pathologise his relationship with his daughter: (‘but you’ll be bringing men friends home’) and questioning how this would affect her. In fact he was living a celibate life to concentrate on raising her as a single parent. There is also the possibility that, in viewing older LGB people as a distinct group with distinct needs, one produces a set rule of thumb for working with older LGB people. This would ignore individual differences and contribute to separation and segregation. Immediate disclosure of LGB status might result in referral to LGB services (were they, of course, to exist at all), while this might not be what the individual requires or wants, and mainstream services would become further heterosexualised. The aim of good equal opportunities policy and indeed the person-centred approach to care is to recognise and value individual differences, to identify factors that may prevent an individual from benefiting from a service in certain ways and to work to overcome them (e.g. Pugh and Williams 2006). At the heart of this is user choice and empowerment, which this project aims to foster in our recommendations.
3. Developments in Mental Health Services

This section aims to:

- provide a description of mental health services in lieu of a definition
- provide an overview of mental health services in Greater London
- describe some of the current developments within mental health services nationally and in London and suggest ways in which these may impact (or not impact) on OLGBs
- describe some of the issues specifically related to ‘older adults’ services’ and accusations of ageism therein.

**Glossary**

The **Care Programme Approach (CPA)** is intended to facilitate inter-agency working in the provision of care to people with mental health needs. Its 4 principle aspects are: a) a systematic assessment procedure for ascertaining health and social care needs; b) the formation of a care plan which addresses those needs; c) the appointment of a care co-ordinator to keep in close touch with the service user and monitor provision of care by various multidisciplinary professionals and d) regular review of the care plan.

**Cognitive behavioural therapy (CBT)** is a psychotherapy based on modifying cognitions, assumptions, beliefs and behaviors, with the aim of influencing disturbed emotions. It is currently a very popular treatment worldwide for a variety of disorders, due to favourable results obtained for patients.

The **Commission for Social Care Inspection (CSCI)** is the organisation responsible for inspection, regulation and review of all social care services in England.

The **Care Standards Improvement Partnership** is an organisation which aims to develop capacity and capability, support policy implementation and support the development of policy within social care. It is a partnership of four national programmes delivered through eight regional development centres, jointly commissioned by the Department of Health and the Strategic Health Authorities.

**Common mental illnesses** is a term used to refer to those illnesses which are most frequently involved in claims for Incapacity Benefit and are subsequently responsible for preventing people from working. They mostly include depression, anxiety disorders (e.g. generalised anxiety) and adjustment disorder. They don’t include chronic or acute disorders such as bipolar disorder or schizophrenia.
The Direct Payments scheme is a government initiative in the field of Social Services that gives users money directly to pay for their own care, rather than the traditional method whereby a Local Government Authority provides care for them.

A Foundation Trust is in a sense similar to a co-operative, in that local people, patients and staff can become members and governors and hold the Trust to account. They are different from conventional Trusts in that they also have the power to ‘buy in’ or commission services from particular clinics or hospitals if they are considered to represent better value for money or more effective provision than those currently administered. They can retain proceeds from land sales and borrow money to support capital investment (amongst other differences).

Local Area Agreements set out the priorities for a local area agreed between central government and a local area (the local authority and Local Strategic Partnership (made up of representatives from the voluntary, community, public and private sectors) and other key partners at the local level. LAAs are intended to simplify some central funding, help join up public services more effectively and allow greater flexibility for local solutions to local circumstances.

The Healthcare Commission is an organisation set up to promote and drive forward improvements in standards of healthcare in England and Wales, through providing an independent assessment of the standards of services provided by the NHS, private healthcare and voluntary organisations. The government intends for it to combine with CSCI by 2010.

The National Institute for Health and Clinical Excellence (NICE) is a Special Health Authority of the National Health Service in England and Wales. It publishes clinical appraisals of whether particular treatments should be considered worthwhile by the NHS. These appraisals are based primarily on cost-effectiveness. It is part of the CSIP.

The National Institute of Mental Health in England (NIMHE) is an organisation mostly sponsored by the Department of Health. It is responsible for supporting the implementation of positive change in mental health and mental health services.

Supporting People is a UK government programme helping vulnerable people live independently and keep their tenancies. It is run by local government and provided by the voluntary sector. It was launched on 1 April 2003.
3.1 Mental Health Services in London: An Overview

Statutory mental health services in London are provided by both the 10 NHS Mental Health Trusts and the 32 local authorities covering the Greater London area. As a broad distinction, the NHS provides clinical services (e.g. inpatient and outpatient treatments and therapies) whereas local authorities are responsible for social care arrangements. Social care could include support in the home via social services Social care (e.g. support in the home via social services or through support services commissioned and funded by Supporting People teams as well as some day services provided at community venues). Some services (such as resource or ‘day’ centres) are variously provided by either the NHS or a local authority, and increasingly by voluntary organisations commissioned by local authorities.

There is obviously a large amount of overlap between these remits, and the government has recognised this by placing emphasis on the effective provision of an integrated service. A discussion document produced by the Department of Health in 1998 entitled ‘Partnership in Action’ proposed that “For the right services to be delivered to local people at the time they need them, health, social services and other parts of local government must work together in partnership” (p8). In order to facilitate this, the Health Act (1999) modified existing working practices. This allows for lead commissioning (where partners can agree to delegate commissioning of a service to one lead organisation), and pooled funds (where partners have the ability to contribute agreed funds to a single pot, to be spent on agreed projects for designated services). It also allows integrated provision (where partners can join together their staff, resources, and management structures to integrate the provision of a service from managerial level to the front line).

In practice, this kind of partnership between local authorities and the NHS in the provision of mental health services varies across London. Camden and Islington Mental Health and Social Care Trust, for example, is a Partnership trust which aims “to ensure that mental health and social care provision can be properly integrated locally.” Services are jointly commissioned and are provided under a pooled budget. In other areas of London, whilst commissioning processes and budgets remain separate, mental health and social care professionals nonetheless work closely together. For example, the 1999 legislation allowed for the development of the Community Mental Health Team, intended as an integrated and multidisciplinary service providing social care and clinical intervention to populations within the community. For adults of 65 and over, CMHTs (or social workers/community psychiatric nurses on these teams) are often the primary source of interaction with statutory services. Where social care and clinical services are functionally separate, the use of the Care Programme Approach tends to ensure that there is joint multidisciplinary working between
agencies involved in drawing a plan of care for an individual and arranging for it to be delivered.

In addition to statutory services, a large number of voluntary organisations also exist which provide their own semi-clinical and support services such as counselling, advocacy and advice. A well-known and widespread example is the charity Mind. It has become increasingly common for local authorities to work more closely with the voluntary (or third) sector, involving it in the drafting of Local Area Agreements aimed at identifying service needs. It is also often the case that a particular authority will ‘contract out’ certain elements of mental health service provision to voluntary organisations – most frequently the running of a day (i.e. non-residential) service, or the provision of housing-related support through the Supporting People programme (as mentioned above). As such the ‘third sector’ may be considered a third (and significant) partner in the care of those who experience mental distress.

Finally, there are independent practitioners or companies who provide clinical and/or support services for profit. These too can be ‘contracted’ by a local authority – for example, in the case of a housing association or care group providing supported accommodation. In the case of social care in some instances they can be bought by an individual with money provided by a local authority via direct payments – for example, where support in the home is needed in order to maintain independence. Increasingly it is the tendency of some local authorities to levy the cost of providing care against payments received by an individual from the Department of Work and Pensions in the form of Disability Living Allowance. Likewise, in the case of private clinics offering ‘talking therapies’ such as counselling, psychotherapy or CBT in most instances an individual is liable for the cost of treatment.

In summary, the term ‘mental health services’ now covers a very broad area of provision in terms of the type of services and the providers. Considering what to include and what not to include within this scoping study was therefore a very pertinent issue. For further discussion of this, see section 3.

3.2 Mental Health Trusts

The trusts and the areas they usually serve are as follows:

- Barnet, Enfield and Haringey †
- Camden and Islington †
- Central and North-West London (covering Brent, Harrow, Hillingdon, Kensington & Chelsea and Westminster) *
- East London and the City (covering the City, Hackney, Tower Hamlets and Newham) †
- North East London (covering Barking and Dagenham, Havering, Redbridge and Waltham Forest) 
- Oxleas (covering Bexley, Bromley and Greenwich) 
- South London and Maudsley (covering Croydon, Lambeth, Lewisham and Southwark) 
- South West London and St George’s (covering Kingston, Merton, Richmond and Sutton) 
- Tavistock and Portman (a specialist centre in psychotherapeutic approaches to the treatment of mental health) 
- West London (covering Ealing, Hammersmith and Fulham and Hounslow)

For a recent review of the Trusts’ performance see Appendix A. At the time of writing, four (*) of the above have Foundation Trust (FT) status and five more (†) are in the process of applying for it. FTs are intended to represent a balance between public and private sector – they have a greater range of means for generating or directing capital than a traditional Trust. The move towards the provision of services in this manner is an important one both for providers and users. For users there will be more involvement in service planning and in the running of the Trust (for example through the appointment of non-executive directors). It is also intended that there will be a greater degree of choice for users in accessing particular services. Consequently, the use and success of a particular service may affect whether it continues to receive support from the Trust. Providers will benefit if they monitor more closely the needs of their catchment population. For instance if a particular service were to gain a reputation for providing LGB-friendly care amongst a large regional population of LGB people there would be opportunities for the Trust to generate income by offering a specialist psychological support service to employers for those LGB staff members who require it. The development of more effective methods of sharing user ratings of particular services might be a useful outcome of consultation exercises such as this (see section 10.5).

3.3 Local Authority Social Care Services

The 32 Greater London local authorities along with 2007 ratings of their adult social care services as provided by the Commission for Social Care Inspection are listed in Appendix B. Adult social services are not, of course, specific to individuals with mental health diagnoses: they provide generally for individuals who need some assistance in order to live independently. The rationale behind providing this information in the appendix is to provide a context for the responses of project participants receiving services in these areas.
3.4 National Service Frameworks for Mental Health and Older People

The National Service Framework for mental health was published in 1999 as part of a series of policy documents aimed at defining standards of care for major medical problems in England. It consists predominantly of a set of seven standards covering mental health promotion, primary care and access to services, effective services for people with severe mental illness, individuals who care for people with mental health problems and action necessary to reduce national levels of suicide. As a very brief summary: amongst many other points it underlines the role of the National Institute of Clinical Excellence in developing protocols for the treatment of various disorders. It sets out the necessity of effective use of the Care Programme Approach, emphasises the need for 24 hour access to and availability of services (and describes roles to be created to facilitate this). It also outlines appropriate hospital treatment (i.e. that is as unrestrictive as possible and close to service users’ homes). For a full copy of the document, visit the Department of Health’s website at www.dh.gov.uk. More detailed discussion of some of the standards more directly relevant in the context of this study will take place below.

This National Service Framework was one of the first two to be published (the other relating to coronary heart disease), and reflected data suggesting that mental health problems are one of the leading causes of ill health and disability in the country. It was described explicitly as applying to ‘adults of working age – 18 to 65,’ (p4) and thus is ageist (ignoring the fact that many adults work beyond the age of 65). The distinction would now seem to be at odds with the Employment Equality (Age) Regulations (2006) prohibition of age discrimination in employment. A Service Framework specifically targeting older adults’ services was originally promised for Spring 2000, which was supposed to include standards for older adults’ mental health services. In the meantime, £700 million over three years was pledged by the government in order to help the NHS to meet the new targets set.

The NSF for Older People actually arrived in 2001. One mental health professional interviewed over the course of this study described the situation thus:

‘It was widely believed that the money that followed the NSF for mental health was (like the document itself) intended for adult services. Therefore, by the time the NSF for Older People was published there was basically little or no money left for older adults’ services and no more money was forthcoming.’

The National Institute for Mental Health in England notes that “It is widely acknowledged that the mental health and well-being of older people has been neglected across the spectrum of promotion, prevention and treatment services,”
(Age Concern 2007, p33). The key issue is that there is an element of age discrimination inherent in mental health services which foster a division of adults into ‘working’ and ‘retirement’ age for the purposes of service planning and provision – as a general rule, such a process is common to statutory services. Reviews of the NSFs have also accepted that a disparity exists – for example, ‘Living Well in Later Life’ (a 2006 joint review of the NSF for Older People conducted by the Audit Commission, the Commission for Social Care Inspection and the Healthcare Commission) stated that ‘the organisational division between mental health services for adults of working age and older people has resulted in the development of an unfair system, as the range of services available differs for each of these groups,’ (p62). The Department of Health paper ‘Securing Better Mental Health for Older Adults’ (2005) also recognised that “Older adults with mental illness had not benefited from some of the developments seen for younger adults, and some of the developments seen in older people’s services were not fully meeting the mental health needs of older people.”

Age Concern published a report in 2007 based on their Mental Health in Later Life Inquiry (MHILLI). It too argues that the current mental health system is failing older adults, pointing to statistics such as the following:

- Only six per cent of older people with depression receive specialist mental health care – this is probably due to under-reporting and under-diagnosing as well as inequity in services.

- Most older people who take their own lives have diagnosable mental health problems but only a small minority are in contact with specialist mental health services.

- The majority of older people with mental health problems rely on unpaid care from friends, family and neighbours, or do not receive any support at all. One in five of all male carers and one in six of all female carers are aged 65 and over. Two-thirds of carers who provide more than 50 hours a week say that caring has affected their health.

The MHILLI report acknowledges that there has been some response from the government to these concerns. For example, in 2005 the Department of Health established a programme board for older adult mental health services to oversee progress and to ensure that its commitment to age equality (as expressed in documents such as ‘A New Ambition for Old Age’ (2006)) is worked towards in service provision. From 2007 onwards, however, it is claimed in the MHILLI report that the programme board ‘no longer has dedicated support from within the department and its future looks uncertain. Given the historical neglect of older people’s mental health issues, the loss of a co-ordinating body is cause for concern.’ The Mental Health in Later Life Inquiry concludes that there is a significant need for a fundamental review of the way in which mental health services are provided to older adults, with the caveat that ‘Older people’s mental
health needs will not be served by moving from the directly discriminatory assumption that older people need only older people’s mental health services, to the indirectly discriminatory assumption that they can be treated identically to younger adults.’

To clarify, in line with the NSF for Older People (which states that “[older] patients with complex mental health needs can and should be treated and supported in the community and wherever practicable at home” (Department of Health 2001 p104)), the primary form of first contact and ongoing treatment with adults of 65 and over in London are specialist older peoples’ Community Mental Health Teams (CMHTs) which work predominantly in the community. Every borough also has a complement of targeted inpatient services for acute cases as well as several day services predominantly aimed at individuals with functional and organic disorders (e.g. dementia). Some boroughs also provide other specialist services, such as memory clinics or psychological therapies.

Most Trusts in London operate on the principal that if a service user currently receiving statutory services turns 65 (or ‘graduates’) within that service they will generally be able to access related services that are technically for working age adults only – for example, assertive outreach or psychological therapies. (However they will often be referred on to older adult services, representing some break in the continuity of their care). This reflects the fact that relatively very few older adults present for the first time with serious mental health conditions other than organic dementia (see Mental Health in Later Life Inquiry). However, some NHS staff have reported difficulties in referring older adults to ‘working age’ services, particularly psychological therapies.

3.5 Primary Care Mental Health Provision / Availability of Psychological Therapies

Primary care has always had a major role to play in mental health service provision, since just over 9 out of 10 people who present with mental health needs will be treated solely at this level. The National Service Framework for Mental Health (Standards 2 and 3 in particular) emphasises the importance of offering effective assessment and treatment at this stage, access to further services if necessary and round-the-clock advice and support (via NHS Direct and/or referral to local services).

There has in the past been a suggestion amongst user groups and others that GPs lacked the specialist expertise to adequately assess and treat common mental health problems, and have tended to over-prescribe antidepressants whilst onward referrals to psychological therapists or therapists carried with them extensive waiting times. NICE guidelines (in particular on depression) have tended to emphasise the effectiveness of talking therapies in treating such ‘common’ problems. Cognitive behavioural therapy (CBT) in particular has
been associated with non-relapsing recovery at percentages as high as the 70s in conjunction with medication for depression, with similar and sometimes even better results for anxiety disorders. Its effectiveness seems to carry over into group and even computerised settings. Some studies have even shown a moderate effectiveness of CBT in helping individuals to manage symptoms that are often associated with a diagnosis of schizophrenia (when used together with anti-psychotic treatment (e.g. Zimmerman et al 2005)).

Against the background of this evidence, the Layard Report was published in 2004 by the Centre for Economic Performance at LSE, arguing that talking therapies (though expensive to provide) would pay for themselves by reducing the benefits bill and helping people back to work. Consequently, in 2006 the DH launched the Increasing Access to Psychological Therapies programme as a key policy objective, reflected in the document ‘Our Health, Our Care, Our Say: A New Direction for Community Services.’ What is proposed is a ‘stepped care’ model for the treatment of common mental illnesses; the principal is that widely available but less intensive interventions (e.g. 6 weeks of counselling or computerised CBT) represent best value in terms of effective treatment outcomes.

As such, Primary Care centres now often have attached counselling services or (in some instances) Advice and Brief Intervention Teams. These often operate out of community venues such as libraries and are able to teach coping strategies, offer brief interventions such as those outlined above and refer on to specialist services if necessary. ABITs are also accessible via the telephone or internet, making them easier to engage with for people who find it hard to leave home due to mobility needs or caring responsibilities. Given the high rates of common mental illness amongst older adults described in section 1 of this report, it seems evident that they too would benefit massively from access to this service. However as the above survey showed, ABITs provide services to adults of ‘working age’ only. One can only speculate that (given the fact that these teams owe their existence in part to an economic assessment of their ability to get people back into work) professionals wish to avoid the service being flooded by adults of retirement age and as such compromising their outcomes and justification for further funding.

Mental health professionals working with older adults interviewed over the course of this study have reported that they often struggle to refer their clients to psychological therapists, even where it is clear that doing so represents the best intervention for that individual. The Mental Health in Later Life Inquiry also claims that ‘older people are rarely offered psychological therapies despite abundant evidence that they are just as effective as antidepressants for older people, with the added advantage of not interacting with other medications.’ One study in particular reported that 57 per cent of older people, especially women, preferred therapy and counselling to medication (Cuijpers et al 2006).
It may be that in the future, if it can be proven that access to psychological therapies does indeed provide a partial solution to the economic problems presented by the ‘epidemic’ of mental health needs, such services will be extended to older adults as their numbers increase. Indeed, there is economic justification for such a move – people aged 50 and over contribute £230 billion per year, or around a quarter of the total UK economy (Meadows 2004). Even when not working, their contributions as unpaid carers, grandparents and volunteers total £24 billion per year.

3.6 The Recovery Model

This is an approach to the delivery of mental health services to individuals with need of them as well as a mode of viewing oneself as a user of such services. The main impetus for its development came from the so-called ‘survivor’ movement of ex- and current service users, as well as the changes wrought by the transition to community-based care in the 90s. This was supported by data from large cross-national studies conducted by the World Health Organisation which showed unexpectedly high rates of ‘complete recovery’ (20 to 25%) and ‘social recovery’ (40–45%). With a political analysis comparable to the social model of disability, it proposes that total recovery is achievable for individuals with mental health needs, and that often it is society and its values and organisational structures that present barriers to this recovery.

Reflecting this, definitions of recovery tend to be broader than ‘improved assessment of function’ or lack of requirement of treatment intervention. The National Institute of Mental Health in America for example defines it as follows:

"The uniquely personal and ongoing act of claiming and gaining the capacity to take control of life that is personally meaningful and satisfying, with opportunities to perceive her/himself as a valued citizen. The person may develop and use their self-determination to grow beyond and thrive, despite the presence of the limitations and challenges invited and imposed by distress, its treatment and the personal and environmental understandings made of them."

This model has increasingly influenced the NHS over recent years. One example is the development of Support, Time and Recovery Worker posts aimed at offering necessary support for individuals living with chronic mental health needs to become included and engaged with their communities (for further information on social inclusion, see below). In addition to this a general trend towards service user empowerment is in evidence. Several trusts have developed User Involvement Programmes and/or User Networks and forums, have made it possible for service users to be involved in the running of the trust through the appointment of non-executive directors (in Foundation trusts).
They have in some instances appointed salaried officers (often service users or ex-service users themselves) responsible for co-ordinating involvement activities and proactively engaging with users.

Of particular relevance within the context of this study is the continued role which meaningful relationships with others, and the ability to develop and sustain such relationships, play in recovery. These may include supportive friendships as well as partnerships. Previous work by Polari and others has tended to find that some workers struggle to comprehend sexuality in older people except as a ‘behavioural problem’, or assume that (because they may be more reticent in talking openly on the subject) the issue is of little importance to older people. In fact, the stereotype of the older LGB person as lonely, sad and isolated, whilst negative and unhelpful both in the context of care provision and across society, can sometimes be relevant, due to discrimination and lack of community resources. Where older LGB people seem isolated this may be the result of exclusion from ageist commercial LGB venues and activities, lack of provision for older LGBs, and lack of knowledge on the part of professionals of what services and opportunities do exist. Also, where close and indeed integral friendships have developed in lieu of family ties lost or never forged, professionals have sometimes failed to recognise the significant input and role played by these significant others and their potential involvement in, and role in informing, decisions about care. Indeed the very notion of multiple significant others is too little understood outside of the field of HIV care. In order to effectively promote recovery amongst older LGB people, an understanding of the barriers to inclusion that are faced is needed, along with a respect for how such individuals have chosen to lead their lives.

Furthermore, whilst service user involvement initiatives are an invaluable development, they seem in some instances to rely on tenuous or temporary funding, as reported to us by one of our service user respondents who had been an Acute Liaison Officer until the funding for this ran out.

Also, concern about homophobia from other service users or of being ‘outed’ in their communities by these users may prevent individuals from becoming involved in groups, in spite of the fact that, ironically, these are aimed at empowerment (see sections 4 and 6 for more details).
3.7 Social Inclusion

As discussed above, the phrase ‘social inclusion’ generally refers to the attempt to remove barriers that prevent a person or a group of people from engaging with and benefiting from society to the extent they choose, and society in turn benefiting from their skills and abilities. It is currently considered a priority policy objective by the Department of Health; Standard 1 of the National Service Framework suggests that ‘health and social services should promote mental health for all, working with individuals and communities’ (p7). The remainder of the section goes on to discuss the manner in which ‘mental health problems can result from the range of adverse factors associated with social exclusion’ and can also be a cause of social exclusion. For example, this could be through direct and indirect workplace discrimination, through social stigmatisation or through financial exclusion and debt related to dependence on benefits. The ‘Mental Health and Social Exclusion Report’ (published in 2004 by the office of the Deputy Prime Minister) also underlines these problems, and has led to the development of a National Social Inclusion Implementation Team co-ordinated by the National Institute of Mental Health in England.

Priorities and arenas of work for this team are outlined at www.socialinclusion.org.uk In brief, the agenda has included (with brief examples):

- encouraging individuals to take up Direct Payments to buy services independently in lieu of directly provided mental health services
- increasing access to educational opportunities (e.g. through subsidising courses for those on low income)
- tackling employment discrimination and supporting people back to work (e.g. through the appointment of employment support officers within the NHS who are tasked with working with employers in order to help them meet the needs of employees with mental health needs, as well as with service users in order to help them to develop the necessary skills or confidence)
- tackling housing problems amongst people with mental health needs (e.g. by providing information resources with regards to housing and benefits)
- making the transition from benefits to work more easy (e.g. by creating a financial safety net, making it possible to return to previous levels of Incapacity Benefit after up to two years of work)
- improving access to volunteering and arts opportunities (e.g. by transforming traditional day services into community resources)

As mentioned in section 1, the association of stigma with both age and with a history of using or needing mental health support was observed amongst members of the LGB community firsthand over the course of this study and indeed has been documented elsewhere. The NSF suggests that work with
specific communities should take place in order to promote health for all. Possibly the (older) LGB community could benefit from outreach work or publicity about facts, services and resources. As discussed in section 9 below, however, this is unlikely to take place until realistic levels of need of LGB individuals have been measured, underlining the importance of monitoring for sexual orientation.

Previous work by Polari (Hubbard and Rossington, 1995) and others (e.g. Heaphy, Yip and Thompson 2004) has identified housing as an area of particular concern for older LGB people concerned about their changing needs as they age and the level and appropriateness of provision available to meet these needs. As a result of encountering homophobia it is seemingly harder for older LGB people to achieve the stability in housing that is recognised by the NIMHE as essential for good mental health (see section 6 for illustration). This is exacerbated by the reduced financial security experienced by many lesbians referred to in section 1).

Support into employment has been massively appreciated by most service users interviewed who have had the opportunity to make use of such schemes. Sometimes these have been provided by the NHS (as described above with regards to User Involvement Projects), others from the voluntary sector. Some participants however have reported experiencing continuing discrimination and difficulty in getting back to work, despite a strong desire to do so.

### 3.8 Day Services

Changes to day services are listed as an important aspect of the social inclusion targets described in section 2.7 above. A significant report from 2006 is entitled ‘From segregation to inclusion: commissioning guidance on day services for people with mental health problems.’ (National Institute of Mental Health in England (2006) ). The report suggests that the old model of day service provision (a discrete centre providing social and group therapeutic activities specifically for people with mental health needs) contributes to segregation of this population from the community at large. Consequently this contributes to stigmatisation, to the extent that people do not wish to use the facilities. This approach, it is argued, should be replaced by a drive to support people in accessing existing opportunities in their local community. Where ‘segregated’ services are offered, these should be held in community venues where possible and should provide opportunities for socialisation with others who do not have mental health needs. It is also emphasised that these services should ‘address the diverse needs of different groups within the population, especially those who have historically been poorly served, being mindful of the need to provide services that are sensitive to age, gender, ethnicity, religion, sexuality and disability and explicitly meeting those needs in their design (p5).’

The survey of day services carried out as part of this study (see section 7) found that indeed large numbers of these facilities are in the process of closing or
redeveloping themselves as community resource centres offering skills-based training and support into employment. It was wondered whether older people might have comparatively less interest in seeking employment and would suffer from the access issues associated with a reduction of previously available social outlets. Indeed, there was some lamentation at the loss of familiar settings and services due to the closing of day centres where group support had been valued.

As section 5 highlights, a large proportion of day services at present cannot receive referrals for adults of 65 years and over and are therefore not accessible to some of the most excluded people. This is despite the mandate of the commissioning document to consider diversity and minimise social isolation. Also, inclusiveness of LGB people was not always possible because of assumed conflicts with the ethos of service providers:

*We are not able to display materials or information relating to lesbian or gay people or community organisations because our day services are run from Christian community venues, and I feel that they would be displeased if we were to do this.*

Day service manager

The report also emphasises the importance of maximising user empowerment. It suggests that it is essential to use ‘the expertise of those with personal experience of mental health problems in designing and developing services, including those who may not be using existing day services because they find them inaccessible or unacceptable (p5).’ Furthermore, it encourages professionals and commissioners to support service users who wish to develop their own services as much as possible. They should also ‘Promote contact with, and support from, people with mental health problems who have successfully resumed their previous roles, relationships and activities, eg via mentorship systems, self-help groups or peer support (p10).’ In every instance, service users interviewed in this study have expressed an interest in forming such a group if support was provided to do so.

**3.9 The Mental Capacity Act (2005)**

Coming fully into force in October 2007, this Act aims to protect and empower individuals who may lack the capacity to make decisions through illness, disability or injury. It provides a clear framework in order to promote common understanding of how to care for such individuals. It is of particular relevance to many older people given the higher occurrence of progressive dementia within this age bracket.
Prior to the implementation of this statute, situations in which close friends or even partners of LGB people had been suddenly ousted from the provision of care or involvement in decisions relating to them by family who had been previously estranged for years were not uncommon. With no clear common guidance for best practice, local authorities or care trusts tended to automatically defer power of attorney to the family of origin where possible. For example, as one participant of this research described:

‘I was caring for a close friend (P) who was suffering an extreme form of dementia, and had been doing so for eight years. He had been in the care of social services for ten years and was in the care of the NHS for the last year and a half before he died. We had been close and affectionate friends for 40 years. We weren’t partners – I think such friendships are as important if not more so to gay people. I was involved in all meetings about his finances, care and mental state and I would help in other tasks where he would get confused and distressed otherwise, such as bathing or denture fitting or eye tests. P needed someone who knew him well to ask the correct trigger questions to spark the few memories that he did have left.

After years of minimal contact (initiated by myself) his brother and sister arrived from Ireland. They went to see the finance officer to see what money he had, and decided they wanted me out. My visiting P and taking him out had kept him afloat. I have a strong suspicion that they excluded me because I was gay – P had never discussed his sexual orientation with them at all. They were concerned to know if he had made a will - I wasn’t in it, I insisted that there was no ulterior motive to my care. Social services colluded with the family, and I was no longer invited to meetings. They eventually pressed for him to be removed from his care home and put in a mental hospital. I continued to visit almost every day, but the staff there totally eliminated me from his care even though obviously he was terrified by the situation and couldn’t communicate his needs to staff. I wrote to the psychiatrist to request involvement in P’s care, and was told that he couldn’t discuss the case with me because of confidentiality requirements. When P finally died I wasn’t allowed to attend his funeral by the family.’

The current Act would *theoretically* pre-empt the possibility of a repetition of such events by:

a) allowing for the development and sanctity of a ‘Living Will,’ in which (whilst they still have capacity) an individual may describe how he/she would like to be cared for and by whom in the event that they lose capacity  
b) even if such a formal document has not been written, the Act still requires professionals acting on someone’s behalf to consider their expressed wishes when they had capacity, especially if they were written down
c) allowing for individuals to appoint an attorney to act on their behalf in the event that they lose capacity in both matters relating to their finances and personal care

d) requires consultation of any person caring for an individual when making a decision with regards to their best interests, which includes close friends and carers as well as family and

e) allowing for disputes about particular situations to be mediated by an independent advocate or (eventually if necessary) to be heard by a Court of Protection.

Polari also has anecdotal evidence of chosen friends being supplanted through the intervention of professionals by family of origin in the care and decision making about disabled LGB people both before and after the Mental Capacity Act 2005. The older LGB person in the situation described above still feels that the Act needs to be ‘contextualised for LGB people.’

3.10 Carers Support

Of direct relevance to the above is the availability of appropriate support for carers of individuals with mental health needs. Standard 6 of the National Service Framework for mental health states that ‘All individuals who provide regular and substantial care for a person on CPA should have an assessment of their caring, physical and mental health needs.’ Issues with regards to access to appropriate services, treatment within those services, perceptions of the NHS and other care providers and so on will potentially be as relevant to carers of older LGB people with mental health needs as to the service users themselves. That being so, interviews carried out over the course of this research aimed to include and reflect the views of this group.

3.11 Summary

There is increasing recognition that ‘care in the community’ has often, in spite of good intentions, led to increased isolation, persecution and segregation for mental health service users. New emphasis on social inclusion and community integration has no doubt resulted in improvement in the quality of life for many people experiencing mental distress. Nonetheless, it also raises particular issues and challenges, particularly in this context. Through being visited in their own homes, the domestic and social lives of older LGBs are more likely to be exposed to professionals, requiring a greater degree of trust from users and a greater need for good practice on sexual orientation issues. In order to support users to engage with those elements of the community that they wish to, there is greater need for support staff to have non-judgemental attitudes with regards to sexuality, sexual behaviour and user choice. Also, if staff are to help individuals
to integrate with a community, they need to understand that community and to some extent what it can offer. For example, the contemporary psychologist referred to in section 2 (who advocated a change in sexual orientation where an individual was unhappy because of the so-called nature of ‘the scene’) displayed a total lack of insight into the diversity of LGB lives. He had no understanding of ways in which LGB people commonly find and maintain social networks (both within LGB-specific arenas and without).

In terms of day services, it is to be applauded that current policy recognises the need for support to be given to help service users to plan and run their own provision, and indeed recognises the benefits to both helper and those helped in peer support situations. However, user choice is a crucial form of empowerment. The Mental Capacity Act (2005) represents good practice in this area. If services are taken away without consultation, even if they are perceived by non-users as having a detrimental effect, the likely outcome is a sense of expendability and lack of self-efficacy amongst those who have wanted the service to continue.

It appears that, in recent years in London at least, access to a wider range of mental health services is becoming possible for older people. However, closing advice and brief assessment services to this group (as discussed in 3.5) represents a missed opportunity and the denial of a useful service to those who need it. Its accessibility within the community, the high rates of common mental health problems amongst older adults and the scope for education about mental health issues provided by the service make it of particular benefit to this age group.

This research should aim (where relevant and possible) to explore some of these contemporary issues and their impact on older LGB service users.
4. Methodology

4.1 Advisory Group

Before beginning any planning or development of the project, an advisory group made up of older LGB mental health service users, mental health professionals and voluntary sector workers was convened. They met subsequently every three months, at which all developments were discussed. The advisory group had significant input into the content of research materials developed, recruitment strategy and the overall aims of the work.

4.2 Sample

This project was intended primarily as an explorative scoping exercise with the aim of providing an overview of the issues facing older LGB people in accessing and using mental health services. There was of course the possibility that areas requiring further research utilising an experimental method would be highlighted over the course of the work. At this stage no specific research question was adopted.

The challenge therefore was to decide upon a sample that would be inclusive enough so as to attract participants from a disparate and hard-to-reach population and that would allow for the inclusion of individuals with varied histories of interaction with different mental health services. Yet at the same time it needed to produce results that would be relevant to the provision of statutory services at present. These would have to be specific enough to allow for useful feedback to particular providers (given the intention of the project to empower users to be involved in the development and improvement of the services they require).

The fact that the term ‘statutory services’ potentially encompasses a huge variety of interventions and schemes (from housing services to psychological therapies) provided by differing bodies, further complicated the issue. It was also recognised that users may not necessarily differentiate themselves between the ‘statutory’ and ‘voluntary’ services that they access, and indeed making such a distinction was difficult at times for the researcher. Does an LGB drop-in centre previously funded charitably but now mostly supported by a local authority and PCT constitute a statutory or voluntary service, for example?

Another difficult issue was whether the sample should be limited strictly to individuals who were current users of services. Doing so would of course provide information more pertinent to contemporary frontline workers. However, it would
also potentially exclude people whose experiences or views of mental health services were so negative that they were prevented from presently making use of them. The same applies to individuals with access needs that they experience as being uncatered for.

It could be argued that no one really chooses to use mental health services, and that once a need becomes significant enough an individual will be compelled to present in one way or another. Indeed, it could be said that it is only really this group that we should be concerned with in a study such as this. Yet, perception of services is important in an age when the NHS is increasingly seeking to present itself as an organisation that aims to promote health in addition to treating the unwell. It is also important to consider the effects of the expectation of stigmatisation (that were described in section 1). For instance, if an individual believes that professionals at a drop-in or assessment service will treat her with respect, will take her issues seriously and that she will be safe from abuse or threat in the environment in which the service is provided, she is surely more likely to access that service by her own will. It is then possible that this intervention, in the long run, pre-empts or postpones a later need for more serious treatment or hospitalisation. In relation to the progression of any of the dementias common in old age, the financial and compassionate need to develop conditions that encourage early presentation is obvious, as decline (and subsequent dependency) can be slowed but not reversed. Even if later hospitalisation is required, the attitudes of those needing mental health support towards environments offering support are likely to be one predictor of the success of the outcome (e.g. Carlson and Gabriel 2001).

Given these considerations and following consultation with the project advisory group, the following definitions were agreed upon:

1) Participants should be 50 or over. It was felt that (based on the reported difficulties encountered by previous researchers attempting to investigate LGB issues in dementia care) targeting users of older adult services only would make recruitment of a substantial sample too difficult. There was some further justification for using this cut-off, in that people of this older age group might have been users of adult services during the period in which invasive therapies to treat homosexuality were most used. The advisory group were concerned that negative experiences or those of other LGB people known or heard of might have deterred an older age group from seeking help from the mental health services, however difficult their symptoms were to live with.

2) Participants should have used mental health services predominantly in the Greater London area. It was felt by professionals in the advisory group that London was fairly unique in the number and type of services provided and the experiences of users may be similarly unique to the area. It was also useful to constrain recruitment to this area because of the capacity of the project, and because of the need to provide relevant feedback to a clear geographical area of
providers. In terms of inclusiveness, however, it was felt that constraining the research to one or two mental health trusts would have been too limiting. In Polari’s experience working in London boroughs 2002-5 (see Davies and River, 2006) the older LGB population who have been prepared to answer calls for engagement tended to be quite dispersed.

3) Participants should have used services of some kind in the last five years (so as to represent a contemporary experience). Five years had passed since the findings of ‘Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales’ (King and McKeown 2003) were made known. This in turn was published five years after ‘Diagnosis Homophobic’ (Macfarlane 1998). Some indication of any changes that seemed to have occurred in the five year periods between each of these studies could be made (despite the comparatively small scale of this one and its focus only on older users).

4) The sample should include carers of LGB people with mental health issues (whether they themselves were LG or B or not). Carers’ perspectives are underrepresented in the previous research, and if they could be included in the study they might provide insight into difficulties faced by users of mental health services currently too ill to take part in this project as well as those experienced by the carers.

5) The size of the sample should be undetermined. There exists no reliable data to indicate the number of older LGB people currently using mental health services in London. It is therefore impossible to aim for a sample size based on a proportion of the total population. Nonetheless, it was agreed that a minimum of twelve individuals should be interviewed.

6) The sample should aim to be representative in terms of gender, professed sexual orientation, age (within the parameters of the project), location, ethnicity and disability. Once again, with no data available to indicate the spread of older mental health service users who identify as LGB, it is impossible to know whether a sample is truly representative or not in this instance. Nonetheless, the study should seek to present the particular issues faced by individuals who vary across the categories described above, as they may differ significantly.

7) For the purpose of admission within the sample, ‘mental health services’ should be deemed to include any help sought out or given to an individual with the purpose of improving his/her mental wellbeing. This could include services provided by the voluntary sector, local authorities and the NHS. The reason for this was that anecdotal evidence from workers at LGB voluntary sector projects suggested that users with significant support needs were utilising their services and yet refusing to engage with public sector professionals due to negative past experiences. Opening the sample as widely as this would allow for the inclusion of these people and their views for the purpose discussed above. However, some
elements of the study should target use and/or views of NHS services in particular since these are generally the most widely used.

8) GPs should be excluded as an instance of a ‘mental health service’ as described above in order to avoid repetition of work. Although the large majority of individuals first present to their GP with mental health concerns, Polari (as part of partnership work with Age Concern) was undertaking, during the same period as the study, research looking specifically at the experiences and expectations of older LGB people in visiting general practices.

4.3 Sexual Orientation

Categorisation of sexual orientation is another consideration worth mentioning at this point. Considerable discussion could indeed take place on the necessary criteria for inclusion in such a category, or indeed on the existence of such a process of categorisation as a social construction. As noted by King et al (2003), an established definition of an LGB person is ‘one with an orientation towards people of the same gender in sexual behaviour, affection, or attraction, and/or self-identity as gay/lesbian or bisexual.’ For the purpose of recruitment for research, it is infinitely simpler and likely to be more acceptable to users to target publicity to individuals who would describe themselves as lesbian, gay or bisexual or who relate in some way to a self-concept that such terms are supposed to refer to. It would be difficult, and probably unacceptable to seek to administer questionnaires asking individuals to detail the contents of their sexual fantasies and experiences. Indeed, the former is the approach that was used throughout this project.

Nonetheless, it must be noted that at least some older people who experience sexual attraction or partnership affiliation predominantly to/with members of the same sex would not use terms such as lesbian, gay or bisexual to describe themselves or their behaviour. These individuals are quite likely to be under-represented in a study such as this, being less likely to respond to advertisements displaying words that have no personal salience (at least of a positive kind). There seems to be no obvious way of overcoming this difficulty, although possibilities will be discussed in section 8. This is just one of numerous examples (to be highlighted throughout the report) of the difficulties involved in attempting to consult with a minority within a minority group.

4.4 Recruitment

Most of the previous research studies aiming to recruit LGB people as participants have tended to initially attract interest with targeted adverts in the gay press and through pamphletting LGB community and social venues as well as LGB-specific voluntary organisations. Then to increase numbers through
'snowball sampling' (in which each participant is asked to pass information about the study on to friends).

As a basic approach, this method was adopted for this project. Also incorporated were the venues that were used during various community events including LGBT History Month, the London LGBT Film Festival, Pride and several LGBT-themed conferences. In addition, individuals eligible for this study and already known to Polari who had previously expressed an interest in being interviewed were contacted and asked to help 'snowball.'

There are, however, problems inherent in this technique. By focusing on places and events associated with the LGB community, the resulting sample is inevitably biased towards individuals who relate to this self-identification. It will overrepresent those who are comfortable or confident enough to approach groups constituted predominantly of LGB people and indeed who feel sufficiently safe and psychologically ready to claim an identity as lesbian, gay or bisexual and to be recognised as lesbian, gay or bisexual by others. Keeping in mind the nature of the target sample, it could be argued that the readership of the LGB press is limited to people who don’t mind buying or receiving such publications, who can afford them, and who are able to keep them privately, if they need to. It might exclude those who keep live with family, who are supported by staff or live together with other residents. Indeed readership may also be limited people who find these publications relevant to themselves (given the typical youth focus of much of the LGB press). Likewise, the ‘snowballing’ technique, though capable in principle of reaching more isolated individuals, tends to produce a group constituted of people known by other LGB individuals, and those more likely to be ‘out’ as lesbian, gay or bisexual. It tends also to produce one that is fairly homogenous in terms of ethnicity and socioeconomic status, and possibly in age cohort generation. This last is important when the ‘over 50’ target group could, theoretically, include individuals born in any one of five decades. Any lack of diversity in the original group contacted is likely to be increased geometrically.

Various possible solutions to these problems presented themselves. Potentially the simplest was to advertise in generic community newspapers. Local advertising across Greater London not only would be a very expensive venture but Polari’s previous experience in two different projects (Davies and River 2006, River 2006) had seen negligible response from such efforts and financial outlay. It was therefore not tried in this instance.

Another strategy was to use LGB internet communities. This seemed a helpful possibility as a method of reaching both physically and socially isolated individuals, as well as those who were not ‘out’ yet to others. Inclusion in such communities (and indeed contact with the researcher) could potentially be anonymous through the use of online pseudonyms and message systems, so that even email contact could be avoided.
On the other hand, despite the potential opportunities offered by online publicity, such a method discriminates against those are not acquainted with or do not regularly use the internet or do not have the skills to do so. It also may exclude those who can only use internet sites in public places such as libraries that ban access to certain LGB sites because of sexual content, or where accessing an LGB site might out the individual to other internet users present. Despite the great increase in 'silver surfers' older people are less likely to have private access to the internet.

In spite of these concerns it was decided to use the internet as well as other systems of publicity. Advertisements about the project were posted on the message boards of all relevant sites where this was possible. It might have been possible to contact messageboard participants individually when their age was known. However it was decided that to do so might be intrusive, might antagonise people or lead them to believe that some negative association was being drawn between age and mental health problems. It is probably for this reason that one particularly prominent LGB site did not accept a request to promote the project. Instead the researcher included a mention of the project on his own profile with directions on how to find further information for those interested.

Perhaps the most obvious tactic used was to target with publicity general mental health voluntary organisations (including carers support and user movement groups) and of course NHS and local authority venues. In the case of the former, it was often possible to include information in user newsletters, which seemingly solved most if not all of the issues of difficulty outlined above. In those NHS mental health trusts in which we were given approval to advertise in this way, two also had newsletters for users. In instances where these were not available, posters and card fliers were sent to CMHTs, trust venues, drop-ins, advocacy centres etc with a request attached for staff to pass details to users who they felt might be interested. Organisations serving minority ethnic, disabled and older people were contacted, as were women’s centres. CMHTs, resource centres with outreach and various similar schemes were also visited, where permission was granted to do so, in order to raise awareness.

With regards to local authority resource centres and services contracted or funded by local authorities, none of the individual borough leads on research governance gave permission for this to take place within the time scale of the project. This was despite Polari receiving approval to advertise in these venues from the Association of Directors of Social Services. In order to be able to do any work at all, a scaled down proposal had to be resubmitted within the last few months in order to get a speedier decision, which essentially involved eliminating all proposed work apart from actual interviews of service users. For further discussion of these problems see section 8.
Nonetheless, we were advised by one research governance lead that an informal survey of day centre managers with regards to the services they provided did not require any approval (although approval was in fact sought by Polari and received from the ADSS). They were asked (as part of the survey described) whether they would have been happy to be sent publicity materials. A substantial proportion stated that they felt there was no need for this, since (in their view) there were no LGB people using their service. See section 7 for a full discussion.

Finally, various carers’ support organisations were contacted and provided with posters and flyers about the project to display and information to include in their newsletters.

Figure 4a shows proportions of questionnaire respondents by the manner in which they received information about the project. As expected, publicity sent to LGB internet sites and community organisations and to mental health voluntary organisations attracted the most participants. It is possible that individuals using these resources could respond more anonymously and/or were more likely to be motivated to take part in such a project, having a sufficient existing interest in mental health or LGB community issues to seek out engagement with voluntary organisations. There was no response from carers’ support organisations to any publicity.

![Pie chart showing proportions of how participants heard about the project](image)

*Fig 4a – How Participants Heard About the Project (by percentage)*
4.5 Publicity Materials

The design of the publicity was a matter for early discussion with the project advisory group. Some felt that it was necessary to strike a careful balance between visibility and discretion in order to attract those who might not wish to out themselves through looking at or picking it up. Others wished to produce material that was obviously LGB-related so as to raise general visibility within the world of mental health care. Some support was lent to this latter view by the manager of a mental health resource centre who reported that displaying LGB publicity had contributed to a more tolerant atmosphere in the centre (see section 7). As a compromise, the final products displayed an abstract rainbow-type image with the terms 'lesbian, gay and bisexual' included visibly.

When sending publicity out to various organisations, advice was sought as to whether there were likely to be any particular language or access needs amongst their user groups. In the end it was only necessary to provide Braille copies of the recruitment flier.

4.6 Ethics

Research governance approval for this project proved to be an unexpectedly complex and even byzantine process. Initial advice around research governance approval was sought from the National Research Ethics Service of the NHS (www.nres.npsa.nhs.uk). They responded by stating that no formal approval was necessary for this project, given the fact that it constituted a service evaluation as opposed to a piece of research. However, they recommended that permission be sought from individual managers before carrying out any work within NHS Trusts.

The researcher proceeded to consult with the research and development departments of each mental health trust before advertising within them, speaking to staff employed by those trusts or interviewing users of their services. Five trusts gave approval within 4 months. Three gave initial approval over the telephone based on the advice given by NRES, and then retracted it about a month later after further consideration. They then required either the acquisition of honorary contracts (even though no interviewing on trust property would be taking place) or a full approval procedure to be completed (with no clear expected completion date). In the case of one mental health trust, nobody could refer me to the individual responsible for research governance. The final trust required a formal approval procedure to be completed from the outset despite the advice of NRES.
Further advice from NRES was sought at this point. The researcher was referred to the initial statement stating that no further approval was necessary, and told to consult the research governance guidelines for further information. Given the conflicting information we received and the time constraints of the project further work to obtain denied permission was not possible. It was decided to work only in those trusts that had given approval.

About 4 months into the lifetime of the study, a questionnaire had been put online but no publicity had taken place. Information about the project had been sent out to individuals on Polari’s mailing list (some of whom happened to be employees of local authorities and individuals may have promoted involvement in the project within their own organisations). At this point the researcher was contacted by the research governance representative of a particular local authority and informed that it was imperative that formal permission was also sought from each local authority whose services were being used by participants we wished to interview. We were advised that this would be necessary whether we recruited via their staff or premises or visited their premises or not. Further advice was sought from a research governance representative at another local authority, who stated that it was the business of individual service users whether they wished to take part in the study or not and it only became the remit of local authority research governance when its premises and staff were to be used. Given this conflicting advice, it was decided that it would be best to limit interviewing and publicity to eleven boroughs, from whom explicit approval would be sought. Any more was thought to require too much work given the now rapidly diminishing time frame; any less would make attraction of sufficient numbers of participants difficult, given the dispersed nature of the population targeted.

We encountered enormous difficulties in locating the appropriate officer to consult in most local authorities. None of the local authority switchboards could provide information as to who was responsible for research governance in their organisations. The researcher was obliged to spend considerable time looking into the development of the research governance protocols, and eventually was able to contact another researcher who sent a list of the contact details of those with responsibility for the matter. Of these boroughs, five stated that they belonged to a common research governance procedure. A further two belonged to a separate research governance consortium with a separate procedure. Two were not sure and promised further information, and one had no person responsible at all for research governance.

A formal application was submitted to every borough according to their varied individual processes (and also to those which had none). Two boroughs (Haringey and Camden) gave prompt approvals within a month. Several others said that they would attempt to combine their approval procedures to save time. One borough (after about 4 months) declined the project. One initially approved it in writing, and then retracted this approval within a couple of weeks, referring the researcher to the NHS for approval (despite the fact that the application
described that NRES approval had already been given). One simply referred on to the NHS in an email without considering the proposal. One didn’t respond at all.

The forms that then needed to be submitted in every instance as part of local authority approval processes had specified that in cases of research taking place over more than one borough an extra level of approval was required. This was from the Association of Directors of Social Services who charge a substantial fee for this service. The researcher called the organisation to enquire about this and was informed that in fact this was optional. Six weeks or so later, when no further news had been heard from the research governance leads in the local authorities, more telephone enquiries found that no progress had been made on decisions with regards to the project because ADSS approval was deemed to be needed.

An application for ADSS approval was completed and submitted with an attached fee of £360. In the meantime, permission from the project’s funder, City Bridge Trust, had to be sought to extend the lifetime of the project as a result of the delays incurred by obtaining ethics approval, and the researcher agreed to cut his hours down in order to make this feasible financially. Approval was obtained from ADSS in January 2008, leaving less than 3 months (on two days a week) to complete interviews of 12 people, arrange a focus group and write the subsequent report. At this point, the researcher was informed by the local authorities that entirely new proposals would have to be submitted in order to include notice that ADSS approval had now been obtained. Some admitted losing or forgetting the original. In some cases staff had changed and there was no continuity.

Polari decided that, in order to encourage faster approval, no advertising in, or contact with, local authority premises and staff (save the telephone survey described in section 7) would be requested, despite the fact that publicity in local authority premises had been approved by the ADSS. All that was asked was permission to interview people who had already volunteered to take part via the online questionnaire or advertising in voluntary sector organisations / LGB community venues and websites. These LGB community participants were keen to be interviewed and in many cases frustrated by the delay. It was early March 2008 before permissions were granted from eight of the boroughs from which it was requested. The others had not responded at all.

In total the process, from initial enquiry to final approval, took about 10 months. In some cases the researcher was able to choose to interview more than one participant from the approving boroughs, which offset the original aim for a Pan-London approach. It is worth bearing in mind that, in the understanding of the researcher, the same Department of Health research governance policy governs both social care and health (and should therefore be relevant for the protection of users whether they are users of the NHS or residents of local authorities). Page:
That being the case, we believe the National Research Ethics Service should have been sufficient authority to advise correctly and give guidance on research governance for both NHS and local authority arenas. Polari believes it is urgent that the currently confused arrangements and rules for research governance are clarified, that consistency in information is given to research organisations, that delays are avoided and there are clear and publicised processes for research approval, and appropriately trained officers to advise on the processes.

4.7 Design

One of the aims of this scoping exercise outlined in the original brief was to assess the need for further work in the area, and to provide the basis for a funding bid for this work if it was deemed necessary. On this basis, it was felt that designing and distributing a questionnaire in addition to conducting interviews would increase the number of potential respondents from whom data could be collected within a limited time frame. This would provide a more realistic spread of opinion upon which to base a judgement about the necessity of an ongoing project and would also furnish descriptive statistics in order to support funding requests. Furthermore, the researcher felt that offering the option of a questionnaire would encourage participation from people lacking in confidence or the motivation to take part in a full interview. It would also encourage those who would find it difficult to discuss issues regarding their mental health or sexual orientation face-to-face with a stranger.

A draft questionnaire was developed based on issues that were highlighted throughout the research literature and through discussion with the advisory group. After one further consultation with this group, a pilot was conducted with four older LGB individuals and additional modifications were subsequently made. Care was taken to ensure that the overall tone of the questionnaire was neither negative nor positive towards mental health services, and that questions were not framed in a leading manner. The final draft was sent in hard copy to individuals who requested it and some copies were left in resource centres, voluntary sector drop-ins and user-involvement organisations. Return was by FREEPOST envelopes provided.

An online version was also created from html code which sent responses anonymously to the researcher’s email account. The URL did not explicitly state what the content was about, the pages were published in inconspicuous plain text and there were instructions given on how to clear the internet history or minimise the window if participants did not wish others to know they had visited this site.
The researcher’s contact details were included on both versions of the questionnaire in case of difficulty in completing it. On several instances participants made contact and it was administered over the telephone.

Participants were given the opportunity to leave details if they wished to be entered into a prize draw for having taken part or they were interested in taking part in an interview and/or a focus group. If the former applied and not the latter, a check box was provided. These details were sent and kept separately from questionnaire responses.

From the individuals who wanted to be interviewed, ten were selected as far as possible with representation of locality, sexual orientation, gender and age in mind (4 lesbian women, 4 gay men, one bisexual of each gender). Two individuals known to Polari from previous projects who were carers of individuals with mental health needs were also invited to interview (since there was no response from carers to any publicity directed at them) – one male, one female. Nine of the interviewees described themselves as disabled, either in connection with their mental health needs or physical impairment. Sadly, one participant died before he could be interviewed. Another man was found to take part. Participants were offered £10 by way of compensation for their time, and interviews took place over the telephone, lasting on average an hour. Notes were made, and respondents were asked to check a draft of the report for inaccuracies. There was no instance where interpretation services were required. All interviews were carried out utilising a semi-structured method, and were subsequently subjected to thematic analysis.

Every person who had expressed an interest was invited to a focus group convened by the researcher and one other mental health worker. Unfortunately in the final event, and only days before the finish of the project due to the immensely long delays created by ethics clearance (see section 4.6) only 4 people were able to attend the focus group. The group discussion lasted two hours. The focus group allowed users to direct the questioning process and the agenda themselves to a greater extent.

In addition to the above, a very brief telephone survey of 36 mental health resource centres (local authority-, voluntary sector- and NHS-run) was carried out in order to ascertain levels of perceived need for and current provision of LGB-specific services. Two presentations were given to assembled older people’s CMHTs in two mental health trusts, with subsequent discussion taking place around the experience of working with this age group and people of this sexual orientation. Two NHS-run day service managers were interviewed in depth. Two gerontological psychiatrists were interviewed informally, and discussion with mental health professionals also took place with those participating in the project advisory group. Three members of staff from LGB-specific mental health projects were interviewed, one trainer and two independent LGB mental health service user groups were visited. Three peer-support projects (non-LGB specific) were
also visited in order to discuss good practice. General discussion with members of voluntary sector and NHS staff took place at various events and workshops relating to mental health.
5. Questionnaire Results

5.1 Demographics and General Information

The following diagrams represent the demographics and general information collected from all participants, of which there were 49 in total. 9 questionnaires were returned uncompleted and were discarded. Unless stated, values given as numbers are percentages of total participant numbers. In the majority of charts gay men, lesbians and bisexuals are subsumed into ‘male’ and ‘female’ categories. This is principally for ease of presentation – every participant who took part identified with one or other of these categories and no women who took part identified as ‘gay’ instead of lesbian. The intention is not to assume that issues pertaining to bisexuals are necessarily the same as those relevant to lesbians and gay men – rather, the number of bisexuals who took part was so small as to make separate presentation of data from them of marginal use.

In summary, they show that:

- The sample was fairly balanced in terms of gender and disability (figs. 5a and 5b).
- Bisexuals as well as people with black or minority ethnicity were under-represented (figs. 5c and 5d).
- The sample showed a strong bias towards individuals under 60 (fig. 5e).
- The majority of lesbians and gay men who took part were single (fig. 5f).
- The majority of participants were home owners; this majority was more significant amongst gay men than lesbians (fig. 5g).
- Just over a third of gay men and lesbians weren’t ‘out’ to anybody (fig. 5h).
- 38% of gay men and 41% of lesbians were ‘out’ to health professionals; similar numbers were ‘out’ to most of their family (fig. 5h).
- Only 36% of lesbians were ‘out’ to most friends compared to 52% of gay men (fig. 5h).
- More lesbians than gay men or bisexuals were ‘out’ to colleagues and employers (fig. 5h).
- 22% of men were found to be drinking at levels over the recommended weekly allowance, of which 8% reported consuming amounts considered to be hazardous to health (fig. 5i). This was lower than the national average for adult men (Office of National Statistics). 27% of gay men reported abstinence as compared to 11.2% of gay men 50+ in the Gay
Men's Sex Survey Survey (2005), where the sample was much larger. Levels of drinking were low amongst women, contrary to expectation based on the research literature (e.g. Abbott 1998).

- The percentage of gay male smokers was almost exactly the same as that reported in the Gay Men's Sex Survey (2005), although a larger proportion of men smoked smaller amounts (fig. 5j). According to that report, this is slightly higher than equivalent rates for heterosexuals. Rates of drug use reported were lower than found in the same age group in 2005. Sample sizes are however incomparable. There is no equivalent data for lesbian women.

- Lower rates of drug use were reported by gay men than found in the Gay Men's Sex Survey amongst the same age group (fig. 5k). Once again, sample size was hugely different.
Figure 5e – Percentage of sample by housing status

Figure 5f – Percentage of sample by openness about sexual orientation
**Fig 5g – Number of respondents by age**

**Fig 5h – Number of respondents by relationship status**
Fig 5i – Alcohol use by percentage of respondents

Fig 5j – Cigarette use by percentage of respondents

Fig 5k – Drug use by percentage of respondents
5.2 Use of Mental Health Services

The following diagrams describe the type and length of use of mental health services by respondents. ‘Use’ in the following denotes regular, continuous use - in terms of length, respondents were asked to describe the longest period in which this term applied. All use described must have taken place within the last five years.

‘Statutory services’ are defined as those provided directly by a local authority or NHS mental health trust. ‘Voluntary services’ are defined as those provided by independent charities or community groups. These may receive some core funding from a local authority or NHS trust. Private services were defined as those for which payment is necessary for treatment.

In summary, they show that:

- The majority of respondents were current users of statutory mental health services (fig. 5i). Those who were not had either used them in the past, or were currently using voluntary / private services.
- Slightly more participants were currently using statutory mental health services than those aware of having a current diagnosis (figs. 5i and 5m).
- Most individuals who were aware of having a current diagnosis were using statutory mental health services, though a small minority were only accessing voluntary services. A slightly larger minority were using both (fig. 5n).
- Very few participants had used voluntary services for more than 6 months. Length of statutory services varied, with most using for less than 6 months but a large proportion having used for over 18 months (fig. 5o).
- Current users of statutory services were most commonly accessing psychiatric and community mental health services. Current users of voluntary services were most commonly accessing counselling (fig. 5p).
- More respondents were currently using or had previously used voluntary sector counselling than statutory sector, although when psychology / psychotherapy was taken into account also the numbers were more similar. Respondents also most commonly reported considering or attempting to access talking therapies (fig. 5p).
- About a quarter of respondents who were using or had previously used mental health services had been in hospital for their mental health needs (fig. 5p).
- Amongst those participants who had wanted to access statutory services but were unable to/ decided against it, the most commonly sited reason was difficulty with disabled access. This was followed by long waiting times, concern about being given unwanted treatment and concern about being told they had a disorder (fig. 5q).
Fig 5l – Percentage of respondents by use of services

Fig 5m – Percentage of respondents with current diagnosis

Fig 5n – Percentage of participants with diagnosis using various services

Fig. 5o – Length of use of service by percentage of statutory and voluntary service users treated as separate groups
Fig. 5p – Use of various services by numbers of respondents. Use was in every instance within the past 5 years.
Fig 5q – Reasons given for non-access of service by number of respondents
5.3 Views about mental health services – comparison between users and non-users

A series of statements specifically about statutory mental health services were presented to participants, who had to rate whether they agreed on a 5-point Likert scale. In defining what constituted statutory services, a comprehensive list of examples was given to participants. Types of ‘mental health professionals’ were also listed, and it was noted that GPs and general nurses were to be excluded from consideration. The diagrams below show participant responses to each of these statements. Once again, participants were asked to think purely about their experiences in the last five years when responding.

Given the small number of the sample once divided into separate groups (current users, previous users, never used) it was felt that statistical analysis of between group differences would not be useful.

The results are mixed and difficult to summarise and there is rarely any consensus amongst respondents, possibly reflecting the variety of experiences had with different professionals. Overall:

- Most individuals who have previously used or are using statutory mental health services believe that it is important to be able to disclose sexual orientation to professionals. There is less consensus amongst those who have never used such services. A similar result was found in terms of the perceived importance of professionals understanding issues that face older LGB people. Most said they neither agreed nor disagreed that most professionals understand what these issues are.
- Nonetheless, most respondents (current and non-users) said they would be more likely to access mental health services and/or talk about their issues if the professional they were seeing was openly gay or gay-friendly. The same also applies to professionals who had received training on working with LGB people.
- There was no real consensus as to whether mental health professionals hold negative stereotypes of LGB people, and it seems more respondents disagreed that professionals think that their sexual orientation is an illness. Despite this there was a trend towards agreement that revealing sexual orientation would result in negative treatment.
- Both those who have never used and those who previously used services believe that, if indications that some people are lesbian gay or bisexual were more visible in mental health service publicity, they would be more inclined to access services.
‘If mental health professionals did not know my sexual orientation, I would feel less able to talk fully about my mental health problems with them’

‘It is important for someone to understand the issues that face older LGB people for them to be able to help me with my mental health problems.’

‘Most mental health professionals have a good understanding of the issues that affect older LGB people’
‘Most mental health professionals hold negative stereotypes of older LGB people’

‘If I revealed my sexual orientation, mental health professionals would treat me as if my behaviour as an LGB person (sexual or otherwise) contributes to or causes my mental health problems’

‘If I revealed my sexual orientation, mental health professionals would make negative assumptions about me because of it’
‘If I revealed my sexual orientation to mental health professionals, it is more likely that I would be given treatments that I don’t want’

‘If I reveal my sexual orientation to mental health professionals they will be able to refer me to places where I can get support more specifically for LGB people’

‘If mental health professionals knew my sexual orientation and treated me badly because of it, any complaint I made would be taken seriously’
‘If I told a mental health professional about my sexual orientation, he/she would tell others who I don’t wish to know’

‘I feel that my sexual orientation is seen as an illness by most mental health professionals’

‘If I knew that the mental health professional who I would see was openly gay or gay-friendly, I would be more likely to access mental health services / talk about my mental health issues’
‘If I knew that the mental health professional who I would see had received training on working with LGB people I would be more likely to access mental health services / talk about my mental health issues’

‘If LGB people were more visible in publicity material for mental health services I would be more likely to access them’

5.4 Experiences of mental health services

The following diagrams describe responses from individuals who are currently using statutory mental health services (n=27). Whilst it would have been useful to provide a comparison between users who were ‘out’ and not ‘out’ within the context of mental health services, only a very small number of those who took part fell into the latter category. Meaningful comparison is as such difficult to make. In the case of questions below which presuppose that mental health professionals are aware of the respondent’s sexual orientation, these few are

* This question was only asked of individuals currently not using statutory mental health services.
excluded. Again, to emphasise, participants were reminded to think about the last five years only.

Generally the lack of consensus of opinion is even more marked here than in the above. To summarise:

- 92% of respondents were able to be ‘out’ within the context of services (fig. 5r), and almost half reported that they were pleased with the way in which professionals treated them when they had been open about their sexual orientation. 41% believed that if there was greater LGB visibility in publicity material they would feel more comfortable to be open about their sexual orientation to all staff.
- The majority also felt that the extent to which homophobia had impacted or continues to impact on their lives was recognised. Nonetheless, it was still felt by over a third that they would have received a better service if they had been heterosexual.
- Over a third of respondents felt that the behaviour of mental health professionals towards them on account of their sexual orientation had made their problems worse. In addition 41% reported being subjected to homophobic remarks from professionals and discriminatory behaviour, with a slightly smaller percentage noting mockery and verbal abuse and disclosure of sexual orientation without permission. 30% claimed they had been subjected to physical violence by staff within the last five years on account of their sexual orientation. With this last particularly alarming response Polari is not able to contextualise the answers. These were not qualitative answers and therefore have no detail, and we are not sure what they represent in a very small online survey where participants could be anonymous. We conclude that further research needs to be carried out in this area.
- About half of respondents report having had inappropriate questions or comments asked about their sexual orientation and/or behaviour. Just under half report hearing staff speak in a negative way about LGB people in general. Unsurprisingly, it was felt by about a third that staff are insufficiently trained to work with LGB people and 38% wouldn’t feel comfortable asking staff to help them to participate in LGB activities.
- Although there is consensus from respondents that they would not keep quiet in such instances, only 38% would know how to make a complaint and (as the above shows) 50% do not believe it would be taken seriously even if they were to.
- Nonetheless, most had not been denied the possibility of nominating their LGB partner as next of kin and for those who had been in hospital (n=11) and for whom the question was relevant, most had not had LGB friends turned away.
- Just over half of respondents note that a positive response from a mental health professional with regards to their sexual orientation really helped them.
Openness About Sexual Orientation Within Mental Health Service Context

Fig. 5r – Percentage of respondents open about sexual orientation within the context of mental health services

‘In general I have been pleased with the way in which mental health professionals have treated me when I have been open about my sexual orientation.’

‘If I was treated badly by a mental health professional because of my sexual orientation, I would just keep quiet about it.’
‘I would know how to make a complaint to the relevant authority if I received negative treatment by a mental health professional because of my sexual orientation.’

‘The negative behaviour of one or more mental health professionals towards me (related to my sexual orientation) has made my mental health problems worse.’

‘In general mental health professionals I have encountered have seemed sufficiently trained in order to work effectively with older LGB people.’
‘I would feel comfortable in asking most mental health professionals to support me to find and take part in LGB activities.’

‘I would have received a better or more appropriate service if I had been heterosexual.’

‘If LGB people were more visible in publicity material for mental health services I would feel more able to be open about my sexual orientation to all mental health professionals.’
‘In general mental health professionals have taken seriously the impact that homophobia has had or continues to have on my life.’

‘One or more mental health professionals have told me that my mental health problems are due to (or partly due to) my sexual orientation.’

‘I have been subjected to homophobic or anti-LGB remarks by a mental health professional.’
‘I have been subjected to physical violence from a mental health professional
because of my sexual orientation’

‘I have been subjected to verbal abuse or mockery from a mental health
professional because of my sexual orientation’

‘I have been subject to discriminatory behaviour from a mental health
professional because of my sexual orientation (e.g. being refused to be seen)’
‘I have been asked inappropriate questions or had inappropriate comments made about my sexual behaviour by a mental health professional’

![Bar chart showing frequency of occurrence.]

‘A mental health professional has told another about my sexual orientation without my permission’

![Bar chart showing frequency of occurrence.]

‘A positive response from a mental health professional with regards to my sexual orientation has really helped me’

![Bar chart showing frequency of occurrence.]

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‘A particular request I have made has been denied me due to my sexual orientation (e.g. placement on a same sex ward, treatment by same sex staff)†.

‘My same-sex partner and/or LGB friend has been denied the right to visit me in hospital when a heterosexual equivalent would have been allowed‡.

‘I have been denied the right to nominate my same sex partner as designated next of kin§.

† Numbers show respondents who felt the question applied to them (n=13)
‡ Numbers show respondents who felt the question applied to them (n=13)
§ Numbers show respondents who felt the question applied to them (n=10)
‘I have witnessed a mental health professional behaving in a discriminatory or negative manner towards another because of their sexual orientation’

‘I have heard a mental health professional speaking in a negative way about LGB people in general

5.5 Views with regards to other service users

The next set of statements were about other users of services. Once again these were open to current and previous users of statutory services along with those who had never used them. The statements are potentially about any mental health service.

In summary:

- There is some consensus between all groups that there are some mental health services that they do not use because of anxiety about experiencing homophobia there, and user groups are not excluded from this.
• There is strong consensus that being in an LGB-specific environment would make it easier to be open about sexual orientation.
• There is consensus that individuals have a right to complain if they are treated badly by another service user because of their sexual orientation. Predictably those who have previously or never used services are less sure they would be able to do this than current users. However, the latter are less in agreement that such a complaint would be taken seriously.

‘There are mental health services that I might like to use but don’t because I worry about homophobia from other service users.’

‘I am discouraged from participating in user groups because I am worried about homophobia from other group members.’
‘An LGB-specific environment would make it easier for me to be open about my sexual orientation.’

‘I have a right to complain if I am treated badly by another service user because of my sexual orientation.’

‘I would feel able to make a complaint to the relevant authority if I was treated negatively by another service user because of my sexual orientation.’
‘If I were to complain about being treated negatively by another service user because of my sexual orientation, it would be taken seriously.’

5.6 Experiences of Other Service Users

The last set of statements were specifically aimed at current users of statutory services who had had significant contact with other service users within the last five years in this context. The majority of this would likely have taken place in hospital, day services or other community venues. Not all current users experienced a sufficient level of recent contact with other service users in a statutory setting to feel able to answer this section and as such the sample is again smaller (n=20). All of this sample but 3 had reported being ‘out’ to mental health professionals – these 3 were also not ‘out’ to other service users. Questions which presume openness about sexual orientation were asked only to those who were ‘out’ to other service users.

In summary:

- Even amongst those who felt comfortable in most instances being open about their sexual orientation to mental health professionals (n=17), just over half (n=9) felt as comfortable when it came to other service users.
- About two thirds of respondents worry that disclosure would result in service users revealing their sexual orientation to others without their permission, and about half would be concerned for their safety in the area in which they live. These fears are roughly equal between those currently ‘out’ to other service users and those not.
- It tended to be more common for individuals who were ‘out’ to other service users to have noticed instances of discrimination or negative treatment. Overall 60% had witnessed other service users talking negatively about LGB people in general, and 45% had witnessed discriminatory or negative behaviour towards another. There was no clear consensus on whether mental health professionals had taken clear steps to prevent or stop such instances.
• Respondents tended to feel that if they knew other LGB service users it would be/was easier to be ‘out’ in this context.
• Of those who were ‘out,’ the majority neither agree nor disagree that they have received a positive response from other service users, suggesting that (as with professionals) experiences varied.
• However, 77% reported experiencing discriminatory behaviour, 66% verbal abuse and 44% violence from other service users on account of their sexual orientation.

![Graph showing openness about sexual orientation with other service users](image)

Fig. 5s – Percentage of respondents open about their sexual orientation to other service users in a service context

‘Feeling able to be open about my sexual orientation with other service users means / would mean that I benefit from using mental health services more than I otherwise would.’

![Bar chart showing responses to feeling able to be open about sexual orientation](image)
'If I am open about my sexual orientation to other service users, they will tell others who I do not wish to know.'

'I am / would be concerned about my safety in the area in which I live because / if other service users may be / became aware of my sexual orientation.'

'I would/do feel more comfortable being open about my sexual orientation in this context if/ because other service users I have met were/are openly LGB'
‘If another service user has spoken negatively about LGB people or behaved negatively towards them, mental health professionals take good steps to stop this.’

‘I have witnessed a service user behaving in a discriminatory or negative manner towards another because of their sexual orientation.’

‘I have heard another service user speaking in a negative way about LGB people in general.’
‘Telling other service users about my sexual orientation has in general resulted in a positive response or acceptance.’

‘I have been subjected to physical violence from another service user because of my sexual orientation.’

‘I have been subjected to verbal abuse from another service user because of my sexual orientation.’
'I have been subject to discriminatory or negative behaviour from another service user because of my sexual orientation.'

5.7 Overall Summary

A lot of demographic data was collected from this questionnaire – the original aim was to examine moderator and mediator effects of factors such as housing status, geographical area and relationship status on experience of mental health services. However, sample size was effectively too small for meaningful analysis of this kind to take place. Problems with representativeness of the sample are discussed in section 8.

There was no evidence here to suggest that rates of drug or alcohol use amongst this group were significantly higher than in the general population. Therefore there is little to suggest that this is an area of particular concern with regards to the aetiology of mental health conditions in older LGB people. However, it must be noted that results from a larger sample may lead to different conclusions.

The responses seem to suggest that views of mental health services within this sample are somewhat diverse. As a general trend, more current- and ex-service users had negative views of statutory services (for example that professionals would pathologise their sexual orientation or make negative assumptions about them) than those who had never used them. Perhaps this demonstrates that negative expectations about services with regards to their treatment of LGB people do not represent the primary barrier to engagement for those who have never used them. Other factors such as ease of physical access, long waiting times and concern about treatment and/or diagnosis may be more pertinent here.

It is possible that expectation of poor practice constituted more of a barrier to continued engagement amongst those who had previously used statutory services. One explanation for the fact that views were generally more negative
amongst those who had some experience in this arena could be that exposure to services may bring exposure to bad practice, which itself taints opinions. Further support for such a view was lent by the findings of the qualitative research presented in section 6. This may be a cause for some concern, since this group (of individuals with a psychiatric history not currently engaging with statutory services) may be at increased risk of poor mental wellbeing as a result.

In respect of the content of negative expectations about services, more respondents agreed that discrimination may take an implicit or heterosexist form as opposed to an overt institutional form. Fewer individuals believed, for example, that mental health professionals saw homosexuality as an illness than believed that LGB identity or behaviour would be pathologised. Reports by Rivers (2006) and McKeown and King (2004) suggest that indeed negative stereotyping of LGB people is more common for users to have experienced than overtly negative stances.

Actual experiences of mental health services by current users were also mixed. There is some difficulty in interpreting the results of such a general scoping questionnaire, since there are rarely indicators of context or details of individual instances given. Given this, the picture seems to be that generally more people had fairly positive than negative experiences in using services, with a substantial proportion having had a mix of both. Most felt able to be out within this context, more in fact that in McKeown and King’s (2004) study."It seems most likely that this disparity is due to large difference in sample size, although it is at least feasible that (in line with previous findings) older LGB people are in fact more comfortable with disclosing their sexual orientations than younger members of the community.

To repeat, nearly 50% of users who had felt able to be open were generally pleased with the way in which professionals had responded. This is a slightly smaller figure than the 58.75% who had reported having experienced a positive response from professionals in McKeown and King (2004), although it must be noted that the question is slightly different in its scope. A marginally larger percentage of individuals reported having had their problems attributed to their sexual orientation in this study than in the previous (22% compared with 20.5%). There is little evidence here to suggest that older LGB people have worse experiences within mental health services than younger peers; nonetheless, whilst the results associated with this study do not paint a wholly bleak picture, it seems that there has been no significant change over the past five years.

According to participants, instances of implicit and overt discriminatory behaviour by staff are still occurring, some quite extreme (for example, experiences of

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**92% as compared to 66% of the 1285 strong sample in McKeown and King (2004). However, bisexuals in the latter study were much less likely to have shared their sexual orientation with professionals, and skewed the overall percentage – 83.5% of lesbians and gay men alone felt able to be open.**

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verbal and even physical violence are claimed to have occurred). With such a small questionnaire response and the option to be anonymous in an online survey we believe that more research needs to be carried out in this area to establish what is happening currently. The same applies to experiences of treatment by other service users, which seems to be an area of at least equal or perhaps even greater concern, given the lower number of individuals out to this group. Whilst on the whole it was noted by respondents that they would make a complaint in instances of poor treatment, fewer felt that they knew how to or that such complaints would in fact be taken seriously. Some of this information (though not the claim of physical violence by staff) is replicated in the qualitative part of this study (see chapter 6) and substantiates that problems of discrimination do exist for some LGB users from both staff and/or other users.

Affirming a zero-tolerance stance on homophobia is one potential way of solving such a problem, and is therefore a recommendation that arises from this study. There was also suggestion that greater LGB visibility in publicity might also increase engagement with services. Interestingly, in line with McKeown and King (2004), some preference for working with openly LGB or LGB-friendly staff was expressed. However, this preference was extended to staff who had been trained in LGB issues to almost the same extent; mandatory sexual orientation diversity training is one example of an innovation that would be endorsed by this report.
6. Qualitative Findings

The following section presents data obtained from 12 interviews of older LGB mental health service users and carers, one two hour focus group (marked with *) and two visits to LGB-specific voluntary sector drop-ins (marked with †). The ages of the participants ranged from 52 to 69 and were from various boroughs in inner and outer London. For purposes of anonymity, no identifiers will be included on statements. Quotes marked with an asterisk are taken from the focus group. Responses are organised as closely as possible thematically.

6.1 General impact of sexual orientation on mental health

Many of the participants discussed (unprompted) topics which highlighted the many ways in which issues surrounding their sexual orientations and indeed their age had been integral to or had affected their mental health, in particular (as suggested by section 2) the impact of dealing with homophobia:

> Generally my sexual orientation has been an important issue over the course of my therapy - well, more the effects of being surrounded by homophobia my whole life. There are also issues about getting older, where you fit in anywhere.’

> ‘I think a lot of my problems stem from being gay, not from being gay per se but socialisation – the societal abhorrence of homosexuality has totally fucked my life up and still does and I’m very angry as a result, constantly angry, constantly feeling that I’ve got to fight this, that or the other. And there’s institutionalised homophobia in the same way that the police finally admitted that there was institutionalised racism, but it’s like we don’t count, we’re the bottom of the pile.’

> ‘People of my age have spent half our lives being illegal. All of us will have experienced some homophobic bullying. Our sexual identities are bound to have been distorted in various ways for some years, formative years. The details of our lives, if we are brave enough to come out, sometimes become very difficult. These issues are a potential minefield.’

> ‘I’ve always been seen as ‘other.’ That can cause problems.’

Some had waited a long time (i.e. until the climate was sufficiently non-stigmatising) to be able to speak openly about these things, or had otherwise had to find support where they could:
'I started going to gay bars. They were really seedy. I felt that the seediness of the gay bars at the time added to the idea that there was something wrong with this. And then I was raped. It was my first sexual experience, and seriously affected my ability to have sexual experiences after that. It was 1977 – who did you go to about rape, especially male rape? I didn’t tell anyone about it until five or six years ago.’

This theme that there was very hard to find anyone to talk to about painful experiences and feelings was repeated by other interviewees. Some had experienced discrimination that had had (and were continuing to have) a huge negative effect on their lives:

‘I was offered this senior position within the council. It was an amazing opportunity, more money that I had ever dreamed possible of earning, the opportunity to be involved in policy. I was very senior within the trade unions, was head of three national committees on disability and LGB equality, so I would have been more than capable of doing it. But basically the occupational health advisor was homophobic and disablist, and advised that I shouldn’t be appointed. She claimed that I was emotionally manipulating my GP, that there was nothing actually wrong with me. My GP called me, saying she was worried because everything she was saying to this woman was being twisted in some way. And in the end, I didn’t get appointed. And that was the last time I worked. If it hadn’t happened, I would still be in the public sector, I would have a better pension, I could afford the services I need.’

Another interviewee spoke of an experience of extreme discrimination, affecting his whole life, that we are not able to quote here. Experiences such as these seem to highlight the need of these individuals to receive support that is non-judgmental and (for them) safe, given their experiences of hostility and stigmatisation in the wider world. Furthermore, they support section 2 in suggesting that LGB people may be at particular risk of developing mental health issues as a result of the effect on self-esteem of being frequently presented with a negative characterisation of LGB identity. As one participant stated:

‘There must be a real need for LGB mental health services. I’ve never met a gay person who wasn’t bullied as a child.’

6.2 Past experiences of sexual orientation discrimination within mental health services (before the last five years)

Unfortunately, despite this need the majority of participants could count mental health professionals amongst their persecutors at some time in their lives. For
some, fear of persecution in an environment (such as hospital) where they were vulnerable had led them to conceal their sexual identity or to feel that they couldn’t talk about it:

‘In hospital years ago, I acted straighter than straight – put on lots of make-up, flirted with men. I probably had issues about my sexual orientation but I couldn’t talk to anyone about them then.’

‘I tried to kill myself in 1977 and I had some psychotherapy after that. It was because of my sexuality really that I had tried to commit suicide, but I didn’t feel I could discuss it with the counsellors.’

Where some had talked about their sexual orientation openly, they had experienced a tendency to ignore or pathologise it, which had in turn reinforced the idea that there was something wrong with it and by association them:

‘I was 17 and an inpatient at the (X London mental hospital). I remember telling the doctor that I was a lesbian. Well, I didn’t actually use that word because it wasn’t really something I knew about at the time, I said ‘I think I’m attracted to women.’ He told me that it was a phase, that I’d grow out of it. So I waited to grow out of it. I had sex with men, which I found boring, so after that I stopped having sex for a while.’

‘I was first hospitalised in 1975 after a serious suicide attempt. I had fallen in love with a friend – he had a girlfriend at the time. So I tried to kill myself. I was told by the staff that my problems were because I was queer, that they would give me some pills and it would make me better. So I assumed these pills would make me straight.’

‘If I discussed my sexual life to staff in hospital then I was told it’s not pleasant to discuss. One nurse said to be ‘don’t you like lovely girls in lovely dresses?’ So I never discussed being gay with my consultant psychiatrist, not even the one I had for 30 years.’

‘I wasn’t happy being queer. The psychiatrist there [in hospital] said that I should try things with a girlfriend. I wasn’t offended. That didn’t work out though and I ended up taking another overdose. I used to talk about being queer in counselling sessions, but it was mostly around doing things to avoid it, because it was when it was. Back then it was a mental illness. I think that that internalised homophobia carried on through my life.’

In at least as many cases, invasive treatment, abuse or discrimination had taken place whilst in the care of mental health professionals:
'I went into hospital when I was 17, I was having hallucinations and believed I was a homosexual reincarnated from the days Christ to free hell. I was very scared of my homosexuality – I was Roman Catholic, and scared someone would find out. After that I had a lot of electric shock treatment and insulin treatment – it was appalling. Anyway after this I had no sex life. I had affairs with men later in life but no sex – my sex life went all those years ago. My life has mostly been survival.’

‘I went through three days of beatings from other patients in the hospital whilst the staff did nothing. It only stopped when one of the other patients screamed at the nurses, ‘aren’t you going to do anything about this?’ One nurse just said, ‘well she’s butch, she should be able to look after herself.’

‘I was living in [a supported housing project run by a voluntary sector organisation] and I started having a lesbian affair with another woman who was living there. It was my first lesbian affair actually. Anyway the staff found out about it and this woman was evicted straight away.’

One interviewee told of marked insensitivity in the psychiatric profession, contributing to a history of self-harming:

‘My psychiatrist told me that I was lonely, that was my problem and that it doesn’t help to be a lesbian and it must be harder to get anyone. I was furious because I had lost my partner, she was gang raped and murdered. ‘I’m old enough to be your mother, don’t talk like that to me!’ The next psychiatrist I saw asked me ‘Did you like being raped?’ Of course, I went mad after that, I was fucking screaming. And I went out and slit my wrists. After that I started saying no more male psychiatrists.’

Unfortunately the existence LGB staff in a service cannot be assumed to be automatically supportive:

‘My nurse keyworker in hospital was a gay boy, but he never came anywhere near me, talked to me or anything. When I asked him why he said ‘You seem like you handle yourself ok.’ One of the other patients told me it was because he didn’t like butch. I asked how he knew, and he said ‘I can hear them talking about you in the office.’ And they were.’

6.3 Recent experiences of sexual orientation discrimination within mental health services (over the last five years)

There was some belief that services had generally changed for the better since these experiences had taken place:

‘At the moment we’re midway between tolerance and acceptance’
'It's more acceptable now than it was in the 90s because of the abuse that used to go on [on the wards]… but now it's not so much. You get the odd occasion.'

'I think that there has been a lot of improvement [in mental health services] over the years. Now when I go into hospital I am offered a brand new en suite room on a women-only ward. There is also much more support in the home.'

However, most service user participants reported some recent instances of perceived homophobic or discriminatory behaviour from staff within a service context, leading to anger and frustration:

'My consultant psychiatrist was homophobic. I was with my then long-term partner at the time, and I felt he didn’t treat our relationship with the respect he would have done if, you know, we were straight. He wanted to split us up. I went to see him once with my partner and he said to my partner ‘how do you feel living with someone who could kill you at any time?’ And my partner said that he didn’t feel that way about me and that he knew me, that kind of stuff… But obviously I couldn’t talk about my sexuality to him, and if you can’t talk about it with your psychiatrist who can you talk about it with?'

'I had one carer who looked at my flat, the shirts, the ties and asked ‘have you got a man living here?’ and I said ‘No, and what’s it to you.’ She then made her way into my kitchen, made herself a cup of tea without even making me one. So I thought ‘Alright’ and I said ‘How do you feel about dressing the bottom half of a lesbian?’ She said ‘A what?’ I said That’s a woman who goes with another woman’ and she said ‘Oh no, I can’t do that.’ I said ‘Leave!’

Most commonly, participants described the vulnerability they felt when confronted with staff in a hospital setting who openly discussed their religious beliefs:

‘The staff in hospital are very religious, and can’t separate professionalism from their personal views.’

‘When most of the staff are fundamentalist Christian it doesn’t make you feel very comfortable about your sexuality. The staff freaked me out a lot more than the patients, even though some of the patients were quite disordered. I kept thinking ‘I can’t believe this is happening.’
'One nurse [in hospital] was really religious, she didn’t like gays. She told me that I should be praying, you know, to save myself from going to hell because I’m a lesbian.’

‘There was one occasion in hospital when a charge nurse tried to get me to become a Christian because of my sexuality, and I thought this was abusive. I did address it with another member of staff who I trusted, and apparently this person was renowned for [this behaviour]. So this sort of stuff does go on. It’s implying that there’s something wrong with you, that you’re going to go to hell because of what you are, and you don’t need that at a time when you are frail.’

‘The only attention anyone got [on the ward] was if they were Christian – some patients had Bibles, and the staff would come and discuss Christianity with them. It made me feel totally unsafe, because I have read about fundamentalist Christianity and attitudes towards gay people.’

Others described feeling that they were being subjected to indirect discrimination through professionals’ lack of recognition of the validity of their sexual identities:

‘I can’t remember the last time I had any kind of sexual experience. This is normally just ignored. If I was straight it would be seen as more important, if say I wanted to have a baby. The drugs I am on have almost totally wiped out my libido, but it’s not seen as important that you have a libido if you have a mental health problem.’

‘I had a boyfriend at the time and he told me that I should try to get some Viagra [to help with my problems having an erection]. So I went to the GP to ask about it and he refused, because he said they can only give it to people who are in meaningful relationships.’

6.4 Expectation of discrimination within mental health services

Perhaps unsurprisingly, experiences such as the above tended to result in participants becoming very cynical about the ability of statutory professionals to provide a suitable service for them and indeed a general lack of trust:

‘It’s always in the back of my mind, the worry about the level of homophobia that is present in these people that will then be masked as a construct that basically labels me a deviant. It shouldn’t be the case but unfortunately it is.’

‘There’s also a lot of evangelical Christianity within the NHS and obviously I don’t need to encounter that on top of everything else.’
'I’m not going to bare my soul to someone who I can’t walk away from or trust not to respond badly to me… I would not trust the majority of the medical profession on LGB issues.'

In some instances, this cynicism was reinforced by NHS staff themselves:

‘My CPN told me ‘you have to be careful what you say to these people [the psychiatrists, with regards to sexual orientation]’

‘I was seeing a counsellor in [London borough] and the sessions came to an end, and we felt that I would benefit from more support. However there was nothing else in the borough and my counsellor (who was herself a lesbian) suggested that I didn’t approach mental health services because professionals still saw being a lesbian as a mental illness. I appreciated the honesty.’

One individual felt that increased prominence and public awareness of certain LGB identities and lifestyles had resulted in greater degrees of stereotyping amongst staff and with it new problems:

‘Now it’s worse in a way because they [heterosexuals] know a bit about us, you know a bit about something and you think you know it all. They’ve seen a few movies, seen Philadelphia or whatever and that’s what we’re about. And after all, all we do is have sex, there’s nothing else to our lives is there?’

Subsequently for some this has meant avoiding statutory services altogether, although the need to access them was there:

‘I haven’t used any [statutory] services since 1976. I stayed away because I was worried, I thought that if I went into hospital again I wouldn’t get out. I didn’t think I could have survived another imprisonment. So I was doing my best to manage outside of services, but I was really struggling – hallucinating, seeing things, hearing voices. It got to the point where I felt like I was on the edge of total breakdown.’

‘There’s no way I would ever go to a day centre. It’s too reminiscent of where I have come from.’

‘I wouldn’t access mainstream services because I don’t think they would understand. To offer support you have to understand where someone is coming from to an extent. Training wouldn’t necessarily improve this – whatever training the leader gets doesn’t stop the group from being homophobic. Essentially if someone’s whole orientation of practice, the
theoretical basis of their work is that you’re ill by virtue of declaring yourself a lesbian… How are they supposed to help?’

6.5 Interactions with other service users

These were mixed. A couple of individuals with more limited experience within the mental health system reported generally positive responses:

‘The other service users seemed ok – I talked about my sexual orientation with some of them. I felt that they were quite accepting – accepting of others’ foibles because they had enough of their own. Quite a few of the people there had very high needs.’

‘One patient said to me ‘have you heard there’s a lesbian on the ward,’ and I just said ‘yeah, you don’t need to worry about that.’ And that was the end of it, the next day I was helping her to do her CV. I think she just needed reassurance.’

For the majority of others, discrimination and attack from other service users was of at least equal or sometimes greater concern than the negative behaviour of staff:

‘Even to this day I wouldn’t be ‘out’ in local authority day centres or hospitals. I’m most concerned about other users, being attacked in hospital. I have witnessed some laughter and ridicule of gay people between other service users. It makes me feel generally uneasy in hospital.’

‘Three years ago I got attacked by other women in hospital. It gets very violent in there.’

‘A lot of the men and women [at the day centre] wouldn’t like [me being gay] so I have never discussed it there.’

‘I’ve had a lot of homophobia from men in resource centres.’

‘I used to get on well with the other patients. But they would say things like ‘fuckin’ lesbians’ or would say to other lesbians, ‘fuck off, lesbian.’ And I would say ‘but I’m a lesbian!’. And they said ‘but you’re different, you don’t flaunt yourself.’

Despite the above, not one individual reported an instance in which members of staff had tackled homophobic behaviour on the part of service users. Making some form of complaint was not seen as a viable option by most:

‘Oh there was nothing to be gained from complaining. I was so run down myself, I couldn’t have managed another battle.’
'If you were to raise issues with staff, would they be taken seriously? I'm not sure.'

'I felt too vulnerable to make any kind of complaint, and nobody gave me any information about it. There was only one woman advocate, and she was totally overworked and didn't even have a computer to herself. She had to share a desk with the OT so anything you said to her you felt wouldn't be confidential. Plus I didn't know if I would be going back into the place so I didn't want to risk complaining in case I felt the repercussions.'

6.6 General problems within mental health services: quality of care, accessibility and availability

Participants in most instances were keen to discuss their concern, frustration and in some cases alarm at what was perceived to be poor standards of care currently offered by the NHS:

‘I was taken out to the hospital at 3am and led down this dark corridor, keys rattling – it was really scary, like some horror movie. I sat waiting for about an hour for the nurse to arrive to do my admission – I handed over my razors and stuff. After I stayed there for one night, I was transferred to another hospital, closer to where I had lived [before ending an 18 year relationship]. My experience there was absolutely horrendous, I was really, really shocked at the level of care offered. The whole experience has left me quite cynical. There was basically no interest in any of the patients. The staff would sometimes come onto the ward to watch the football on the TV but that was it. Oh and if you had kids, then they would help you out a bit but obviously I didn’t.’

‘Sometimes the staff would even take the mickey out of the most vulnerable patients. It was not in a way that was obvious, but you could tell what the intention was. They would goad people, make snide comments – it was vicious. In that environment it could send someone into a total fit. Nobody intervened at all, the manager turned up once the whole time I was there and just went into the office and talked to the staff. The more ill you are, the worse you’re treated and you can’t get it across because you’ve lost your mind! The hygiene was also a huge issue - there were cockroaches there!’

‘If you ask anyone to talk to you – ‘yeah in five minutes.’ You’re waiting all day and by that time the patient has gone mad. Some of the patients had shit on the floor, shouting and bawling at each other whilst the staff were all sat in the office chatting.'
Despite a supposed (now over 10 year old) emphasis on continuity of care between different areas and services, there were still complaints about this:

‘There is no continuity of care moving from one service to another. I was excluded from care in one place whereas I had been a part of it in the other. This continuity is especially important for people with dementia.’

Nurses were really important to me. But when I moved to [London borough], after one meeting with the registrar, I was dismissed and I never saw a nurse again.’

The general picture painted of the hospital environment in many instances was often one of inadequately trained, unmotivated staff making mistakes with regards to practice which (in once instance) had especially serious consequences:

‘When I was working as a patient counsellor, the staff left my file out in the office and there were patients inside having tea. One patient then found my home, kicked the door down whilst I was inside and threatened to kill me and my dog. I said ‘she dies, you die.’ He trashed my flat, took my lighters and cigarettes.’

Several participants complained of being unable to access services that were supposedly present, despite efforts to the contrary – particularly counselling, despite current initiatives to increase access to talking therapies:

‘I’ve been asking for a mental health assessment, but for some reason they won’t give me one. I’d like the opportunity to access a counselling service, but it’s important to me that I get someone who is sufficiently qualified. I’m pretty up on this stuff, and I think if I had someone who wasn’t fully trained I’d be running rings round them. I tried to access counselling through my GP, … I didn’t think [the counsellor] really knew what she was doing, and I was concerned about opening myself up to someone who didn’t know what she was talking about. So I said that I thought that it wasn’t a good idea for us to continue. Anyway, some time later I tried again to access some kind of service through my GP, and I waited ages again. And I went and it was the same woman, and she was so aggressive to me, really aggressive, I couldn’t believe it. So obviously I stopped going.’

‘[My partner and I] find community care assessments so stressful – that’s the adult ill health and disability team. There are high levels of aggression from social services, and having to keep repeating traumatic events after 12 months instead of seeing what needs have changed is painful and unnecessary. I’d rather [my partner] was able to get an assessment from a mental health professional, but we haven’t been able to get that despite trying.’
'I feel I got no help or support whatsoever leaving hospital, I was given no counselling. I’m still seeing a psychiatrist every 3 months who has referred me to counselling and yet my GP is totally incapable of arranging this. I have been waiting months for it and I’m desperate now.’

This feeling – of being left isolated and without support outside of hospital – was often repeated in some form, and ‘outreach’ was generally criticised as offering inadequate care:

‘If I was in crisis, I would have to walk up to the hospital, by which time you have already done the thing you were thinking about doing in the first place. The only way to stop me was to be in contact with somebody, you know, ‘It’s happening, it’s happening.’ And that talk just stops it, you know. And I didn’t have that.’

‘You’re out there working, getting no support. You know that if you fall over you’re fucked. It’s harder if you’re only a bit mentally ill than if you’re really mentally ill because you might suffer but believe me you get support. That’s why people fall through the hole, because there’s nothing there.’

‘The crisis team is a load of cobbler’s – spent three minutes with me. Make sure you’re alright, then ‘bye.’ Then the next thing is that I’m back in hospital because I’ve taken a massive overdose. That doesn’t work.’

Several participants were so disillusioned with statutory services that they saw private clinics as the only feasible route to getting the support or treatment they required, but were unable to pursue this avenue due to the high financial cost:

‘Ideally I would like to be able to access a private service, I feel like it’s the only way I’m going to be able to get what I need. But it’s just not a possibility at the moment, financially.’

‘In the private sector you can pick and choose. But there’s no way I could begin to afford that.’
6.7 Day centre closures

Related to the final points above, several participants felt very strongly about the current programme of day centre closure, and there was considerable discussion of this issue at the focus group. Contrary to the suggestions of the Department of Health paper mentioned in section 3, they felt that closures had been a) detrimental to user empowerment since users had campaigned fruitlessly to keep their centres open where they had in fact been consulted at all and b) detrimental to the social inclusion of individuals with chronic mental health needs since the majority of these had (subsequent to closures) ended up back in hospital, or simply wandering the streets:

‘They came into community group and said centre would be closing in November. No consultation. Our action group delayed it for two years. Eventually they found one room where the floorboard was loose and used this as a justification for shutting down the centre on the basis of health and safety when I had been using the centre for 8 years in my chair with nothing happening.’

‘Can’t just drop in and sit there and play darts or whatever, you have to be in a group, you have to be doing something. That centre has been doing something for ages – pottery, music, drama – before they even brought that in. But the ironic thing that we’re finding is that now there are less people coming to the centre. More in the street now because they can’t face being told what to do, where to go, would you do this, would you do that. I’m on the art project at the moment – this only lasts 10 weeks, and if there’s nothing there after that I can’t come to the centre.’

‘The people that will really be affected by this are what’s called the long term mental health people, who can’t really communicate with the outside world. For example there is one guy who just sits on a bench in X all day because his mother doesn’t want him in the house all day, in the rain and everything. Because he can only be in the centre at a certain time. These are the people who are going to suffer. These people might get in trouble, get into drink or drugs, end up where? In prison?’

‘Out of 55, only 5 survived outside – the rest ended up back in hospital when they closed the centre.’

‘Without the centre you are more isolated. When we had mental health communities, we used to get together – Mad Pride and stuff like that. But now we’re just isolated individuals. Who do you turn to? You’re on your own.’
The combination of lack of consultation in service closures and perceived doublespeak in terms of user empowerment resulted in the general perception that saving money was considered to be of greater importance than the wellbeing of service users.

‘I think we’re expendable and that money is the controlling factor, I think it doesn’t matter if we die, in fact they’d prefer it because it’s cheaper.’

There was also general disillusionment expressed concerning the ‘care in the community’ model – once again, isolation was discussed as a common problem:

‘Hospital has always been a sanctuary for me – I feel comfortable and safe there. It’s more real to me, being with people in psychosis, than this fucked up world. It’s sad that it’s now so difficult to get this sanctuary. In fact I feel more isolated in the community – I feel I have gone backwards.’

6.8 Positive experiences of statutory mental health services and good practice

It is of course important to note that experiences of staff within the NHS have by no means been universally negative. Nearly every participant spoke positively of at least some individuals, most frequently (though not exclusively) CPNs:

The hospital staff weren’t unkind, usually the nurses have been wonderful to me. I had a Chinese man nurse for a while, he was probably the best. My CPNs are very important to me – they have never let me down.’

‘Women CPNs by and large are brilliant, and one male CPN I’ve had over the years I’ve trusted, because it’s about trust, especially when you’re in crisis because you’re talking about things that are scary and could be used against you. Trust is one of the most important things when you’re vulnerable. These kind of relationships [with professionals] help you to develop trust in others. Or not, as the case may be.’

‘The hospital staff were extremely nice, very very kind. Several of the care staff were gay, very friendly and supportive.’

‘Only two psychiatrists I’ve had have had an inclination of how to treat me. One said, ‘I don’t care what you are, it’s your life not mine. I’m just here to help you.’ And the other one told me that I had a lovely character, and that they really admired me.’

However, the following caveat was also offered:

‘My CPNs have generally been really good. They have treated me with respect, listened, didn’t judge me and weren’t shocked by things that I said. But I think really good staff in the NHS are marginalised or pushed
out. They either get burnt out because everyone wants them because they’re good, or marginalised.’

A non-judgmental and respectful attitude seemed to be the key trait of staff who were judged to have been helpful. Awareness of LGB resources was also seen as being of benefit, but contact with actual LGB members of staff was not deemed strictly necessary for good service:

‘My consultant psychiatrist for some time was an ‘out’ lesbian. I felt because of this that she would be non-judgmental of me. I currently have a gay male support worker. It’s easier, you feel you have more in common. But having said this, I get on fine with my current consultant who is not gay.’

‘One of the psychiatrists suggested [LGB voluntary organisation] and through them I was able to set up six weeks of counselling.’

‘My CPN once gave me a book about male rape, they had it in the resource centre which was good. I felt like I was taken seriously, the fact that they had the book there was quite impressive.’

Several participants spoke highly of attempts to develop service-user involvement initiatives within services, although in one instance funding for this had been ceased:

‘One good thing [in hospital] was the users’ forum.’

‘I had a permitted work post as an acute patient liaison officer. I went on to all the wards to speak to all the patients that wanted to talk to me, about their experiences, any complaints and especially the way the staff were treating them. That was good but the funding stopped for it.’

‘I asked if it was possible to do a spot check on the ward. This was brilliant. He didn’t tell them he was coming, came onto the ward – it was one of the patients who let him in. A report was written and the whole of the staff group was changed.’

Practice with regards to recognition of same-sex partners was also said to be good on the whole:

‘Whenever I’ve gone into hospital they always ask you who your next of kin is and they’ve never questioned when I’ve given my partner’s name.’

‘In general my partner has been recognised as my carer by mental health professionals, I’ve been really lucky actually.’
6.9 Issues raised by carers

The two carers interviewed (and included in the focus group) had particular issues to raise about their own experiences of participating in the care of friends or partners experiencing mental distress. Lack of support offered available from both the voluntary and statutory sectors (despite the mandate of the NSF (see section 3)) was mentioned as a problem and corroborated by service users talking about their own carers:

‘No support offered to [my friend] as a carer. He has been under a lot of stress at times, has almost gone under himself.’

‘Carers support organisations are focused towards disabled children or the elderly, not mental health or disabled adults.’

‘I’m not aware of any LGB carers support groups. A lot of LGB people I know are caring for people. I wonder what the picture will look like a few years down the line.’

A wider issue discussed was general lack of recognition and exclusion from the care of LGB loved ones, both as an LGB friend or as a disabled person:

‘Nobody has seen me as anything but disabled – I’ve not been given the opportunity for any input or support. Because I have my own care needs, I’m not seen as a carer. But if I had more support as a disabled person, I could care more effectively for others.’

‘If you don’t have a civil partnership, you’re considered a non-partner. Apart from in the case of benefits.’

6.10 Voluntary sector services

Several of the participants were one-time or current users of voluntary sector services, and tended to speak highly of them:

‘The voluntary sector is a godsend, they were the only ones who really helped me get myself back into work and back on my feet. I felt that these people must have been there themselves because they have a bit of compassion and patience. Whereas the GPs just didn’t know what to do at all.’

The service user movements have been good – Mindlink have LGB user reps.’

‘I’ve recently started going to [LGB voluntary sector mental health project]. It’s even better than the resource centre because you’re with gay people, there’s no homophobia. That’s a whole area you don’t have to worry about hiding or guarding. It’s scary how conditioned we are to hide. It’s really nice and I’m enjoying it.’
Speaking to members of an LGB mental health support group tended to confirm the increased sense of safety experienced by users in this environment, and the consequent benefits for their mental wellbeing:

‘I feel safe here’
‘I feel that the fact that we all have the same sexual orientation unites us as a group.’
‘It’s informal and there’s no pressure – anyone can just join in.’
‘The workers are also from the LGBT community and that’s important, it makes you feel safe.’
‘You can be yourself – you don’t have to look over your shoulder.’

Several participants had themselves initiated or volunteered for support organisations, and had found this to be a positive experience:

‘I used to volunteer for an LGB switchboard and support centre, which I really enjoyed. Years later a woman I had talked to when she was thinking about coming out recognised me and introduced me to her friends as someone who had really helped her. It was good to see her as she is now, settled and happy.’

‘I think that in the process of counselling others, you come more to terms with your own sexual identity. Helping someone else, you find out more about yourself.’

Nonetheless there were various concerns about access for several people, given the relatively small number of LGB-specific services available, and also recognition that as such they tended to be overstretched:

‘The group only runs for one day a week during the day time, so I have to take time off work to attend. I wish it ran on any day of the week, or in the evenings.’

‘It’s miles away, I couldn’t possibly get there. If there was something in South London I would go.’

‘The waiting lists for both [X LGB voluntary sector organisation] and [Y LGB voluntary sector organisation] are full, you can’t even get on to wait. Which just shows how much of a need there is out there.’

Some women (and indeed men) recognised that existing groups had difficulty attracting enough lesbians regularly, which in turn made it intimidating for new women to join:

‘There used to be a lesbian support group at [voluntary sector organisation]. That was useful at the time, but it has gone now. I’m not impressed with [another voluntary sector organisation] since it is predominantly gay men that go there. [Another voluntary sector organisation] is miles to get to.’
'Not enough women attend the group. It’s possible that women aren’t keen on a mixed group, they have in the past tended to say that the group wasn’t for them.’

There were also concerns about changes to services occurring as a result of funding cuts, especially around the provision of HIV support and prevention:

‘At the time the project had some NHS funding because politically this was the thing to do, at the time of the HIV crisis. But this has long since ceased, and now there is a real fight for funding.’

‘I’m worried about the future of HIV services because all of the funding is stopping for that now.’

Finally, one user (who had been refused a statutory assessment and who could not afford to seek out private services) expressed concern about the fact that voluntary organisations can only really afford to employ trainees in therapeutic roles:

‘I’ve accessed [LGB organisation] before, for courses. They’re really lovely people, but I would be worried about the level of competence. I wouldn’t think the counselling service would be suitable for me.’

### 6.11 Wider issues within the LGB communities

In addition to feeling isolated from society at large, most of the participants felt to some degree discriminated against within or excluded from the LGB community due to stigma attached to and lack of consideration for age, mental health issues or disability:

‘General stigma for being a survivor can be very severe at times. I have issues around coming out as a survivor amongst the lesbian community.’

‘There is an emphasis on young, fit and healthy in the gay scene. I can’t hear in lesbian bars because of the background noise, but I like this. I like modern music, just hanging out – like I’m merged into a melting pot. But if you’re not a regular, it can be hard to break in. And access [for people with disabilities] is shit.’

‘There’s not much opportunity for contact between generations. Which is a shame because I have found, talking to younger women, that they’re much more open, really open to discussion of feminist issues.’

‘It’s difficult socially [being an older lesbian] – there’s not much in London. I find the scene very druggy so I don’t go to bars much. There are issues about age on the scene – there aren’t many women’s bars to start with, and they tend to be full of much younger women in designer clothes, that kind of thing. The older dykes tend to stay at home.’
'The mainstream scene is really body fascist and ageist. When you get to a certain age, you just disappear. I feel as oppressed by young gays now as I have done by straight people.'

'There is a real lack of access to LGBT community events or consideration of disabled issues, so you just become more and more isolated.'

There were a variety of views expressed with regards to whether LGB friends had been more or less supportive during times of crisis than straight friends and indeed whether there is greater stigma attached to mental health issues and disability among this group:

'I find it is much easier to raise LGBT issues amongst the disabled community than vice versa. The disabled community accepts everyone but with the LGB community many are still seen as ‘other.’ There’s a huge amount of stigma attached to mental illness and indeed to HIV, I don’t know what it is that creates these attitudes. I feel isolated from the LGBT community at large.’

'I do find my lesbian friends to be a bit better with the mental health stuff, perhaps because gay people have had to do a lot more thinking, they can maybe relate a bit more to the difference. I think there are more parallels because being lesbian or gay you suffer an oppression, the same kind of invisibility.’

'I certainly feel like I can’t talk about my mental health problems with my friends, straight or gay – gay a little bit more actually. This shocks me actually, I think they don’t want to hear it because they don’t know what to say, so I find myself not talking about it but feeling very false because I’m not who I am.’

Concerns about the future and hopelessness concerning the possibility of finding meaningful relationships seemed to contribute significantly to several peoples’ distress:

'The future looks a bit bleak. If you don’t have a relationship, what is there for you? There is less available for older gay people, you feel a bit passed by.’

'I’m very lonely and depressed. I’ve never had a proper meaningful relationship and it’s too late for me now. I can’t see what anyone would like about me anymore, I would think they were after my money.’

'I worry mostly about getting older, about my physical health. Who will look after me, what will happen. I think this contributes a lot to my mental distress.'
6.12 Sexual orientation monitoring

This issue was raised in particular to investigate whether fears that asking about sexual orientation as part of service user monitoring would be perceived as offensive or an invasion of privacy. It must be noted that here participants were, in the main, ‘out’ to services which as such may have affected their responses. The consensus tended to be that the question was useful, but that it had to be asked sensitively:

‘I’ve got no problem with being asked, because to me that is getting it over with.’

‘I would be glad to be asked at assessment. If I was asked I would think that my sexual orientation was being considered or taken seriously.’

‘Obviously it depends how you ask it – ‘how do you classify yourself?’ instead of ‘are you a gay man?’ Giving people an open-ended question, or the opportunity to make a response that was anonymous would be better.’

‘I can see that there would be people who might be embarrassed by it. I think you have the right to privacy – you don’t have to reply.’

‘Personally I find the attitude of staff not wanting to ask clients patronising, it’s like confirming that it’s a problem in some way. If you think someone is going to be offended by admitting to who they are, then essentially you’re saying that you’re offended by it.’

6.13 Housing issues

As suggested by the recovery model, suitable housing was seen as being integral to mental wellbeing by several service users who felt that such concerns played a large part in the story of their mental health difficulties:

‘I couldn’t get in and out of my flat. It was with a housing association. I waited 16, 17 years for a transfer. Really a lot of my worries, my mental health needs were to do with this.’

‘When I came out of hospital I was offered a B and B but I turned it down because I had heard these places were really homophobic, so I had to go back to my partner [even though the relationship break-up had precipitated my breakdown].’

‘It was the totally inadequate housing situation, the lack of disability access that was causing a lot of mental distress. This was discussed with the psychologist, who basically said ‘what am I supposed to do about it?’"
The high cost of housing and other financial concerns had in one instance prevented a service user’s partner from being able to offer the level of care that she wished to:

‘Even if we could get a place together [so that I could continue to care for my partner] we couldn’t afford the arrangement because of benefits restrictions.’

In every instance, individuals felt disempowered and without representation when confronted by these situations:

‘I felt like absolutely nobody was listening [with regards to my outstanding housing issues]. I would have accessed some kind of advocacy service but there wasn’t one.’

6.14 Recommendations

Ideas for improving accessibility and practice within statutory services were offered freely. Adequate, mandatory diversity training for staff on sexual orientation issues was mentioned most frequently:

‘I’m not aware that staff get any training in LGB issues or homophobia awareness.’

‘When I was working as a patient counsellor one of the big issues I was trying to get across to [the nurses] was that they needed to have training on sexual identity issues.’

‘I used to be involved in training carers. Some of the attitudes of the people who came were really shocking but I think they realised that they had done things wrong at work and took this knowledge away with them.’

‘[Staff] need to be aware that they are working in the NHS with patients who might be gay or of another religion and that it should not be that obvious what their own beliefs are.’

‘I think there is just as much training needed for officers in the authority, that is to say the people who write the policies.’

A related issue is that individuals experiencing crisis or mental health issues need to feel safe in the environment in which they access services, and guarantee of protection against homophobia or even acknowledgement that LGB people exist can be an important way of ensuring this:

‘Staff need to be sensitive to homophobia or discrimination and convey to perpetrators that it isn’t acceptable. It would help if there were perhaps posters up to confirm that there will be no tolerance of homophobia.’
'I've never seen posters or information that's gay-friendly in GP surgeries, and I have seen quite a few. Even putting up the current Stonewall posters would make a difference. It's at least an acknowledgement – I would feel that at least somebody realises that not everyone is straight.'

Others have described a need for LGB-specific services, and indeed a change in the way in which the NHS treats mental health issues. Where this is impossible, the availability of information pertinent to LGB people is seen as being desirable:

'There needs to be clinic sessions for LGB people.'

'The NHS gets it wrong by treating mental health problems as a medical symptom. What is needed is a holistic approach, wellbeing centres for gay people where you can take care of yourself and can be treated holistically – massage, therapy, exercise, diet.'

'It would be really useful to have some kind of literature about LGB issues and mental health and coping with mental health problems as an LGB person. No mental health professionals have ever offered me this.'

Some participants who were disabled also called for greater physical accessibility of services:

'More physically accessible mental health services are needed. It is like our mental health needs aren't recognised because we're physically disabled.'

In terms of wider support and (potentially) voluntary sector initiatives, almost everyone felt that a peer support network of some form would be massively beneficial:

'I can be in hospital for up to six months, and it can be very difficult when I come back out. I think some peer support would be useful, someone to talk to about my feelings. I think that's something the LGB community has been bad at providing. It could be survivor or a non-survivor.'

'I would be absolutely interested in some kind of peer support for LGB people with mental health issues.'

'It would be nice to have a mental health group [for LGB people], I think [sexuality is] a big issue for a lot of people with mental health problems.'

'What would be good is some people who have recovered from mental health problems to advise those who are coming out of crisis.'

'I do think some kind of lesbian and gay network, maybe an email network would be good. Because there must be a lot of lesbian and gay people with mental health issues. Often when we're coming out there's a lot of stress.'
Potentially the function of a peer support group could be combined with advocacy along the same lines as the Liaison Officer post described above. This was identified as something that would be useful, but only so long as advocates were taken seriously by service providers:

‘I really needed somebody outside of the ward who was linked to me, like a support worker, who could represent me at case conferences. I couldn’t rely on my friends or family to do this, and there was no attempt to put me in touch with anything of this kind.’

‘I think people need advocates. I think advocates are the only way to help people in a mental health crisis. Because how are you supposed to cope with these difficulties yourself? You can’t, because you’re ill’

‘Some kind of LGB champion or counsellor on the wards would make a huge difference. I’ve done it before though, I’ve championed peoples’ rights and you just get fobbed off, and you just end up getting ill yourself.’

‘Advocates were appointed who were skilled in understanding what people with severe dementia were trying to say. When the meeting came to close the care home, the advocates weren’t invited. There’s a gap between rhetoric and reality.’

Beyond the above, some individuals called for awareness raising of disabled and mental health issues within the LGB community:

‘I think there needs to be more contact between the relationship between the gay mens’ and disabled communities with regards to the effects of AIDS. My friend [with AIDS] would never admit he was disabled, there was a real resistance to it. He had such a sense of isolation, was so angry, distressed, isolated and bitter. If there was more dialogue between the disabled and gay communities, they could share insights and support.’

Finally, there were specific recommendations made about legislation as it applies to LGB people:

‘The Mental Capacity Act has gone a long way towards preventing the kind of situation that I experienced from happening again. But it must be contextualised for LGB people. Many LGB people are not civilly partnered, and friends are that person’s family. I think there is still a problem in that there is no clear process for deciding who a significant other should be, what criteria should be taken into account and if there are objections what process there is for deciding on them.’
6.15 Summary

As predicted in section 2, long time users of mental health services certainly seemed to present their experiences of homophobic discrimination, abuse and attack in the wider world along with the pathologisation of their sexual orientation ‘during formative years’ as being integral to their struggles with mental health issues. As one participant firmly maintained, ‘I am not mentally ill because I am a lesbian’ but rather because of the abuse and the tragedy she had managed to survive, much of it the result of being a lesbian within a homophobic society. The importance of trust during times of vulnerability and indeed of the need for sanctuary and a place to feel safe through crisis was frequently described throughout the interviews. Several spoke highly of the non-judgmental attitudes encountered in some NHS staff. However, more so than with the quantitative data the qualitative suggested that others had been so scarred by their early experiences of mistreatment within statutory services that they had ceased to see them as a viable route to these things and were attempting to cope on their own. Yet more were continuing to experience direct and indirectly homophobic behaviour from staff at times and when they felt too weak to challenge it or defend themselves and their self-esteem.

Furthermore, participants reported feeling stigmatised by or excluded from mainstream LGB community (as a result of both age and mental health needs) and also that they were unable to rely on friends to help them through difficult periods. The voluntary sector, whilst seen as an indispensable resource and occasionally a lifeline, was often perceived as overstretched or hard to access and useful services had changed or ceased due to lack of funding. Day centres were, on the whole, valued as a means of social inclusion and solidarity (contrary to what is suggested by the Department of Health report discussed in section 3) and users felt expendable and marginalised after closures occurred with minimal consultation or despite lengthy campaigns.

Support outside of hospital was perceived to be minimal or totally inaccessible, in particular (supposedly increasingly available) talking therapies. Poor quality housing, a lack of viable housing options and generally unsympathetic or powerless authorities were seen as contributing to mental distress. Together all of these factors seemed to contribute to a sense of isolation amongst interviewees, of fear that there would be nothing to catch them should they begin to experience difficulties but indeed also of anger and frustration at the inadequacies of the system. In turn LGB carers faced exclusion and lack of recognition when it came to offering support to their loved ones, were offered no support themselves by statutory services and could find no support in the voluntary sector.
There was some general consensus that, in order to let LGB people feel the safety that they require in order to get the most from services, the NHS needs to actively demonstrate that it recognises their existence and needs by taking a hard and visible stance on any kind of homophobia. Staff need to be trained so that they are aware that it is unacceptable to confer religious or judgmental views on patients in their care. Where possible, a holistic approach to the treatment of mental health issues should be taken. Advocates, where they exist, need to be taken seriously and included in decisions made on patients’ behalf. Finally, some kind of LGB peer support would possibly help to provide a safe space for individuals to socialise, some emotional back-up when required, some perspective from those who have been through crisis themselves and perhaps even some representation when people feel too unwell to defend their own rights.
7. Perspectives from staff and services

A small survey of 36 mental health day services for adults across London was conducted as part of this scoping research. Managers were contacted by telephone and asked a short series of questions as follows:

1. Do you currently provide LGB-specific activities for your users?
2. Do you currently display publicity relating to LGB events or services?
3. If not, would you consider doing so?
4. Do you currently work in partnership with an LGB organisation?
5. Would you know how to refer to an appropriate LGB-specific service if requested?
6. Do you, as far as you know, have LGB people currently using your service?
7. Are service users able to continue in the service when they reach 65?
8. Do you accept new referrals for users 65 and over?
9. Do you think there is a need for a support service tailored to older LGB people?

Centres were a mixture of those run by the NHS, commissioned by the NHS, run independently by the voluntary sector, run by and/or commissioned by local authorities. Because of the disparity, crossover and lack of clarity in terms of organisations responsible for providing each service, results are not broken down in this way. Figure 6a shows overall positive responses by percentage.

![Bar chart showing positive responses for various questions related to LGB services](chart.png)

**Figure 6a – Percentage of positive responses from day service managers to questions about access / LGB equality**
As discussed in section 3, some contact with staff working in older peoples’ mental health, adult mental health and voluntary sector older peoples’ and LGB-specific services took place also. This proved to be important due to the fact that we had not been able to attract users with early dementia to the survey interview or focus group and only one ex-carer of someone with dementia, and as such it gave at least some anecdotal reflection of another set of LGB users even though this was from the perspective of professionals. Local authority staff were not contacted further after this survey due to difficulties with the research governance approval process. Findings from this work (together with discussion of the survey results) are presented under various headings below.

7.1 Anecdotal stories about older LGB service users

All staff had encountered older LGB people amongst their service users, although those individuals were not (in every instance) explicit about their sexual orientation:

‘Several of our [older] clients are known to be LGB within the service. We sort of work it out through fleeting mentions of lifestyle, things like that. One man in his 80s with dementia has what we think is his partner who cares for him, although he has never referred to himself or his partner as gay as such. We refer to him as his friend.’

CMHT staff member

‘Once we had an older gay couple use the service for a while. They would hold hands on the ward, show affection for each other. We didn’t really have any problems from other service users because, well, a lot of our users are quite disordered and it’s hard to tell whether they really noticed. Certainly if they did no-one made a fuss to my knowledge.’

Day service manager

‘I think one of my clients is gay. I couldn’t tell you exactly why, it’s just something about his manner, his style of dress. I don’t want to come right out and ask him though, I don’t want to offend him. And I think it’s really up to him whether he tells me or not.’

CMHT staff member

The overall perception of older LGB people amongst staff (particularly those not offering an LGB-specific service) was that they tended to be very isolated from their peers and the rest of the community:

‘We had this one client who was an older gay man. He lived on one of the estates around here – you know, these estates aren’t an easy place to be
if you’re a gay person. He was really cut off and isolated, didn’t really have any friends or social activities, no peer group essentially. I think he would have been interested in a service for older LGB people.’

CMHT staff member

As suggested by the above, they noted that issues around sexual orientation or sexuality at all tended to be difficult to raise with older people:

‘If I have tried to discuss these things before with people, I have been told that it’s none of my business. I think this is a common attitude amongst older people, they don’t really want to discuss what they see as something very private.’

Day service manager

Voluntary sector staff (especially those providing LGB-specific services) tended to report instances of non-engagement with statutory services amongst users:

‘A couple of our users received aversion therapy when they were younger. They don’t use statutory services at all now, even though there is quite obviously an unmet need.’

LGB-specific service manager

‘Many LGB users get all of their needs met in the voluntary sector. Nothing has changed in terms of homophobia within the NHS.’

Mental health organisation manager

‘Many older LGB users we encounter have really negative views of public services; social services, the police.

Day service manager

7.2 LGB-specific services

Only two of the 36 centres surveyed provided LGB-specific groups. Perceived need for such groups amongst staff was slightly higher at 14%. A commonly reported reason for lack of specific groups was difficulty in generating sustained interest. Where groups were set up, they had sometimes folded or dissolved; despite the day service commissioning framework’s emphasis on users providing their own support services, unfortunately this has not always seemed practical:

‘We did used to run a group but it folded due to lack of interest really.’

* See section 3.8
‘[X voluntary organisation] used to have a group that we would refer to, but they folded a few years back.’

‘We suggested a group, but not that many people were keen for it to take place, so instead we refer on to other services.’

‘The original aim was for the [LGB-specific] group to be self-running, and that happened for a while. The group organised its own meetings, and held them in a separate venue. But the support needs of one or two of the users were proving too much for the others to be able to manage on their own and eventually the group dissolved.’

A few (including older peoples’ day services) were open to the idea of developing LGB-specific services, but had concerns about doing so:

‘I’ve been keen on setting something up for some time, in fact I’m worried that there isn’t any provision. But I’m concerned about ‘outing’ people.’

‘I heard that [another day centre] was running an LGB group and I thought it was a really good idea, but I wasn’t sure how to go about it’

‘Many other [older] service users would have been lesbian and gay people’s oppressors during the less tolerant years. Many have extremist views on race and sexuality and aren’t reluctant to express them, so I’m not sure that groups are necessarily the best forum for openness.’

Older peoples’ day service manager

Others described being constrained by the priorities identified by their service level agreements:

‘The council provides the criteria for our service, and LGB-specific activities aren’t on there.’

‘Local authorities are gradually broadening their outlook. At the moment our priorities in the service level agreement are women and BME communities, but nothing on LGB.’

A substantial proportion of managers felt that LGB issues were more appropriately tackled in one-to-one work:

‘It’s up to keyworkers to discuss any issues to do with sexual orientation, they provide any information or onward referral.’

A few simply felt that specific services weren’t necessary:
'I would like to think that we adequately tackle issues around sexual orientation in group discussion.'

'We have one older LGB person and he just blends in'

'We don’t have any gay people in our service. Gay people are much less common amongst Asians than whites. I would know if there were any.'

It is of course possible that users do not always want an LGB group to take place in the premises used by the mainstream service they access if there is a chance other heterosexual users may realise they go to the LGB group and it outs them. One seemingly successful approach to this problem taken by a particular day centre was to run a group that promoted itself as for all users, but on the premise that LGB issues would be discussed. The group tended to attract a mixed attendance of heterosexual and LGB people, but appeared to offer particular benefits to those not out yet. They could attend without having to take a difficult psychological step in automatically outing themselves, but once there they had the potential support of out LGB users and a generally safe environment in which to do so should they choose.

Amongst CMHTs there was some consensus that a peer support network of some kind would prove useful for isolated clients, and wished that the researcher could develop such a service since they were not in a position to be able to do so.

7.3 Displaying LGB Publicity

The importance of displaying LGB publicity was underlined again by one day centre manager, who noted that:

'We’ve found that, when we have put up LGB materials, about Pride or other events or services, there has been less in the way of homophobic comments or behaviour in the centre. Just doing that has helped.'

Whilst it is recognised that many services may not attract sufficient numbers of LGB people to justify running a separate group, or may not have the resources or confidence to attempt to do so, displaying publicity and signposting to LGB specific services at least caters for those who may not feel able to be open about their sexual orientation to their keyworker and fulfils the commissioning framework’s inclusivity requirement. Nonetheless under 20% of centres surveyed actually had any publicity and only a further 28% said they would consider having any. Most commonly the reason given for this was that there were not any LGB service users in the service (as far as they knew) – of course, this is the kind of
assumption that makes openness about sexual orientation in this context difficult in the first place. In the case of one facility (as quoted in section 3):

‘We are not able to display materials or information relating to lesbian or gay people or community organisations because our day services are run from Christian community venues, and I feel that they would be displeased if we were to do this.’

Whether or not the manager was aware of it, this is in fact an instance of indirect discrimination – that is to say, LGB people are receiving a poorer service in this instance than would be afforded a heterosexual person. More work needs to be done to explain the value of materials that value LGB people whether or not there are any users of the service known to be LGB. Too narrow an understanding of LGB inclusion ignores the possibilities that users may not be out or may have relatives or friends who are LGB. Inclusion is also helpful to them, and indeed an atmosphere of respect for LGB people may be supportive to the self-esteem of users who are aware of intermittent same sex desires even though they may never wish to act upon them.

7.4 Exclusion from services at 65

As displayed in figure 6a, only 56% of services surveyed allowed users to continue to use the service once they reached 65 and only 28% received new referrals for individuals who had reached this age. When asked why this was, no single service mentioned any particular difficulty anticipated (in terms of levels of support or staff required) in catering for or including older people; rather, referral criteria were said to be determined by NHS or local authority policy. There was also recognition of limited remit:

‘We wouldn’t accept a referral for someone who is 65 or over. There are other services for the elderly.’

One manager mentioned equal opportunities policy:

‘We couldn’t refuse the service to someone who was already receiving it if they turned 65 because that would constitute age discrimination, but we can’t take new referrals because of the local authority’s criteria.’

Unfortunately as discussed in section 8 there is at time of writing no law to safeguard older peoples’ right of equal access to services.†

† Since the report was written the government has announced that it intends to bring in legislation on age discrimination, but how this will be framed and how this will affect mental health services remains to be seen.
Nonetheless, this age cut-off was not universally observed, and many service providers described a level of flexibility in their policy for accepting new referrals:

‘We have an open policy with regards to age. If after assessment we find that the person’s needs are mostly around mental health, then we would accept them.’

‘We have a wide range of ages using our service and it seems to work fine. We accept people based on need and not age.’

‘Nominally our cut off point is 65, but it would really depend on the circumstances of that individual.’

‘We accept people up to 74 years old because usually at that point there are physical support needs that we aren’t able to provide support for. However, we get quite a lot of people at the older end of the age bracket.’

Staff within older peoples’ services tended to question the rationale behind the distinction between adults’ and older adults’ services:

‘I think the distinction is a historical one more than a practical one. It think it is likely that things will change as more people live and work for longer.’

Older adults’ consultant psychiatrist

‘The older people’s cut off is in some ways arbitrary – 80 yr olds don’t necessarily want to hang around with 65 yr olds and vice versa. In some ways it is a functional distinction, to keep older people separate from potentially dangerous younger adults within mental health services.’

Older adults’ mental health nurse

‘I don’t think it’s always especially to do with the division between functional/organic and other mental health problems. Dementia is more common amongst older people, but a diagnosis of dementia doesn’t necessarily prevent successful interaction with other users who don’t have dementia.’

Older adults’ mental health nurse

7.5 Recognition of homophobia amongst other staff

Many of the NHS staff reported a climate of homophobia within the organisation, reflecting the findings of the 2007 Stonewall report ‘Being the Gay One.’ In some instances concerns about particular groups of staff were mentioned:
‘In my job I meet a lot of nurses and GPs and in general I’ve found them to be outrageously homophobic. I would not trust the majority of the medical profession on LGB issues.’

‘The NHS is not a very gay-friendly workplace. You have to be very confident to be out and proud.’

‘Every ward I’ve worked on has had this, where there are really religious staff making their views obvious to other staff and to patients. It’s not always totally open – sometimes it’s subtle things like telling patients that they would pray for them. But I think if I was a gay person in that service, I would feel uncomfortable around that.’

Some concerned staff made statements about groups of NHS colleagues from particular countries of origin that Polari could not support as generalisations, but which flag up the need for health service management to tackle the issues of how better to support both Christian staff and LGB service users. Staff need better guidance on their rights to hold personal views on homosexuality in tune with their faith, but not to discriminate in the workplace. Staff who may have migrated from a society where homosexuality is viewed more negatively may need better training, support and clear uncompromising direction on this issue than they receive at present.

‘The NHS is full of very fundamentalist Christians …. They are usually frighteningly, appallingly homophobic.’

‘When I was doing my nursing training, I would encounter a lot of people with really strong religious beliefs who were quite vocal about them. And these included beliefs that gay people were evil or wrong. And I thought ‘God, these people are going to be working in hospitals with vulnerable people.”

Some staff reported recognising these problems, but experiencing a sense of powerlessness to change anything:

‘I completed a project on this issue as part of my care management training, but I was marked down on it. I think it was because the issue was too personal to me. But I remember my manager saying that I was very brave for being honest about it.’

There was also some recognition of a gradual process of change within the organisation:

‘I think it wants to change and some bits are changing. I think there are people on the inside who are trying to drive that change. But I think it’s not clear enough how things have to be – that certain behaviour is just not
acceptable in public servants, representatives of a public service. It needs to be more punitive.’

7.6 Training

Several staff highlighted insufficient training on equalities issues as being one contributing factor to this situation. As some of the above comments highlight, some did not feel confident tackling certain equalities issues:

‘Sometimes users quite vocally express really racist or homophobic opinions, often to members of staff from ethnic minorities and it’s really embarrassing. In one sense you really want to challenge those opinions, but then in another it can be unclear how much of what they are saying is due to their level of dementia.’

Mental health nurse

It was also recognised that there is currently a drive within the NHS to address this, and yet the approach was having little meaningful effect:

‘During my equalities training, people were saying things like ‘what about my human rights to refuse to care for a gay person?’ or ‘what about my human rights to refuse to share a toilet with a transgendered person?’ The trainer didn’t challenge this at all. I was really offended by these comments and I made a complaint to the trainer about it at the end. He said that he sort of saw where I was coming from, but nothing more took place. I’m not confident that those people really took anything away from the training. I mean, if they have these religious views to back up their beliefs, they’re not going to change after just one session. Plus I think others will be wary of challenging them because they don’t want to appear as if they’re discriminating against them because of their beliefs.’

Primary care service co-ordinator

Some expressed the opinion that appointing staff correctly was more important than training:

‘A good staff team contributes to people being able to be open about their sexual orientation, which then lets you provide a more effective service. For example, we paired up one older gay man with a gay male member of staff, and this really worked well. It was really important to [the older man], the feeling that he could talk without judgement. In some ways it doesn’t matter how much training you give people, it’s their attitude towards the work that counts. And this needs to be demonstrated from the top down.’

Day service manager
7.7 Sexual Orientation Monitoring

The issue of monitoring for sexual orientation on the Count Me in Census was raised with older peoples’ CMHTs and NHS day service staff contacted. The primary issue expressed was that people felt uncomfortable asking what they perceived to be a very personal question of users:

‘I wouldn’t want to go straight ahead and ask people in case you offend them or make them feel uncomfortable.’

Mental health nurse

7.8 Summary

The first thing to note is that all the staff providing older peoples’ services that were visited over the course of this research had encountered older LGB service users. Despite the fact that there was some indication that (due to lack of confidence in services) older LGBs are steering clear of statutory provision, they do present regularly within this field and will (as one staff member noted) continue to do so with increasing regularity as generations with historically more open attitudes about sexual orientation begin to reach old age. This tended to present issues that staff sometimes felt ill equipped to tackle – for example, tackling homophobia, helping someone with isolation or deciding whether it was appropriate to broach the subject of sexual orientation or not. Often staff had very good intentions towards older LGB service users, but had no service available to refer them on to or no means or guidance on how to develop one themselves. Sometimes they appeared to feel constrained by the policy objectives of the commissioning bodies that fund their services. There was also some evidence to suggest that (contrary to the recommendations of the day service commissioning framework) expecting users to develop and run their own services will not always be effective due to varying levels of support needs to manage and perhaps indeed due to the stresses of doing so whilst attempting to cope with their own mental health challenged.

The levels of homophobia reported as inherent in the NHS was disturbing, but came as no real surprise after reports such as ‘Being the Gay One’ and ‘Diagnosis Homophobic.’ There was some indication that current training aimed at tackling the problem is only proving to be of limited efficacy, and in one case there was an apparent lack of confidence in knowing how to tackle instances of homophobia in users. More worrying was the perceived sense that staff felt unable to tackle instances of appalling practice in staff because they felt they wouldn’t be backed up to do so within the organisation (itself perceived as being ‘not very gay-friendly’). As one day service manager highlighted, the general climate and attitude within the service provider is as essential to the wellbeing of
service users as staff. Producing a climate where staff can feel able to be open about their sexual orientation allows constructive working relationships with LGB service users to be formed (especially where users express a preference for working with LGB staff). It also results in staff being able to lead by example and through pro-social modelling, the effectiveness of which was demonstrated by the reported effect of increasing LGB visibility through displaying publicity mentioned above.

An impression of a lack of awareness of equalities and implementation of equalities policy was formed from this survey of a relatively small number of day services. In some instances staff simply assumed that their users were not LGB without making any provision for the possibility, and in doing so contributed to producing an environment where being openly LG or B was possibly easier and indeed (as supported by results presented in section 6) which LGB people may be less likely to access. In another, choice of venue impeded adherence to equalities good practice, suggesting limited understanding at different levels of service planning. Nonetheless, in many cases sexual orientation had been considered, and different approaches were being used to incorporate consideration of it into care (for example one-to-one keyworking and group work). In terms of age discrimination, the majority of staff expressed the opinion that the division between adults of working and non-working age was arbitrary. Voluntary sector day services seemed freer to offer broader eligibility criteria and reported no difficulties resulting from having done so.

Staff do seem to have been reluctant to monitor for sexual orientation because of concern that doing so would upset or embarrass service users. Nonetheless, as section 6 demonstrated, LGB users find this view patronising and based on the assumption that being LG or B is something to be ashamed of. An effective method of allowing for anonymous collection of this data is perhaps required.
8. Problems and Limitations

This section aims to discuss some of the problems encountered whilst attempting to carry out this study with recommendations, where relevant, for alternative approaches researchers might adopt. It also looks at some of the limitations of the research design and examines the reliability and validity of the information collected.

8.1 Research Governance Approval

As a voluntary sector organisation conducting a consultation with users of statutory services across the whole of Greater London, procuring approval to proceed with the work was a very long and difficult process. Because participants were potentially users of NHS services and local authority services, it was necessary to follow two separate streams of approval procedures. In fact, despite the use of common guidelines drawn from the government’s Research Governance Framework document, most mental health trusts and borough councils approached had a slightly different process or opinion on whether ethical approval was necessary in this instance and if so what had to be done to obtain it. From the point of view of some local authorities, approval was necessary even though a) no staff time was required to recruit or involve participants and b) no advertising materials were to be left on their premises as a result of their duty of care to ‘vulnerable adults’ falling within their jurisdiction.

Due to the time limitations that play an inevitable part in the running of a project with fixed funding, advertising and recruitment through staff could only take place across four mental health trusts who had given immediate consent with slight refinement of the protocol. Approval was also sought and obtained from the Association of Directors of Social Services and those borough councils where individuals who had responded to publicity distributed outside of statutory services. We also approached those who hosted services which had expressed an interest in being involved in the project. Therefore it must be noted that the sample obtained is much less representative than it could otherwise have been.

Recommendation - Since the formal research governance approval procedure is fairly new to local authorities, it is likely that future work of this kind will proceed with fewer obstacles. It is also probable that, had this work been commissioned by a statutory provider or (better still) carried out within statutory services, clearer guidance would have been available. Research and voluntary organisations should consider discussing their plains informally with research governance officials within the service being researched even before a funding bid is
submitted as doing so may influence the design and scope of your work. This would also provide an opportunity for honorary contracts\footnote{Full contracts with NHS trusts for voluntary work} to be procured from the outset of the project if necessary, which would allow for greater contact with staff and service users within the NHS.

8.2 Reaching LGB People Over 60

Problems associated with this have already been discussed to some degree in section 3. With very few resources aimed at older LGB people available, recruitment through statutory services, through older peoples’ community centres or through voluntary sector newsletters seemed like the major viable routes outside of Polari’s existing links. However, there was very little response from any of these. It is possible that (in the case of the former two) this was due to discomfort or fear of being seen taking notice of a poster aimed at LGB people. Where fliers were given to staff to pass on, obviously only those who were open about their sexual orientation to professionals were approached, potentially biasing the sample. Even in these instances, as noted in section 6, staff reported that LGB people within this age bracket had expressed no interest in discussing matters around their sexual orientation, stating that it was ‘their business alone.’ It is of course possible that this view was expressed because these older people did not view mental health services as an appropriate forum for discussing issues surrounding their sexual orientation, or because of concerns surrounding confidentiality or response from professionals. Unfortunately this project has not succeeded in discovering whether or not this was the case.

Those older peoples’ LGB groups that did exist were reluctant to take part in the project due to the fact that they had previously been consulted frequently by other researchers. The problem of stigma also arose, with individuals not wishing to out themselves as mental health service users by displaying an interest. The result is that the sample used by this study is heavily biased towards individuals under 60. This is of particular concern in this instance because older adults’ services accept referrals at age 65 – however, this report has very little to say about these services. This is unfortunate as if they could have been focused on it would have filled a gap in the previous literature on LGB people and mental health services.

Recommendation - Until there is a reasonably large-scale, established network of older LGB people in operation with an associated newsletter or means of communication, it will remain extremely difficult to recruit participants to this kind of study with such a narrow focus. An alternative would be to gradually to build confidence and contacts with older LGB people by visiting older peoples’ services on a regular basis and spending time getting to know people there. Ideally long term work by older LGBs themselves on peer support and advocacy might be
able to improve the situation, however little or no funding has been available for volunteer projects benefitting older LGB people.

8.3 Number of Participants / Respondents

, as this work was funded by City Bridge Trust, to benefit Londoners. Although intended as a scoping study, the number of participants attracted (given the significant amount of time spent on advertising and recruitment) was considerably lower than might have expected. It may simply be that (in line with research such as King and McKeown (2003)) mental distress is significantly less common amongst older LGB people than younger individuals who also identify as such. It may be that (in accordance with the findings of the Mental Health in Later Life Inquiry) older people who experience mental distress are generally less likely to use mental health services, and that this study might have done better not to make use of services part of its inclusion criteria. Alternatively, the recruitment strategy and methodology may have failed sufficiently to address the problems presented by the target populace. For example some of the issues that may have been relevant are: stigma around mental illness, lack of confidence proactively to seek to discuss opinions, fear of discovery or fear and discomfort about discussing sexual orientation, lack of awareness around mental health or a decreased. Possibly too there may have been a greater cynicism about the possibility of impacting services through this kind of consultation.

Another possible problem was the fairly tight inclusion criteria. For example, had the opportunity to take part been opened up to the whole country larger numbers of participants would no doubt have been involved. However, one aim of the project was to provide feedback to specific mental health services, and it is possible that the wider the geographical net the more disparate the services would have been and the less relevant the conclusions of the work to each individual provider. Comparisons between differing areas would have been difficult, the problems associated with small amounts of data in each area would have remained despite a largely inflated cost associated with advertising and recruitment. A different funding strategy would also have been necessary.

As mentioned, the problems faced gaining research governance approval prevented advertising in local authority day centres and many NHS premises as well as through organisations sub-contracted to provide support by local authorities. In all instances staff were also unable to donate time to help in recruitment. This no doubt limited the number and range of participants attracted to the study, as some main potential avenues of recruitment were thus cut off.

Recommendation – One option would be to conduct wider publicity work using media such as radio to advertise further research. Another option would be to secure permission for the involvement of NHS, social services and Supporting
People-contracted staff, premises and publications before embarking on any research of this kind, although doing so may require a considerable amount of time. Researchers working from within the NHS or social services may find that they are faced with fewer hindrances, as research governance procedures seem tailored to them.

8.4 Other Sample Problems

Disregarding age, the project succeeded in its aim of attracting a fairly balanced sample in terms of gender and of involving a significant number of individuals who consider themselves to be disabled in some way. People widely and partly open about their sexual orientation were represented, as were those who choose not to disclose this information to others. The spread of participants across geographical area was also fair – 18 of the 32 boroughs were represented amongst those who responded to the survey (including a mix of inner and outer London areas), but more importantly users from every mental health trust (save the Tavistock and Portman) took part.

Unfortunately bisexuals were under-represented in this work. Although there are no official estimates as to the percentage present in the general population, the 2007 Count Me In Census (though providing limited data) suggests that there are as many bisexual individuals receiving inpatient care as there are lesbians and gay men. It is possible that ‘bisexual’ is a concept or self-definition that has developed more recently, and that older people are less likely to relate to the term. There is however no evidence to back up this hypothesis.

Less than half of the 49 questionnaire respondents reported having a current diagnosis of mental illness. Since the project aimed to attract those whose needs were being unmet by statutory provision as well as current users of services this was not seen as a significant problem in terms of the relevance of the data. We might also speculate that older LGB people, with generational memories of widespread use of ECT for depression and also of the aversion therapies, might be particularly keen to avoid a formal diagnosis, whatever their need. However, with no objective means employed of ascertaining the level of need of participants, it could be argued that the results are of only limited concern to providers (whose resources only allow them to cater for those whose conditions are severe enough to seriously impact on their quality of life or ability to sustain employment). It is impossible to say how many of the 27 participants without a diagnosis fell into this category.

Economic spread (with housing status as a rough measure) was also poor, with a large bias towards home owners. This is different from other Polari work that has been done by development in the community. This was predicted once the recruitment strategies had been determined and is likely to be in part the effect of the success of the online questionnaire (available only to those with internet
access). It must be recognised however that amongst older generations housing status is less likely to be reliable indicator of current economic status, since individuals living in their own homes may still depend on limited income in the form of a pension.

The most striking deficiency however was the lack of participants from black and minority ethnic groups. Despite extensive efforts to advertise within mental health projects and LGB community organisations targeting these groups and despite sensitivity to diverse language needs only three non-white people provided data. This mirrors the relatively low numbers of people identifying as LGB within BME patient populations in the 2006 and 2007 Count Me In Censuses. This ciykd also be a partial effect of the snowball sampling technique used in this project. Once again, it is only possible to speculate about cultural factors that may be sources of influence here, although it is also worth noting that encounters with professionals working with BME communities were sometimes characterised by their belief that there were no LGB people of their ethnicity, which tended to lead them to dismiss considerations of LGB issues out of hand (see section 6).

**Recommendation** - Further study into the use of the concept or term 'bisexual' amongst older people may be of interest and use with regards to informing future work. Likewise, large-scale research into whether openness about sexual orientation amongst BME-specific and indeed other community projects varies as a function of the expectations of staff with regards to the possibility of having LGB users may provide insight into some of the reasons for the under-representation described above. Again, a better response might have been seen if more time had been spent visiting specific projects and developing relationships with staff and service users.

### 8.5 Use of Qualitative and Quantitative Method

The rationale behind adopting a mixed data collection strategy (questionnaire, interviews, focus group) for this project is discussed in detail in section 3. It is difficult to say conclusively whether its aims were served conclusively by this method. As mentioned, the number of individuals taking part who were not open about their sexual orientation to others was fairly high (just under half the sample) – it is possible that this was due to the provision of an anonymous online resource. All of these individuals took part via this resource – indeed, it was by far the most popular form of involvement. Recruitment from internet communities was also relatively high compared to other sources – this may be due to the relative ease of just clicking on a link and filling out a form.

However, the value of the questionnaire could be challenged. Developing it (including researching questions, gaining feedback from the advisory group, conducting pilots and developing and publishing the online version) was time-
and labour-intensive. Although more participants were no doubt recruited as a result, the vast majority of these were under 65 and, as such, not users of older adult services, suggesting that access to the online format created some bias. It is also probable that concentrating on providing an online resource biased the sample towards wealthier participants able to afford the internet. Had research ethics approval been forthcoming earlier, development time might have been better spent developing relationships with staff and patients on wards and encouraging involvement in this way.

Furthermore, feedback on the questionnaire was not always positive. The intention was for it to be, potentially, the only means of involvement for individuals who were not attracted by the prospect of being interviewed. Therefore the final draft was a fairly lengthy document covering a number of topics which on average took about 30 minutes to complete. Some participants complained that it was unwieldy, and in fact there was a fairly high percentage of copies returned unfinished or indeed not completed at all (24%). Others reported that it was too directive as a format and didn’t provide enough scope for accurate description of their experiences. As an example of this, it was anticipated that in the section that aimed to uncover which services people would like to see, the majority of respondents would be likely to ask for everything suggested. In the original draft, the participant needed to choose three options that were the most important. This was abandoned after the pilot sessions due to the fact that people found it too difficult. The result, however, is that there is a fairly unanimous request for LGB-specific services and training with little direct information relating to what elements of these are deemed to be most important. By attempting to collect both qualitative and quantitative data this research tool sacrificed some efficiency at collecting each type of data.

**Recommendation** – In conducting research such as this where one is likely to attract a small sample, it is probably better to use a qualitative method, spend time trying to find good participants and conducting in-depth interviews) rather than trying to increase general involvement through use of more accessible quantitative tools. Working more closely with particular groups, wards or resource centres may have provided the opportunity to include individuals anonymously by making a FREEPOST address available for suggestion or comments to be sent to anonymously (in addition to enabling the researcher to attract interviewees).

### 8.6 Other Design Limitations

A partial aim of this project was to investigate whether there is an unmet need amongst older LGB people for mental health services or a need for change of practice in the services that they already receive. For a scoping study, this was a reasonable goal. However, future research would have to endeavour to demonstrate such a need more objectively.
For example, because no comparison groups of older heterosexual people or indeed younger LGB people were included, it is impossible to say on the basis of this work whether older LGB people have specific or particular needs relevant only to themselves. The broadness of the scope also makes it difficult to make any specific claims which may be helpful to service providers based on the evidence. For example, a narrower focus on dementia and views of mental health services may have helped to demonstrate whether identifying LGB is likely to prevent someone from disclosing their concerns and seeking treatment sooner rather than later.

**Recommendation** – As well as the suggestions made above, future research would benefit from the incorporation of a more objective measure of mental wellbeing (for example tools such as CIS-R, GHQ 12). A possible protocol would be to compare use of mental health services by older heterosexual and older LGB people as well as providing a comparative correlation between mental wellbeing and use of services. Previous experience of aversion therapy or drug and alcohol use within the groups could be included as mediator variables. Although comparisons could have been conducted between differing areas, the problems associated with small amounts of data in each area would have remained despite a largely inflated cost associated with advertising and recruitment.

### 8.7 Other Reliability and Validity Concerns

There are some further issues with regards to the reliability and validity of the responses provided by participants. These are listed below:

- Given the limited incentive attached to participation in this project and indeed the length of the data collection tool, it is possible that the sample is more likely to represent users angry about difficulties they have had with mental health services. Such a group may have had an additional personal incentive for taking part in the research, seeing it as a possible outlet for such grievances. As such, responses may have seem to suggest a bleaker view of services than is generally held amongst older LGB service users.

- Similarly, there was a perception amongst some participants that this research would result in some form of LGB mental health support group. Such users might have been motivated to take part hoping that they would receive an opportunity to alleviate their social isolation. It is possible that the sample draws from those older LGB users who are more isolated than is typical amongst this group.
- In the few instances where questionnaires were administered over the phone or in the case of the interviews, demand characteristics may have played a role in shaping participants’ responses. Knowing, for example, that the researcher worked for an LGB voluntary organisation and that the research may have as such resulted in more LGB-specific services may have led individuals to place greater emphasis on the role of sexual orientation in their experiences of mental health services than they truly experienced in order to support our aims (as perceived). If the sample was indeed biased towards those with negative experiences of services, this seems to be even more likely.

- This potential problem is exacerbated by the fact that the questionnaire itself was, in order to facilitate data collection, fairly directive in its design. In particular it asked respondents to rate the perceived desirability of various service options determined by previous research, as well as allowing them to describe their own ideas. The presence of such suggestions may have presupposed the importance of LGB-specific services, which otherwise may not have occurred to users.

- When interacting with mental health service staff, demand characteristics may have resulted in respondents being more explicitly positive about local practice around sexual orientation than they genuinely felt. It is possible that staff felt ‘put on the spot’ by a researcher who they knew as representing an LGB voluntary organisation.

- Findings from both the interviews and the questionnaire may be too specific or indeed not specific enough. It is rarely clear, for example, whether respondents are talking about negative (or positive) experiences taking place in a particular service or across many different services. Likewise, five years is a relatively long time in terms of service development, and it is similarly unclear whether participants are talking about relatively recent or distant experiences across that timespan. It may have been useful to know, for example, whether services had improved after the introduction of the current program of equality and diversity training. Where users have disclosed that instances of abuse (physical or verbal) have occurred in a service context, the questionnaire offered limited means for further description of the circumstances. The potential usefulness of the data is as such limited, though perhaps this is an inevitable outcome for a broad scoping study of this kind.

**Recommendation** – Many of the problems posed by demand characteristics could have been avoided by conducting research such as this from an academic institution or another more ‘neutral’ organisation (for example, a general mental health charity). Research conducted by voluntary sector organisations with an ideological stake (purely perceived or otherwise) in the outcome is less likely to
be considered as independent by participants and as a consequence produce independent results.

As noted, lack of specificity in the findings is in part a product of the aims of a scoping study. Future research should target current users of particular areas of service provision – indeed, questions surrounding sexual orientation diversity issues could or should be incorporated into existing in-house processes for monitoring quality of service delivery.
9. Current Initiatives Aimed at Improving Mental Health Services for LGB People and for Older People in London

9.1 Voluntary Organisations and Groups

There are several organisations or groups which provide services for LGB people with mental health needs in the London area and for LGB people who care for individuals using mental health services. Likewise, there are a small number of organisations and groups which provide information and social and other opportunities for older LGB people. A (non-exhaustive) list of these is provided in Appendix C. As yet, there are none which cater specifically for the two combined. Given the issue of ‘triple stigma’ discussed throughout this report, this may be an issue of some concern.

9.2 Training for Professionals

In 2006 the Department of Health produced a paper entitled ‘Core training standards for sexual orientation: Making National Health Services inclusive for LGB People.’ It states categorically that training is needed for all NHS staff to make services inclusive for LGB people, and ‘Core training standards in sexual orientation to inform training and development are a crucial component of the NHS drive to promote equality,’ (p5). It also strongly recommends that equivalent training be organised by non-NHS organisations providing health and social care services.

The report is based on consultation with stakeholders, key agencies, training providers and LGB participants and sets out 13 core standards for sexual orientation training (with further specialist areas for specific services and service user groups and for managers). Older LGB issues are explicitly included. The standards are said to be aimed at eliciting outcomes including

1. An increased understanding of the issues related to sexual orientation in the context of a social rather than clinical model
2. An increased understanding of the issues of silence and invisibility faced by LGB people
3. An increased awareness which gives participants a flavour of the lived experience of the discrimination experienced by LGB people
4. Increased understanding and development of best practice
5. Provision of a skills/toolkit to support organisations and individuals to be more gay friendly
6. Clearer criteria to be used in policies, procedures, appraisals and other training packages such as customer care.

The need for this training to be initiated formally at an organisational level is emphasised, and it is suggested that ‘this can only be achieved by embedding the standards within organisational structures and systems,’ (p50). Linking these core training standards to the NHS Knowledge and Skills Framework is the approach proposed.

Training and training resources are currently available for mental health professionals on providing inclusive services that cater for LGB and (in some instances) specifically older LGB clients, and indeed have been for some time. See Appendix C for a non-exhaustive list of providers and resources. In some instances, however, core funding for advertising and supplying training to frontline workers has ceased. In others, despite successful pilots with CMHTs, within training establishments or with social services teams, the subsequent take-up has been low and resources do not exist to promote it sufficiently. At the time of contacting the training providers for this report none of the training listed is active (within statutory services).

Over the course of the current research, one mental health professional (himself a gay man) reported that

“Diversity training is given to us, but it is short. I think it was a one day course? How can you hope to cover the issues relating to all diversity in a day? The section on sexuality was really short.”

It seems that this is not an uncommon opinion. The DH report mentioned above also notes that ‘responses in interviews indicate that a number of people within the health service feel that there is effectively a hierarchy between the diversity strands with sexual orientation holding a low ranking,’ (p20). The researcher of the DH report in this instance proposes that the belief that sexual orientation represents a choice has probably led to the view that it is as such not equivalent to other diversity strands. Research discussed in part one of this report provides some evidence that such a view is of questionable accuracy.

An additional problem was highlighted by a diversity trainer interviewed, who said that

“If you try to offer LGB-related training, it’s always optional and only those who are interested or open to it will turn up. These aren’t really the people who need it, if you know what I mean.”

Once again, the DH notes that ‘There was considerable reference throughout conversations with stakeholders, key agencies and training providers that part of the process of making services for LGB people inclusive is to mainstream both services and training on sexual orientation,’ (p21). One approach considered is to
include LGB case studies in non-diversity training. Another possibility would be to extend diversity training to ensure that each strand is adequately discussed and practice scenarios are covered (e.g. tackling homophobia).

Statements such as these also reflect the findings of the 2007 Stonewall report ‘Being the gay one: experiences of lesbian, gay and bisexual people working in the health and social care sector’ (commissioned by the Department of Health). Most of the professionals interviewed in this study highlighted training as an ‘essential step to prevent discrimination against people on the grounds of their sexual orientation.’ The instances of discrimination, harassment, prejudice and bullying detailed indicated that often ‘staff lacked understanding about sexual orientation, and failed to realise that discrimination against LGB staff was not acceptable.’ (p20)

9.3 LGB Representation within Statutory Services and Organisations Responsible for Policy

There have been some significant developments in LGB representation at the level of policy formation within health and social care in recent years. The National Institute of Mental Health convenes a Special Interest Group on Gay and Lesbian Mental Health to advise its policy development. The Department of Health appointed a National Director for Equality and Human Rights in 2004, which was seen as an opportunity to further develop a strategy and approach on equality and sexual orientation and gender identity. Commissioned reports on LGB equality issues (such as those mentioned above) signal a growing recognition of the need to tackle institutional discrimination against this population. At the Department of Health the Sexual Orientation and Gender Identity Advisory Group (including members from both the voluntary sector and the NHS) has assisted with the development and delivery of a programme of work with this goal in mind. It produced a number of resources for working with LGB and T people, all of which are available on the DH website (www.dh.gov.uk). It is also possible to order a large pack of briefings for health and social care staff entitled ‘Reducing health inequalities for lesbian, gay, bisexual and trans people’ from the DH Publications Orderline (tel. 08701 555 455, email: dh@prolog.uk.com). This advisory group has also been responsible for commissioning a bank of LGB and T images, which were then put into the NHS photo library for use in NHS and DH publications.

In terms of staff representation, many borough councils, PCTs and mental health trusts across London host LGBT staff forums which can be contacted through equality and diversity officers. These groups are often responsible for highlighting issues of sexual orientation within their own arenas. The Department of Health itself has an LGB staff group (called PRISM), as does the Royal College of

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1 The Lesbian Gay Bisexual and Transgender Advisory Group has now taken over the work of SOGIAG at the Department of Health and initiated a new work programme.
Nurses (which has produced guidance on the nursing care of gay and lesbian patients, available from their www.rcn.org.uk). There are other professional organisations such as the Greater London Association of Doctors and Dentists and the Association of Gay and Lesbian Psychiatrists which advocate for LGBT issues within their spheres of influence. However, as the ‘Core training standards..’ report stated, the need is felt for mainstream and organisational uptake of LGB discrimination onto the equalities agenda. A member of one of these staff groups, for example, has stated

‘I think it is left to LGB people alone to champion the rights of other LGB people. A lot of the time improvements only take place in a service because someone working there has had to out themselves.’

In light of this experience, we might conclude that in some areas there have been noticeable improvements in recent years, as noted by one manager within a voluntary sector LGB project:

A few years back we would send leaflets [about the service] out to surgeries and clinics and when we visited they weren’t left out. Now I get GPs calling me up asking me what to do about LGB patients, and referrals are mostly coming from professionals in the PCTs or mental health trust. I think it might be because we are part-funded by the NHS, that we are taken more seriously.’

9.4 Monitoring

In 2006 LGB rights organisation Stonewall produced a report called ‘Monitoring sexual orientation in the health sector.’ It proposed that the aim of monitoring is to look at health inequalities between minorities, identify potential barriers to services, monitor incidents of discrimination, actively identify areas where discriminatory practices might be occurring and proactively address these problems,’ (p20). An example within the mental health field would be the employment of new community outreach officers in response to data suggesting there are increased rates of hospitalisation for individuals from BME groups. Monitoring on grounds of sexual orientation, it is suggested, could lead to similar improvements for LGB service users. It also provides an indication that an organisation is taking proactive steps to prevent discrimination and to deliver appropriate services.

The report also mentions that monitoring within public services was not universally welcomed when it was first introduced – it was felt that if organisations were institutionally racist they may use information about ethnicity against an individual or group. For example, the Metropolitan Police Service used ethnic data in 1982 to identify black people as being disproportionately involved
in street crime; there was subsequent concern that data collected under the Race Relations (Amendment) Act would also be used to discriminate as opposed to support communities. The Metropolitan Police Service has had to make a sustained effort to change public perceptions of institutional racism and homophobia, an effort which has paid off since the Service now regularly receives awards for its practice on diversity and its reputation as an equal opportunities employer.

Since 2005 the Department of Health has been commissioning an annual ‘Count Me In’ census of mental health inpatients using NHS and independent services. From 2006 onwards information about sexual orientation has been collected from patients 16 and over. What is notable about the results of both the 2006 and 2007 surveys is that:

- Rates of refusal to answer have changed in just a year – 19% in 2006, 9% in 2007. It’s possible (but purely conjecture) that this represents a change in views with regards to the safety and acceptability of discussing matters pertaining to sexual orientation within a mental health care setting.

- 144 out of 238 providers in 2006 and 127 out of 257 in 2007 refused to collect information around sexual orientation, many of which were in the London area. This may reflect once again the familiar and commonly held view that sexual orientation is not a diversity strand in the same way that ethnicity or disability is because it represents a ‘choice.’ Stonewall’s 2006 report suggests that providers have reported reluctance to monitor sexual orientation because they see it as a ‘fluid’ or questionable categorization. Nonetheless, the fact that a group lacks clear boundaries does not mean that individuals who identify with, self-label or are labeled according to that group will not be treated differently as a result or require particular services or a particular form of practice. This study has tended to find that staff have been reluctant to ask service users questions about their sexual orientation for fear of offending or embarrassing them or putting them ‘on the spot.’

- Percentages of gay and lesbian respondents were reported at roughly 2% in both the 2006 and 2007 surveys (compared to the estimated 5% in the general population). The results were similar for the London Strategic Health Authority area alone. Nonetheless, these figures are almost certainly artificially low as a result of both failure to collect information and reluctance to disclose. The government-commissioned Discrimination Law Review notes that ‘There is some evidence that prior experience of discrimination has led to wide-spread sensitivity among lesbian, gay and bisexual people about the monitoring of sexual orientation. For example, local surveys show that many lesbian, gay and bisexual people are not comfortable to reveal their sexual orientation to public service providers— a survey in Brighton showed that 50% of gay men had not told their GP about their sexual orientation†.

† See Department of Health document Core Training for Sexual Orientation p 14.
- It is noted in the report of the 2006 survey that ‘Among the 149 organisations that returned records describing some of their patients as gay/lesbian or bisexual, the proportion of such inpatients ranged from less than 1% to more than 10%.’ This suggests that LGB people are over-represented in some areas – this is probably the result of the tendency of this group to cluster in particular (typically urban) environments.

- Interestingly, reported percentages of LGB people amongst certain ethnic groups (for example, black African, black Caribbean, south Asian) were mostly slightly lower than amongst the majority white group, but were very slightly higher amongst people of mixed race. It may be that this group are more inclined to seek a positive LGB identity as a result of feeling ‘separate’ from discrete racial identities. It may also be that individuals from the communities mentioned above are less likely to self-disclose due to cultural pressures surrounding homosexual behaviour. Again, it is impossible to know from this data.

The findings of this study suggest that users are willing and indeed in some cases happy to be asked about their sexual orientation by professionals, depending on whether it was asked sensitively, in an appropriate context and that the information was kept similarly appropriately (for example, not emblazoned on the front of a file, as one participant reported). However, those participants who had reported this were amongst those who already felt comfortable being out in a service context. Anecdotal evidence gathered elsewhere by Polari has suggested that many users would prefer not to be asked.

Whilst the monitoring of sexual orientation in this form is a positive step forward, as with the Metropolitan Police Force it seems likely that, until the NHS is recognised widely as providing a truly non-discriminatory service, it is improbable that accurate data will be obtained with regards to sexual orientation. Stonewall’s report concludes that ‘fundamentally, the health sector needs to take significant steps to demonstrate inclusion and indicate that it is supportive of LGB people before it would be appropriate to introduce patient monitoring on the grounds of sexual orientation,’ (p 47). It examines several steps necessary before the introduction of monitoring. Demonstration of support and commitment to LGB staff and the development of a culture of trust is seen as essential – without this, staff will not participate in monitoring on the basis that ‘if no-one knows, they can’t discriminate,’ (p26). Visible employees who are LGB may help patients to feel that there is universal acceptance of LGB people within the organization. Sufficient training for workers, providing them with the tools to treat LGB people equally, is also described as important.

Monitoring cannot be introduced alone but must be part of a broader and evident commitment to tackling discrimination on the grounds of sexual orientation. It must have a clear purpose couched in this agenda. Furthermore, it should not take place without discussion and consultation with LGB staff and patients in
order to gain information about steps that need to be taken to increase confidence and awareness about lesbian and gay equality. Commitment to equality on the grounds of sexual orientation (nationally and locally) should be demonstrated at every level, including senior managerial.

9.5 Legislation and Policy

The Equality Act (Sexual Orientation) Regulations came into force in April 2007. This legislation makes it illegal to discriminate in the provision of goods, facilities, services, education and public functions on the basis of sexual orientation. The law now provides a new powerful protection but individuals are not always in a position to contest their rights and resources to assist them to do so are limited or inaccessible. There is a need for all services that older people use to be aware of the new regulations and for users to be aware of what legal remedies they have for discrimination.

Unfortunately at the time of writing† there is as yet there is no equivalent legislation tackling age discrimination in the provision of goods and services: current law applies only to employment and training. The Equality and Human Rights Commission (EHRC) begun work in October 2007, its task to devise a strategy to ensure equal treatment across six areas of equality: race, gender, physical and mental disability, age, sexual orientation, and religion and belief. One element of this agenda is the commissioning of a Discrimination Law Review aimed at examining the case for a Single Equality Act, which would consolidate and simplify existing discrimination law and possibly extend protection to areas where none currently exists. A progress report was published in 2007 entitled ‘A Framework for Fairness: Proposals for a Single Equality Bill for Great Britain,’ which allows that ‘there is evidence that some people experience unjustified discrimination in the provision of goods, facilities and services because of their age’ (p 135), and specifically mentions ‘perceived unfair differences in the mental health services available to those below state pension age compared with older adults.’ It is recognised that ‘legislation could send out a strong signal that discriminating unnecessarily on grounds of age is unacceptable and thereby help to change cultural attitudes to ageing, as well as providing a means of redress for individuals who experience harmful age discrimination,’ (p 135). Nonetheless, the authors of the report remain unconvinced that legislation is the most appropriate way to tackle this problem, and also highlight the importance of ‘seeking further evidence of what the costs of legislation would be for service providers, particularly in the areas of health and social care,’ (p141).

† The Government announced since this report was completed its intention to introduce age discrimination legislation but the scope and implications of this remain to be analysed once legislation has gone through parliament.
It seems that there is implicit recognition that provision of equal services regardless of age within a rapidly ageing population would represent a substantial and spiraling cost, with limited desirable means for any government of raising funds to cover such a cost. Nonetheless, the review does state that it '[wishes] to consider the case for extending the coverage of a single public sector duty to all the protected grounds of discrimination. This would mean requiring public authorities to identify whether there was a need for specific proportionate action to address priority objectives on age, sexual orientation and/or religion or belief equality objectives.' (p95) With regards to health service provision, the Department of Health is working with 18 NHS Trusts to develop single equality schemes. The learning derived will be used to provide case studies and tools to assist other NHS Trusts to incorporate practices which will enable them better to respond to the needs of their local communities.

Whilst this is unquestionably a positive step, the report does go on to mention that ‘the priorities pursued by any public authority will depend on the particular circumstances of the authority, the needs of its employees and service users and national priorities.’ Once again, this flags up the importance of supporting providers to monitor for sexual orientation so that level of need amongst LGB people is accurately recognised.
10. Recommendations

As part of the questionnaire survey conducted during this study as well as in interviews and the focus group, mental health service users were asked what kind of services they would like to see or how they thought services could be improved. In the case of the former, respondents were given a series of possibilities (with the option of writing their own) which they were asked to rate on a 5-point scale in terms of importance. The mean scores are displayed in figure 9a.

1. Publicity material for mental health services that visibly includes same-sex partners
2. LGB-only activities at mental health day centres
3. Openly lesbian, gay or bisexual mental health workers
4. More information about LGB voluntary mental health services in GP surgeries, day centres and hospitals
5. A regular LGB mental health service users’ forum
6. LGB-specialist counsellors and therapists
7. LGB-specialist case workers (CPNs or support workers)
8. LGB mental health advice service
9. All mental health professionals to be trained in awareness of older LGB issues

10. More information and more support in making complaints about unfair treatment

11. LGB-only supported housing options

12. More explicit guarantee of protection against homophobia

Figure 9a – Mean ratings of importance of service development / improvement ideas

10.1 Training

This was considered as most important both by questionnaire respondents and during discussion in the focus group. As one service user wrote on the questionnaire:

‘I really don’t care what the sexual orientation or speciality of the counsellor or therapist or caseworker is. What matters is a) they have enough experience of BOTH gay and straight stuff to convincingly help identify what issues if any are sexuality-specific, and which are not, and b) have knowledge of appropriate specialist LGBT agencies to help with any practical problems associated with mental health issues (housing, debt, etc).’

As noted in section 8, the Department of Health document ‘Core training standards for sexual orientation’ recommends, training on this strand of equalities should a) not be subsumed into a hierarchy of equalities where it is dealt as a sub-issue and b) be mandatory for NHS and social care staff at all levels (within the first three years of appointment) and tied to the key skills framework. This training should also incorporate the views and experiences of older gay men, lesbians and bisexuals, and ideally (in the spirit of social inclusion) should be delivered by or in conjunction with LGB service users and/or ‘survivors.’ The training package developed by the Royal College of Psychiatrists is inclusive of older LGB issues, and further work should aim to promote and/or incorporate this into plans to deliver training in the future.

Concerns about the effectiveness of training have been made by staff within the NHS and social care sectors over the course of this report, and the point has been made that the fundamental attitude of staff (towards human rights, towards what is acceptable and what is not as a representative of an institutional body of a society which espouses equalities legislation to protect the human rights of LGB people regardless of personal opinion) is of greater importance in predicting actual practice. It is proposed therefore that (as the Metropolitan Police has
The NHS needs to take greater lengths to promote itself as taking a hard line against homophobic attitudes. Upon appointment of staff, there needs to be (as part of induction) training on all equalities strands, but also a clear statement that discriminatory behaviour of any form towards any minority will result in a defined disciplinary procedure that is actively followed through as standard in instances where complaints are made or issues arise. Essentially, it needs to be obvious to individuals wishing to work in a public capacity that if they feel that their personal beliefs prevent them from offering an equal standard of care to everyone regardless of circumstance, then this arena is not a suitable avenue of employment for them.

A guide to good practice in working with LGB service users is available from the Department of Health (as described in section 8). Age Concern has also produced a useful resource pack detailing good practice in working with older LGBs which is available from their website.

10.2 Information about LGB Services

Some of the services listed above (such as LGB mental health advice) already exist (e.g. PACE) – one implication is that users simply do not get an opportunity to learn of their existence. This was indeed confirmed anecdotally during interviews. Mental health services and indeed healthcare settings should as standard provide and if possible display information that allows service users from all minorities to signpost themselves to relevant resources if they desire to do so. Doing so empowers service users by maximising choice. It partly fulfils the requirement of the service to consider the specific needs of minority users (where they are unable to cater for them themselves), and it also helps the organisation to develop a reputation for taking minority issues seriously (with the subsequent benefits for staff and service users described elsewhere in this report). As one person stated over the course of this research:

‘It’s at least an acknowledgement – somebody in the service realises that not everyone is straight.’

In instances where services are provided from venues owned by organisations which do not subscribe to equal opportunities policy, the question must be asked by service managers and/or commissioners whether it is possible for the NHS or local authority to uphold its own policies by commissioning and providing services in this manner.
10.3 Information and support to make complaints

Service users have often noted understandably that they have not had the strength to face a lengthy complaints procedure whilst in crisis themselves, which makes them particularly vulnerable to abuse. Provision of information about advocacy services and/or referral to these services where necessary must be standard practice, especially within inpatient settings. A directory of advocacy services (including information about LGB-specific resources, such as PACE) available to service users on request would perhaps be useful.

Several service users have mentioned being employed in user involvement projects or as patient councillors in the past. These schemes have (by their own account) increased their own sense of self-efficacy as well as giving a voice to service users who may be more inclined to trust peers than staff whilst in a situation of potential vulnerability such as hospital. Several mental health trusts have funded or currently fund such services; for example, Camden and Islington Partnership Trust funds a user-focused monitoring project run by the voluntary sector (Peter Bedford Trust). In very basic terms, this project provides training in research skills to service users to enable them to conduct audits of the trust’s services. Making such projects common practice across every MHT would provide a useful check of good practice and service effectiveness. Given the findings of this study, it would be useful for audits such as these to take into account LGB issues and for LGB service user volunteers to be actively recruited.

10.4 LGB-specialist counsellors and/or therapists

As documented in Appendix A, these services do currently exist in both a voluntary and private form. Nonetheless, in the case of private provision, participants reported being deterred from accessing these due to prohibitive cost. With regards to the voluntary sector, we encountered some concern about long waiting times and, when trainees were used, if they would be sufficiently experienced for those with complex and enduring mental health issues.

It is unlikely that a scoping study such as this, involving small numbers of participants, is able to provide sufficiently substantial justification for funding specific services, both within the NHS and indeed in the voluntary sector. Furthermore, it is possible that further specialising or separating services would result inevitably in a decrease in overall efficiency. Nonetheless, this work can perhaps hope to inform initiatives that are already underway, such as institutional training. In the case of those individuals interviewed, the majority felt that contact with a sufficiently trained member of staff would be nearly as or equally desirable as contact with an LGB specialist – as described in section 6, qualities such as a respectful, non-judgmental attitude were attributed to members of staff that had
been of genuine help without any notably specific expertise in the area of sexual orientation counselling.

Given funding restrictions and high demand, voluntary sector organisations may not be able to meet the costs of employing fully trained counsellors offering one to one sessions. One possibly equally useful way of deploying volunteers (as suggested during the focus group conducted as part of this research) would be to assign advocacy- or counselling-trained LGB ‘liaison’ officers to psychiatric wards on a part-time and/or rotating basis in order to provide a visible point of contact for LGB patients who feel under threat in that environment. Considerable thought would have to be given as to how such contact could take place in a confidential fashion.

### 10.5 LGB Service Users’ Forum

This suggestion was a key topic of discussion of the focus group, with users keen to see something develop as a result of the fact that current similar services were felt to be either inaccessible to lesbians, or too geographically dispersed to be feasibly reachable. It was felt that such a group would provide much needed peer support during times of crisis or following discharge from hospital, and indeed that peer support was particularly valuable due to the benefits wrought by shared experiences and insight as service users. It was also felt that it could serve as a non-judgmental, accepting social outlet for older LGB people who feel isolated. The evidence presented in section 2 pertaining to the therapeutic benefits of an accepting community, coupled with the anecdotal accounts of section 6 noting the benefits both of receiving support from peers but also of offering support provide additional justification for the development of such a resource. Some suggestions for how such a group might function are given below:

1. It should be primarily facilitated by at least one mental health worker, who may themselves be an LGB current- or ex-service user. Discussions with day centre staff (see section 7), supported by anecdotal experience known to Polari, has indicated that groups which are entirely user-led can often fold when the needs of individual users become too difficult for the group to collectively manage, especially when they may be experiencing periods of distress themselves. Trained facilitators can help to maintain structure, can devote resources to managing crisis or difficulties within the group, and provide a clear route for supervision when individuals are struggling to cope in peer supportive roles. It is of course also necessary for this worker/these workers to have their own access to supervision.

2. It could run separate social, support and campaigning events. It may be useful for the NHS to volunteer a (central) venue for support events to take place, as doing so may help to raise their profile as an organisation that takes the needs of LGB users seriously.

3. It could incorporate a separate telephone or email support network. Those volunteers willing to offer this kind of support to others should themselves
be provided with some training on assertiveness with boundaries and on recognizing their own limits in helping others.

4. Existing successful peer support schemes (for example, Positively Women∗) function successfully by incorporating a mentoring and gradual integration structure. New members are paired with older members who provide some one-to-one support until it is felt that they are ready to become a part of the group itself. Once in the group, mentoring serves to further support the individual until they reach a point where it is felt that they can manage further responsibilities (such as mentoring others, or getting involved in campaign work). This method could potentially prove effective as a means of ‘screening’ new members for those who might prove difficult for the group to manage, and of preventing individuals from becoming overwhelmed in their attempts to support others.

5. It should be non-discriminatory with regards to age. Reports from service users (section 6) suggest that there are huge benefits to be had by fostering inter-generational contact, and reports from staff have suggested that there are no particular problems that arise from doing so (section 7). This contact may be of special benefit to young LGB people who often lack visible older role models.

6. It could incorporate training for members who wish to undertake it in research and audit skills so as to pursue activities described in section 9.3. A website associated with the group could be developed, and user reviews of various mental health services in terms of their accessibility for LGB people could be published there. It could also host an anonymous forum for individuals who are not yet out to have some access to peer support and discussion.

7. It would need to advertise proactively in order to attract an equal balance of lesbians and gay men, as previous groups have had trouble retaining women. Staff working in LGB-specific services have also suggested that encouraging lesbians to stay with a group even if numbers are low is sometimes effective, as new women will be less daunted if the group is not totally dominated by one gender.

Polari also recommends that while a specific LGB forum in London was wanted by those we consulted, across the UK user participation initiatives need to be more inclusive of minorities including LGB and T minorities. Where local LGBT service users do not feel safe to discuss concerns related to their sexual orientation (or gender identity) in a mixed user group, LGBT forums or groups will be needed.

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∗ A voluntary peer support organisation targeted at supporting and campaigning for recognition of the needs of women living with HIV.
10.6 LGB volunteering and awareness raising

Several participants raised issues about the non-inclusiveness of the LGB community in general to those with mental health needs, to disabled people or to older people. A drive to improve disabled access in LGB community venues would be beneficial. Hopefully social projects and opportunities arising out of Age Concern’s Opening Doors project will help, in the boroughs in which it works, to improve the situation currently faced by older LGB people who feel isolated.

Cross-generational contact has been identified here as potentially beneficial for both older and younger LGB people. A befriending scheme which maximises recruitment from younger age groups could have an impact as well as emphasising the benefits of doing so (for example, skill sharing, training and experience) would be important in attempting to make such an approach a success.

LGB community events (for example Pride, the London LGBT film festival and associated events, LGBT history month) could become more inclusive of marginalised groups by giving a larger profile to mental health charities or mental health service user projects and presentations. Funding arts projects for this group could give them a means of making their experiences known within such forums.

Some participants reported feeling that their sexuality had been marginalised or ignored. A campaign that aims to raise awareness of the potential that positive sexual identity and indeed activity has for improving mental wellbeing both across statutory and voluntary sectors could help to reverse this situation.

10.7 Access for older people to primary care mental health support

Where older people are currently unable to access services such as advice and brief treatment teams, trial periods of inclusiveness could be implemented and treatment outcomes / cost effectiveness audited in order to assess whether (as the literature suggests) early treatment may shorten subsequent periods of intensive care and improve quality of life for this population.

10.8 Mental Capacity Act

Any review of the current Mental Capacity legislation should aim to incorporate consultation with LGB service users with regards to the success of the Act in providing clear and acceptable guidance and protocol for individual cases where LGB carers or partners have been involved
10.9 Sexual Orientation Monitoring

In the context of this study, users have felt that it was more important to monitor for sexual orientation than not, despite recognition of the fact that some may find such a process offensive or intrusive. Nonetheless, it is likely to be the case that (as Stonewall’s 2006 report suggested) the NHS must still make efforts to represent itself successfully as an organisation which values diversity before such monitoring can successfully be carried out. ‘Monitoring sexual orientation in the health sector’ ([www.stonewall.org.uk](http://www.stonewall.org.uk)) provides a specific two year plan of action for health trusts wishing to carry out sexual orientation monitoring, with recommendations for improving confidence within the organisation. It also gives useful suggestions on good practice in carrying out monitoring.

Whilst *Count Me In* continues to take place annually, amongst those trusts who do monitor it is important to remember to a) give sufficient information in a manner that is clearly comprehensible concerning the use and storage of data given, who will have access to it as well as the potential usefulness of such data in terms of service commissioning, b) give participants the means of submitting their responses anonymously, even though this may present some challenges for those with some kinds of impairments and c) continue to consult with LGB services users in order to identify what steps are necessary in order to increase a sense of trust and equality.
11. References

Age Concern (2007), *Improving services and support for older people with mental health problems* - www.mhii.org.uk


Bennett, J. (2001) *Self harm among Lesbians, an Executive Summary*, University of Strathclyde.


Department of Health (2005) - *'Securing Better Mental Health for Older Adults'* - www.dh.gov.uk

Department of Health (2006) - *'A New Ambition for Old Age'* - www.dh.gov.uk


Gabbay, S. G. (1997). *Gay and lesbian gerontology review*. Outword, 3(3), 4-8


Jones, EE.; Farina, A.; Hestrof, AH.; Markus, H.; Miller, DT.; Scott, RA. *Social stigma: The psychology of marked relationships.* New York: Freeman; 1984.


McFarlane, L (1998). Diagnosis homophobic: The experiences of lesbians, gay men and bisexuals in mental health services. P.A.C.E


National Institute of Mental Health in England (2006). *From segregation to inclusion: commissioning guidance on day services for people with mental health problems* - www.nimhe.org.uk


River, L (2006). *A feasibility study into the needs of older lesbians in Camden and surrounding boroughs* - www.polari.org

Rivers, C (2006) *Interrogating Pathology: An Exploration of Mental Distress and Lesbian, Gay and Bisexual Identities*


Stonewall (2007). *Being the gay one* - [www.stonewall.org.uk](http://www.stonewall.org.uk)


Polari, March 2009
www.polari.org

Polari (1993-2009) closes at the end of March 2009

The author and Polari’s ex-Director can be contacted c/o

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c/o Consortium of LGBT Voluntary and Community Organisations
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Southwark
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ageofdiversity@googlemail.com
Appendix A – Healthcare Commission review of adult mental health services

It is worth mentioning that the following review of adult community mental health services was conducted with focus on the successful treatment and management of schizophrenia (according to NICE guidelines) and may not be wholly reflective of the level of service provided to individuals with other diagnoses. Furthermore there has as yet been no systematic review of older people’s mental health services - according to the Healthcare Commission, such a review is scheduled to begin in February 2008.

<table>
<thead>
<tr>
<th>Trust</th>
<th>Quality of Service</th>
<th>Use of Resources</th>
<th>Patients’ Rating of Service</th>
<th>Adult Community Mental Health Service Review</th>
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<tbody>
<tr>
<td>Barnet, Enfield and Haringey</td>
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<td>Fair</td>
<td>Satisfactory*</td>
<td>Fair</td>
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<tr>
<td>Camden and Islington</td>
<td>Excellent*</td>
<td>Good</td>
<td>Satisfactory*</td>
<td>Good</td>
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<tr>
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<td>Good</td>
<td>Satisfactory*</td>
<td>Excellent*</td>
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<tr>
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<td>Oxleas</td>
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<tr>
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<td>Good</td>
<td>Satisfactory*</td>
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**Figure 2a** – 2006/7 Ratings for London Mental Health Trusts as published by the Healthcare Commission – from [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk). Highest possible overall ratings are shown with *.
Appendix B

The 32 Greater London local authorities are listed in figure 2b below, along with 2007 ratings of their adult social care services as provided by the Commission for Social Care Inspectorate. For further information on how these ratings were produced, see www.csci.org.uk. Adult social services are not specific to individuals with mental health diagnoses – they provide generally for individuals who need some assistance in order to live independently. The rationale behind providing this information (and the above) is to provide a context for the responses of project participants receiving services in these areas.

<table>
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<th>Local Authority</th>
<th>Star Rating</th>
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<td>Richmond-Upon-Thames</td>
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<td>*</td>
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<td>**</td>
<td>Sutton</td>
<td>**</td>
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<tr>
<td>Hammersmith &amp; Fulham</td>
<td>***</td>
<td>Tower Hamlets</td>
<td>***</td>
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<tr>
<td>Haringey</td>
<td>*</td>
<td>Waltham Forest</td>
<td>**</td>
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<td>Havering</td>
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<td>Hillingdon</td>
<td>**</td>
<td>Westminster</td>
<td>***</td>
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Figure 2b – 2007 ratings for adult social services by London borough as published by the Commission for Social Care Inspectorate (www.csci.org.uk). One star represents adequate services, two good, three excellent.
Appendix C - Resources

Services in London for LGB people with mental health or related needs

**PACE** is London’s leading charity promoting the mental health and emotional wellbeing of the lesbian, gay, bisexual and transgender community. They offer counselling, employment coaching, family support, mental health advocacy and workshops. All their services are free or low-cost.

PACE
34 Hartham Road
London
N7 9LJ

Tel: 020 7700 1323
Email
info@pace.dircon.co.uk

**London Friend** exists to promote the social, emotional, physical and sexual health and wellbeing of lesbian, gay and bisexual people and all those unsure of their sexuality. They offer counselling and support services which set out to explore issues of same sex-relationships, sexual identity and promote personal growth and self confidence. They also provide a safe space as an alternative place to meet and socialise.

London Friend
86 Caledonian Road
King’s Cross
London
N1 9DN

General LGBT helpline: 020 7837 3337
LGBT bereavement helpline: 020 7403 5969
Email: etalk@londonfriend.org.uk

**Kairos in Soho** is a community organisation in the heart of Soho, run by and for the LGBT community and friends. They offer events and activities on personal development, holistic health, social, psychological and spiritual issues and self-help. They offer a one hour session on Friday evenings which offers LGB people help and advice in finding the best counsellor or therapist for their needs. This costs £35/20.

Kairos in Soho Office,
Unit 10,
10-11 Archer Street,
Soho, London
W1D 7AZ

Tel: 020 7437 6063
Email: info@kairosinsoho.org.uk
The Metro Centre provides a range of services to lesbian, gay and bisexual people and those questioning their sexuality who are experiencing mental distress. These include: counseling, advice and advocacy, 1-2-1 crisis support, alternative therapies, workshops and groups and a weekly mixed drop-in on Thursdays between 1pm and 4pm. They also host a 50+ group for lesbian, gay and bisexual people over the age of 50 which is held on the last Tuesday of every month between 2:00pm and 4:00pm.

The Metro Centre  
Unit 401,  
49 Greenwich High Rd,  
SE10 8JL  
Tel: 020 8265 3311 / Fax: 020 8265 1645  
Email: info@t-metro.co.uk

Outcome is a day centre facility for lesbians, gay men, bisexuals and transgender people with mental health problems living in Islington and Camden. It is run by Islington Mind. The service provides counselling and support, advocacy, a midday meal and alternative therapies.

Contact Brian Hagan on: 020 7272 5038

The Pink Practice is a creative counselling and psychotherapy project for lesbians, gay men and the queer communities which works with individuals, couples and families. It is based in Holborn, London WC1.

Tel: 0207 060 4000  
Email: info1@pinkpractice.co.uk

Pink Therapy is the UK’s largest independent therapy organisation working with gender and sexual minority clients. As an organisation they aim to promote high quality therapy and training services for people who are lesbian, gay, bisexual and transgender and others who identify as being sexual minorities.

Tel: 020 7434 0367  
07971 205323 (mobile)  
Email: info@pinktherapy.com
The Antidote Project is a drop in service which offers information and support to lesbian, gay, bisexual and transgender people around drugs and alcohol. Complementary therapies, one to one counselling and drugs work and men’s/women’s groups are available.

c/o The Hungerford Project
32A Wardour Street
London W1D 6QR
Tel: 020 7437 3523
Email: antidote@turning-point.co.uk

East London Out Project (ELOP) is a registered charity providing a range of services to East London’s LGBT communities. They provide safe emotional support and counselling services across East London - including Waltham Forest, Newham, Redbridge, Barking & Dagenham, and Havering - and also offer community safety initiatives, social and support groups and young people’s services.

Tel: 020 8509 3898
Email: admin@elop.org

Gay, Lesbian and Bi-Sexual Depression Support Group

The support group works towards relieving the effect of the depression condition through provision of information and experience sharing. With offices in England and Scotland, the support group endeavors to provide a wide range of contacts and information to those affected by depression. The depression support group offers publications, support services and works through self-help groups.

Depression Alliance
212 Spitfire studios
63-71 Collier street
London
N1 9BE
Tel: 0845 123 23 20
Email: information@depressionalliance.org
The Healthy Gay Living Centre is a pan-London gay health promotion project which includes the provision of counselling services.
40 Borough High Street
London SE1 1XW
Tel: 020 7407 3550

The Lesbian, Gay and Bisexual Alcohol Project provides free service, individual and couples counselling and complimentary therapies.
34 Electric Lane
London SW9 8JT
Tel: 020 7737 3579

In addition to the above, the following resource centres offer or host LGBT support groups. These centres receive referrals from a social worker or a mental health professional.

The Castle, Hampton Street, London SE1 6SN
Tel: 020 7525 3477

The Crayford Centre, 4-6 London Road, Crayford, Kent DA1 4BH
Tel: 01322 521162

Pritchards Road Centre, Marion Place, Pritchards Road, London E2 9AX
Tel: 020 7366 1032

Groups for LGB carers of individuals using mental health services

The Alzheimer's Society's Lesbian, Gay, Bisexual and Transgender (LGBT) Carers is a telephone support service for anyone who is lesbian, gay, bisexual or transgender and who is, or who has been, caring for someone with dementia.

Trained and skilled volunteers are able to offer a listening ear to enquirers.

For information about the LGBT Carers Group contact the Alzheimer’s Society Dementia Helpline on 0845 300 0336 (weekdays 8.30am to 6.30pm)
If you would like to talk to someone, phone:
Roger – 01843 220932
Bruce – 01865 847471
Email: gaycarers@alzheimers.org.uk

Groups for Older LGB people in London

Age Concern runs a number of initiatives for older gay men, lesbians and bisexuals across London.

Age Concern Camden runs a group that aims to support the needs of older gay men in the borough. It aims to provide an opportunity to socialise with other gay men. Speakers, trips, outings and special events are all organised by the group. Contact Gian Montagna on 020 7794 7076 or email ogmg@ageconcerncamden.org.uk.

Age Concern Lambeth runs ‘Lambeth Goldies,’ a group for older lesbians and gay men which meets regularly to provide support, social contact and to discuss access to appropriate services. For further details please contact Julia Shelley on 020 7733 0528.

In addition to these, Age Concern Camden, in partnership with Age Concerns in Hackney, Islington, Kensington and Chelsea and Westminster, have recently employed two full-time Development Workers to develop services that combat isolation amongst older LGB people through the provision of regular social activities, a telephone advice / signposting service and a befriending scheme. They plan to organise events that promote community safety, in partnership with the Metropolitan Police’s LGBT liaison team, and raise awareness about the services available for those who suffer from homophobic crimes. The project will also increase knowledge about, and access to, training and development opportunities, including access to adult education. There will be support to enable people to remain independent and live at home for longer, through advice sessions on welfare rights, benefits and direct payments. For further information contact Antony Smith (National Development and Policy Officer OLGBs) on 020 8765 7576.

The Older Lesbian Network was formed in 1984 to provide a safe space for women to meet socially for discussion, support, and fun. Meetings start with lunch followed by general socialising and workshops. It is open to women aged 40 and over.
Caffmos is an online community and dating service for older gay men. Initial membership is free. The URL is www.caffmoscommunity.com.