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Mental Health and LGBT People: Call for Evidence

British Psychological Society response to the London Assembly Health Committee

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Publication and Queries
We are content for our response, as well as our name and address, to be made public. We are also content for the Committee to contact us in the future in relation to this inquiry.

Please direct all queries to:-

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About this Response

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We hope you find our comments useful.

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	Why is it important to focus on the mental health needs of LGBT people?
1.	LGBT people remain a specific population that faces significant threat and discrimination. They manifest greater prevalence of poor mental health, health risk behaviours and psychological distress. Despite some social change, LGBT people still have to navigate subtle and explicit negativity from family, the media, and policy makers on an almost daily basis. Structural inequality also means that psychological threat and minority stress is a common experience for LGBT people. There is a compelling evidence base, and an emerging one from the UK, for mental health disparities in the LGBT population. Research findings indicate that LGB people demonstrate more suicidal behaviour, poorer mental disorder, and increased substance misuse and substance dependence than heterosexual people. We know that UK LGB are at higher risk of suicide attempts (esp. gay and bisexual men) and ideation than heterosexuals (King, Semlyen *et al,* 2008), of increased mental disorder (King, Semlyen *et al*, 2008; Semlyen *et al,* 2016), increased substance dependence (especially in lesbian and gay women) (King, Semlyen *et al,* 2008). They are also at risk of increased smoking and hazardous alcohol use (Hagger-Johnson, Taibjee, Semlyen *et al,* 2013) both related to poorer mental health. There are different disparities within this group for example the bisexual population demonstrate higher self-harm risk than lesbians or gay men. There is very little available data on trans mental health and no population data exists. One UK survey study found that 88% of 889 respondents had experienced depression, 84% of respondents had experienced suicidal ideation, 75% had experienced anxiety, 53% had self-harmed and 35% had attempted suicide (Ellis, Bailey & McNeil, 2015). Adolescence is a particularly important developmental period as it is often a time when identity and self-concept formation occurs (Ward, Sylva, & Gresham, 2010). Moreover the negative effects of anxiety and depression may persist into adulthood (Marshal et al., 2013; Needham, 2012). Sexual minority youth may also have to contend with new and difficult obstacles such as disclosing their sexual preferences to peers, friends and family in a potential climate of stigma and/or little support. Research shows that LGBTQ young people experience higher levels of verbal, physical and sexual abuse, and fear of such abuse (Rivers 2004). Harassment in school can interfere with an LGBT youth's academic achievement Russell at al 2011. Family support and acceptance can enhance outcomes for LGBTI children and adolescents across a range of indicators (Smith et al., 2014) as can supportiveness of the local community Hatzenbuehler (2011). Sexual identity development or the "coming out process" can be defined as the process by which sexual attraction and sexual preferences are explored and incorporated into an individual's sense of self (Mohr & Fassinger, 2000). Concealing one's sexual identity, likely influenced by both internalised stigma and victimization leads to isolation and living a double life can be detrimental to mental health

	Hatzenbuehler 2009. More accepting reactions from others upon disclosure has been found to buffer the effects of negative reactions from others. The older population are also an important group to consider. Many older LGBT people have a lived history of direct discrimination and the impact of criminal justice system. Indeed *The Diagnostic and Statistical Manual of Mental Disorders (DSM)* included homosexuality in its diagnostic classifications until 1973. These experiences can create on-going barriers to accessing mental healthcare (Brown et al., 2015). One specific older group will be LGBT people affected by dementia (Semlyen et al., 2016*, in press*). This group experience a triple marginalisation – their age, sexual and/or gender identity and their declining mental health.
	What are the main mental health challenges faced by LGBT people today?
2.	There are a number of very real risk factors for mental health that LGBT people in particular experience. Actual and perceived stigma and discrimination impact on LGBT self-concept and self-esteem particularly in the light of a context of other and multiple stigmas and problems (such as poverty, racism, HIV/AIDS). Societal pressure and the heteronormative environment means that there is a strong reliance upon the pub/club scene as a unique safe space for social contact and identity affirmation placing LGBT people is the environment where smoking, drugs and alcohol are ever present and, to some extent therefore, normal practice as part of socialising and connecting. They are growing up, coming out and continuing to come out surrounded by family, religious and social intolerance of LGBT identity and with the very real threat and/or experience of homo-trans-bi- phobia. Bisexual people may additionally experience a 'double minority stress' as they also have to navigate invisibility within the mainstream lesbian and gay community (Barker et al, 2012). This threat may mean many LGBT people especially those who are older are socially isolated because they avoid risk of negative reactions. Van Orden (2010) identified that, 'social isolation is one of the strongest and most reliable predictors of suicidal ideation, attempts, and lethal suicidal behaviour across the lifespan' (p.582). Moreover social isolation prevents LGB individuals from opportunities to strengthen social relationships and interaction with other LGBT adults. This can happen in a work environment but LGBT people may also experience prejudice from their employers meaning they avoid work or experience discrimination and victimisation in their daily working life. There is wide evidence that LGBT are experiencing– heterosexist homophobic and heteronormative attitudes from mental health professionals. Research has shown one-third of gay men, a quarter of bisexual men and over 40% of lesbians reported negative or mixed reactions from mental health professionals when they disclosed their sexual orientation. (King and McKeown, 2003). A key issue is providing appropriate support to LGBT people in ways that are sensitive to their gender and sexuality, without presupposing that it is the reason for their mental health conditions. Recent research showed that One in five lesbians and gay men and a third of bisexual men stated that a mental health professional made a causal link between their sexual orientation and their mental health problem. King and McKeown 2003. As such many LGBT people state they do not feel confident about accessing mental health services.

	(King, Semlyen et al 2007). Therefore it is safe to conclude that LGBT people are less likely than others to seek health care because of discomfort in disclosing sexual or gender identity to providers. In addition to negative experiences, from research carried in the last decade, we know that lesbians, gay men and bisexual people use mental health services more frequently than non-heterosexuals, seek counselling/therapy more and have more episodes of therapy and a greater number of sessions than non-LGB (King, Semlyen *et al,* 2007). Recent research showed LGBT access 'informal' sources of help - internet, family/friends rather than NHS or school-based mental health services. Felt safer with these sources of help in terms of their sexual orientation, gender identity and mental health. Queer Futures 2016. Therefore there are a group of people who need support more than the general population and yet are seeking it less often.
	What can be done to promote better mental health for LGBT people and prevent mental ill health?
3.	Any and all forms of inequality and negativity need to be taken seriously and effort made to challenge it when it happens, and change it by way of education and legislation so as to limit the chances of it manifesting itself. From a public health perspective LGBT mental health can be supported by better recognition of the risk and protective factors that operate, action to continue to reduce discrimination against LGBT people in wider society, action to reduce bullying and abuse and action to address the perceptions of, and any current occurrences, of discrimination by help in providing services and workforce. Education needs to be provided in relation to the fact that human sexuality is more fluid than society constructs it and thus we should not be surprised to see a full range of forms of expression in any group, whatever age. This needs to be provided to children and adults, through formal education programmes and through the media and policy. Addressing homophobic and transphobic bullying in schools and workplaces is key, implementing full monitoring of sexual orientation will enable organisations to assess bias and barriers to access. Local organisations run by and for LGBT people play an important role in promoting and preventing mental ill health. MindOut, in Brighton & Hove, is an exemplar. They run support groups focused on particular themes (e.g. HIV, suicidal distress, work) and groups target at particular groups (e.g. gay men, lesbians, BME, trans). They also offer an advocacy service and peer-support. Community-based services offer a more accessible service and they are often trusted more than mainstream statutory services where LGBT people have had poor experiences. We have seen the closing of LGBT specific services in the charity sector in recent years and the Assembly might want to see how they can support the work of such organisations. Within mainstream services, there needs to be better connections between sexual health, substance misuse and mental health services to support LGBT clients and service users. There are specific gaps in commissioning of drug and alcohol services for LGBT people despite the clear evidence of need from the research.

	How do stigma and discrimination affect the mental health of LGBT people?
4.	Received discrimination and stigma related to sexual orientation and/or gender identity is an important determinant of poor mental health. People who identify as LGBT are at increased risk of exposure to institutionalised and interpersonal discrimination and marginalisation, which in turn increases vulnerability to mental illness and psychological distress (King & Nazareth, 2006) Such adverse experiences may lead to internalized stigma (shame) and negative health consequences (to cope). UK population data shows that LGB are twice as likely to have a history of cigarette smoking as those reporting a heterosexual identity at age 18/19 years. And LG nearly twice as likely to report drinking alcohol more than twice per week, and more likely to report binge drinking more often than weekly. (Hagger-Johnson et al, 2013). The Trans Mental Health Study (Ellis et al, 2012) found 24% (of 577 respondents) had used drugs in the past year and 47% with high and potentially problematic levels of alcohol use. Actual experiences of discrimination and abuse, as well as fears of negative treatment for mental health conditions are major barriers for seeking healthcare quickly. Delayed help can lead to exacerbation of symptoms. Experienced or anticipated prejudice, discrimination and victimisation, the internalisation of negative societal attitudes and the denial and/or concealment of sexual preferences all act as stressors which can lead to poor mental health outcomes (Meyer, 2003; Hatzenbuehler 2009). There are two main theories that hypothesise why sexual minority status is associated with negative mental health outcomes. Both theories are based upon the predication that sexual minorities face specific and unique stressors compared to heterosexuals. In line with psychoneuroimmunology principles (Ader & Cohen, 1993) it is the consistent effect of these stressors that have a deleterious effect of mental and physical health. Minority stress theory (Meyer, 2003) suggests that the social norms and context in which the sexual minority youth live are more important than being a minority group itself. Experienced or anticipated prejudice, discrimination and victimisation, the internalisation of negative societal attitudes and the denial and/or concealment of sexual preferences also act as stressors which can lead to poor mental health outcomes (Almeida, Johnson, Corliss et al 2009 (Williamson, 2000). Poorer mental health does not only result from difficult and traumatic events but also from incongruent and *repeated* interactions with heteronormative and homophobic societal structures (Whitman 2015) and Newcomb & Mustanski (2010) show these effects become more pronounced with age. Hatzenbuehler, Nolen-Hoeksema and Dovidio (2009) posit that sexual minority stigma specific stressors can lead to psychopathology. In particular structural stigma can impact significantly. In the USA, states with anti LGBT legislation have higher rates of psychological distress (Rostosky *et al,* 2009) and LGBT people living in these states have a 12-year shorter life expectancy and higher rates of cardiovascular disease (Hatzenbuehler *et al,* 2014).

	Victimisation and discrimination in the context of adolescent mental health is especially relevant given the intense and often hostile school social environment (Crosnoe, 2011). A recent meta-analysis found that sexual minority youth have an increased risk of harassment and victimisation compared to heterosexual youth (Toomey & Russell, 2016). These occur particularly in the form of increased teasing, threats, and actual inter-personal violence, (Espelage, Aragon, Birkett & Koenig, 2008; Kosciw, Greytak, Diaz & Bartkiewicz, 2010). Physical harassment and violence may also be common place in school settings, Kosciw et al., (2011) found that 38.3% of students reported that they were physically harassed (e.g. pushed or shoved) because of their sexual orientation, with a further 18.3% physically assaulted (e.g. punched, kicked or injured with an object) in the past year. As a result 63.5% of sexual minority students reported feeling unsafe in school because of their sexual orientation. Experiencing harassment, bullying and victimisation has been linked with diverse negative outcomes. Compared to heterosexual youth, sexual minority youth display increased school absenteeism, poorer academic performance, lower educational aspirations, decreased life satisfaction, increased depression and suicide feelings, increased post-traumatic stress risk, increased alcohol and marijuana use and increased STD risk (Bontempo & D'Augelli, 2002, Espelage, Aragon, Birkett & Koenig, 2008, Espelage & Robinson, 2011; Fedewa & Ahn, 2011; Kosciw et al., 2011; Martin-Storey et al., 2013; Rivers, 2004; Russell, Ryan, Toomey, Diaz & Sanchez, 2011). They are also at risk of increased smoking and hazardous alcohol use (Hagger-Johnson, Taibjee, Semlyen *et al,* 2013). We know that there are gender differences regarding the prevalence, and therefore subsequent consequences of discrimination (Almeida, Johnson, Corliss, Molnar and Azrael, 2009) found that male sexual minority youth were twice as likely to have experienced discrimination compared to female sexual minority youth (50% vs. 25%). Thus young gay and bisexual males form a specific minority that require targeted intervention.
	What are the main barriers for LGBT people trying to access mental health support?
5.	After a lifetime of recognising that people may not expect or understand your LGBT experience one hurdle is that trust in public sector services may be low. In addition, the history of mental health services poor responses to LGBT people is well known and creates another reason for LGBT people to be nervous of approaching support agencies. Where they do access support agencies there are additional issues. They may well encounter the impact of inadequate culturally sensitive training of mental health professionals on the specific needs of LGBT populations (coming out issues, for example; being in the closet as a barrier to seeking care of providing truthful information to MH clinicians, etc.). Some providers remain unaware of specific LGBT stressors and about LGBT sensitive approaches to mental health interventions. Thus many LGBT people seek support from the charitable or private sector, and of course in these cases personal or service funding becomes an issue.

	What steps could mental health service providers take to make their services more accessible for LGBT people?
6.	It might be useful to audit staff to determine existing LGBT knowledge and sensitivity. This would indicate levels of awareness and offer evidence for targeting training. Where levels are low, gender and sexuality training should be sought made available and should be rolled out. An example of e-learning LGBT awareness training has been developed by Oxleas NHS Trust (Semlyen and Collings, 2015). Moreover, the British Psychological Society has published guidelines on working with sexual minority clients and these are extremely useful for practitioners (BPS, 2012). It would be useful to audit LGBT population access to mental health services and if necessary carry out outreach work to ensure they are being reached. Without knowing who is accessing services it is not possible to know they have been reached. Monitoring of sexual orientation and gender identity data should be mandated within NHS services and particularly mental health and primary care services to allow this data to be collected and the population to be audited. The training and education of health professionals (primary and secondary) and other agencies to promote understanding of the prevalence of mental health issues would be useful, as well as the importance of making sensitive enquiry, avoiding assumptions, and using inclusive language, even if it requires using outside consultants to train them. Those providing in depth psychological therapy or regular support should be offered LGBT affirmative supervision. This can serve to ensure appropriate support is being provided and thus serve to monitor the manifestations of living in a heterosexist culture. Counselling and psychotherapy treatments should not use 'reparative' therapies. Conversion or reparative therapies, based on psychoanalytic and behavioural principles, are a particular form of therapeutic intervention that purports to change sexual orientation and to help an individual 'get rid' of feelings of same sex attraction. They are usually (although not always) associated with and driven by particular religious ideologies that view non-heterosexual behaviour and identity as psychological and moral pathology (Bartlett, King & Phillips, 2001; Bartlett, Smith & King, 2009; Garnets et al., 1991; Milton, 1998; Milton, Coyle & Legg, 2005). The Memorandum of Understanding (MoU) of Conversion Therapy in the UK released in 2015 reflects a position that efforts to try to change or alter sexual orientation through psychological therapies are unethical and potentially harmful. The memorandum was signed by all of the major regulatory and therapy accrediting bodies including the Royal College of Psychiatrists, British Psychological Society, British Association for Counselling and Psychotherapy and NHS England. Of note is the clear stipulation that as a signatory 'NHS England does not endorse or support conversion therapy and will make this clear to Clinical Commissioning Groups'. (MoU, 2015; point 23). Links could usefully be made with agencies and professionals who have particular expertise with LGBT clients. Links could also be made with other organisations to think preventatively and so address bullying and homophobia e.g. schools and colleges before it becomes manifest as poor mental health.

	While services have undoubtedly improved, LGBT people can still be cautious about approaching psychiatry and psychology and mental health services. This is sensible, as when a client approaches such a services they can be in great distress and very vulnerable so they need to be sure that the service understands and can work with their concerns appropriately. Organisations can assist by being upfront about their stance towards LGBT distress and mental health problems. Efforts to demonstrate services being known as LGBT sensitive, employing staff who are out as LGBT, and signposting their commitment to a community by supporting fundraising activities, taking part in Pride events etc. could all be useful. Also, they could consider advertising directly to LGBT media outlets the availability of services. At another level, services might consider their websites and public profiles so as to have statements as to their openness to a diverse population.
	What evidence is there of what works to improve the mental health of LGBT people?
7.	There is minimal evidence showing whether LGBT-specific services or interventions have any greater impact for LGBT people. What we do know is that provider's sensitivity and attunement to the LGBT person is an important factor in promoting and facilitating access to services. We know that LGBT people do take up psychological support and that it is reported as very helpful when the therapist is able to understand the specific experiences of LGBT people and tailor the approach sensitively (King, Semlyen, et al 2007). Thus, we know that psychological treatment is helpful as long as it is tailored to the context of the client and allows them to utilise it to their own needs. Funding tends to be focused on documenting that LGBT people have mental health issues – it would be welcome to see more funding directed as the role of evaluating the effectiveness of particular interventions (e.g. community-based, online, peer-to-peer support) for the LGBT community.
	How effectively are the needs of LGBT people incorporated into mental health service commissioning?
8.	This varies by local area but generally this is not done well. It is often driven by key individuals based in that local area. There is no routine data collection so commissioners are unable to judge whether services are reaching these communities or indeed if services have embraced multi-cultural and LGBT sensitive practice comprehensively. Along with mandating collection of sexual orientation and gender identity data to inform this question, in order to address the current variability, and to harness the pockets of expertise that there are, perhaps a citywide strategy would be more effective.
	What examples of good practice are there in London and further afield?
9.	Many of the London Sexual Health Centres are appreciated by LGBT clients and utilised for more than just sexual health. These centres also carry a caseload of LGBT

	clients in relation to their wider psychological wellbeing. There are some LGBT specific agencies such as Metro who were commissioned to provide IAPT talking therapy to LGBT clients and Broken Rainbow (recently closed) invaluable for offering helpline support for addressing domestic violence in this population. There is also Pink Therapy, which both runs sexual and gender diversity training and manages a list of approved practitioners for LGBT clients. Note, many agencies and services are small and staffed with volunteers. In mainstream services, an example of an LGBT-friendly mainstream service is Southwark IAPT ("Talking Therapies Southwark") which makes it clear on their website that they welcome everyone regardless of their sexual orientation or gender identity (Slam). Northamptonshire mental health trust had an LGBT liaison nurse role for several years to improve their services. This is no longer current but offers an example of best practice. Generally, best practice is promoted through systematic assessment of local needs e.g. through a JSNA or proactive engagement of local communities with conscious/proactive inclusion of LGBT people. Regarding guidance for best practice, the British Psychological Society has published guidelines on working with sexual minority clients and these are extremely useful for practitioners, (BPS, 2012).
	What are the key issues faced by organisations working to support LGBT mental health in London?
10.	London has the highest proportion of LGBT people in the UK, many who have moved to live there to be part of a group for shared identity and social support. London therefore needs to consider the mental health needs of its LGBT population as a significant issue. The health service and services in the charitable sector are stretched due to insufficient funding and thus can struggle to be available to all that might use them. There have been notable closures of organisations such as PACE closed after 31 years due to financial cuts leaving a big gap in provision (pink news). Where services rely on volunteers and honorary trainees, there is an issue of how competent practitioners are in LGBT sensitive practice. Thus training and supervision is an important issue that needs attention and organisations need resources to audit their treatment outcomes to evaluate their service provision. There is a lack of coherent commissioning across London - rarely enough critical mass in an individual borough to justify specialist commissioning pathways so boroughs tend to commission inclusive universalism which in reality lacks the appropriate capacity or knowledge to invest in engaging local LGBT communities.
	What can the Mayor and the London Assembly do to support better mental health for LGBT people?
11.	At the outset, set an agenda of appreciation of diversity, including within it that of gender and sexual diversity and Recommend to commissioners that mental health of LGBT individuals is specifically addressed. It is vital to address the systemic problem of anti-LGBT attitudes in society as well as the specific issues that a particular service

	or group of clients might need. Heterosexism and homonegativity need tackling generally alongside our efforts to help those of us who have experienced such negativity. Thus it is also necessary to comprehensively challenge those boroughs and services that fall short of specific LGBT affirmative an attuned practice. Draw on psychological expertise in the field and convene a cross London commission or task force on LGBT mental health that specifically include psychologists that specialise in psychological services for LGBT people, to actively work with providers, commissioners and communities to address the health inequalities and improve service access. Carefully review existing funding strategies to prevent funding low-level evidence from research using convenience samples to answer questions that have been answered (such as mental health disparities). Instead it would be far more important to see funding directed to research to explore the causal pathways to increased mental health in this population. Recommend that more research is taken to help us understand and treat poor mental health in LGBT people, including the needs of specific subgroups including women, transgender individuals, bisexual individuals, those from particular ethnic / religious / other cultural backgrounds, older / younger, disabled etc. Act to ensure that the mayor's family of organisations systematically apply the actions recommended to all provision that is commissioned and all campaigns that are planned and delivered. In particular for all polices that are being considered that may impact on mental health. This may include wider policies on transport, safety and policing, affordable housing etc. Where possible, support services that reach out to the LGBT population. These services can overcome barriers that prevent LGBT people seeking help and support prevention work in schools, workplaces etc. Depending on statutory reach, the London Assembly might support health education and training to normalise difference, offering gender and sexuality (and wider diversity) sensitive training for mental health providers at all levels in all sectors.
	Who else needs to be involved in addressing the mental health needs of LGBT people, and how?
12.	Expert skill and knowledge needs to be harnessed to address the mental health needs of LGBT people. In consultation with LGBT people and their families as well as the wider population. The Society has clear expertise in this area along with other LGBT psychological and psychotherapy organisations such as Pink Therapy, and third sector LGBT mental health agencies such as Metro Centre. Moreover all service providers, service managers, commissioners and policy makers need to be included such as NHS mental health service providers and primary care psychological therapies services i.e. IAPT services in addition to secondary care mental health services.

	GP's need to be targeted, as they are usually the gatekeepers for accessing mental health services. Specifically trained professionals employed within statutory services could deliver psychological interventions to LGB clients and/or "sign-post" and direct their care pathways to agencies with LGB expertise Academic psychologists and psychiatric researchers are needed to undertake further research to address causal path in increased risk of mental health problems in this population and to implement and assess appropriate interventions are needed. Funding is required for this research to be effective and useful.
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