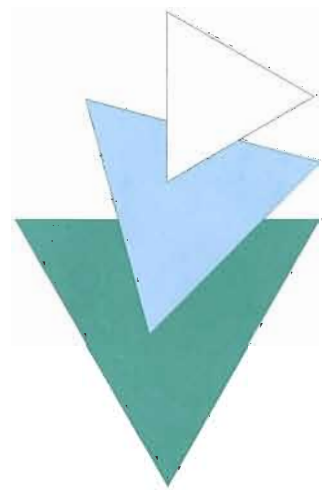
DIAGNOSIS: HOMOPHOBIC

The experiences of lesbians, gay men and bisexuals in mental health services



P.A.C.E.
Linda McFarlane

Contents

Acknowledgments

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to all those who took part in this research. We sincerely hope that your courage in making such a study possible will help bring about improved services for all of us who come into contact with the mental health system.

Many thanks also

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Foreword

PACE is an organisation committed to providing counselling, groupwork and mental health advocacy, free from the damaging effects of homophobia and heterosexism. This report is the result of 18 months research carried out by PACE, into the experiences of lesbians, gay men and bisexual people who have used, or are using mental health services.

The evidence in this report reveals a large area of unmet need within mental health services. Need that is not just ignored, or marginalised - need that is invisible. The need for a culturally sensitive approach towards mental health care for lesbians, gay men and bisexuals.

For many of us who have used, or are using, mental health services, there is very little choice in mental health care, often because at the point where we need such care, we are experiencing such distress that our ability to make decisions has become seriously impaired. It is a time when we are extremely vulnerable and dependent on those to whom we turn for mental health *care*. And it is times like this when being a lesbian, gay man or bisexual user of mental health services can be a risky business.

Without culturally sensitive knowledge, those to whom we turn for mental health care will be unaware of the basic facts of our lifestyles. Lacking awareness about the needs of lesbians, gay men and bisexuals can mean that myths and stereotypes about us are mistaken for 'facts' - 'facts' that become dangerous when used as a basis for diagnosis.

This research has provided all of us with a source of education and knowledge. PACE has provided the mental health system with a way forward, ensuring that lesbians, gay men and bisexuals become the recipients of mental health care rather than homophobia, biphobia and heterosexism.

I welcome this report, for all who want to provide effective mental health care. For all who want to understand and combat the prejudice that lesbians, gay men and bisexuals experience within the mental health system. And for all lesbians, gay men and bisexuals who have courageously taken a 'risk' in using mental health services and have taken part in this research.

Gloria Gifford
Survivor
January 1998

Introduction

'DIAGNOSIS : HOMOPHOBIC'

"A few months ago I started seeing a psychologist because I was depressed, self-harming and bulimic. She mentioned being an in-patient somewhere but I said no and she put me on anti-depressants. They didn't work and a few months ago I took an overdose. I was in hospital for a week and put into a psychiatric hospital specialising in eating disorders and self-harm. I told my new therapist I'm gay but he tells me it's a phase and I've had bad experiences with boys so that's why I feel the way I do, it even says in my care plan "confused sexuality !". I'm not confused.

A month ago I took another - bigger - overdose. I've been to A and E five times so far for stitches and X-rays. I feel so lonely. My new anti-depressants haven't 'kicked in' yet and last night I sniffed hairspray. I feel so desperate and alone. Please, please, write back soon. I hope you can read my writing (my hand's bandaged)."

Extract from a letter received by LYSIS (Lesbian Youth Support and Information Service) in December 1997 (see Section 6.2).

'Diagnosis:homophobic' is the first qualitative research study carried out in Britain which looks at the experiences of lesbians, gay men and bisexual people in mental health services.

We wanted to discover whether lesbians, gay men and bisexual people received mental health services which worked for them and if so, what it was that made them work. If, on the other hand, LGB service users were unhappy with services, why was this the case?

In the main, in-depth interviews and focus groups were carried out to elicit from respondents what their experiences (service users) or observations (MH workers) as lesbians, gay men and bisexuals in mental health services had been. Our intention in gathering qualitative data was to help us understand the difficulties lesbian, gay and bisexual service users faced, how and why services were experienced in the ways that they were, and to present that information in a way which would inform both mental health practice and LGB communities. As well as presenting the research findings therefore, the aims of this report are also to:

* help MH professionals understand the implications and effects of being a sexual minority in a heterosexist, homophobic and biphobic society
* encourage them to consider their own individual practice with LGB clients and service users

* encourage them to consider the practices of the institution in which they work, in terms of LGB clients, service users and workers
* raise the profile of mental health issues in the LGB communities and encourage alliances between mental health service users and non-users.

Structure of report

The findings which emerged from our data are summarised into the following seven sections.

Section 1 'Motives and Means', describes the context in which PACE (Project for Advice, Counselling and Education) identified the need for this research, how funding was found, and how the research was designed and carried out.

Findings presented in Section 2, 'Understanding the Mental Health Issues Specific to Lesbians, Gay Men and Bisexuals', illustrate issues unique to lesbians, gay men and bisexuals which can impact on mental health.

The range of attitudes participants experienced towards them as lesbian, gay and bisexual users of mental health services, and the effects these attitudes had, are explored in Section 3 : Accessing Services as Lesbians, Gay Men and Bisexuals; Section 4: Diagnosis, Treatment and Care; and Section 5: Thinking About Attitudes.

Section 6 presents participants' ideas on the roles of mainstream and specialist LGB services and the relationship between them, and lays out the improvements to services which findings show are needed.

The conclusions and recommendations drawn from the study are presented in Section 7.

Decisions about terminology and perspective

Terms used to describe people who have used or are using services were chosen in a similar way to that described by Wallcraft and Read (1994):

> "We have already referred to service users, patients and clients. We could have used recipients or survivors of psychiatry, or even consumers or customers. There is no one generic term that can take account of the different relationships people have with mental health services - from voluntary attenders of a drop-in, to people held against their will in secure units. Within this limitation, we have tried to use the most appropriate term on each occasion, knowing that we will not always have made the same choices as our readers."

Describing one's sexual orientation can also be complex, and where people have used terms other than lesbian, gay or bisexual, these have been used.

The use of particular terminology can sometimes denote particular perspectives, and it is important to outline here why certain phrases and not others have been used. 'Mental illness' is a term which tends to be used in psychiatry, and represents a 'medical model' of distress which is not the analytical perspective used here. This is not to deny however that some service users do employ this term and subscribe to

this model - that there are biological, chemical or genetic causes to their distress. The view taken here is that no one theoretical perspective can provide an explanation for every experience, thus our own use of a social model will not necessarily apply to everyone. All models may well have a part to play, but it would be interesting to speculate what effect the eradication of homophobia and heterosexism would have on the mental health of individuals generally, irrespective of sexual orientation. The inspiration at the heart of this research is that one day we will know the answer to that question.

Difference and Diversity

All sorts of differences between lesbians, gay men and bisexual people exist, not just in terms of sexuality but also in relation to variables such as ethnicity, age, gender and physical ability. Any of these characteristics can influence the ways in which workers and institutions choose to deliver services. Experiences other than those arising from attitudes to sexual orientation have therefore been described in order to draw attention both to the diversity of lesbian, gay and bisexual communities, and to the ways in which lesbians, gay men and bisexuals can be multi-oppressed. Multi-oppression can also mean that it is not always clear what it is that people are discriminating against, as the quote below illustrates.

> *"This service was saying that it didn't want people who were suicidal. It didn't want self-harmers. Well I mean, this is a crisis house. These are exactly the people we want it for ... It's a bit difficult to tell whether they are being homophobic. The gay men who have had this problem [i.e. been turned down by the service] also come into the categories of self-harmers and [are] suicidal. So it's difficult to tell what they're discriminating against them for, since they are all these things!"*
>
> Jay, Lesbian

Questions of difference and diversity need to be considered in much greater detail, and it is hoped that funds for future research will be made available to take this preliminary study forward.

A small number of transgender people contributed to both the pilot and the research study, but experiences have not been analysed in terms of that characteristic. Neither does this report attempt to address transgender issues, but acknowledges that research does need to be carried out in this area. The experiences of those who did contribute indicate that mainstream mental health services are failing transgender people in the same way they are lesbians, gay men and bisexuals.

Confidentiality

In order to respect confidentiality, participants chose the name and identifier by which they wished to be known in this report. Place names, names of hospitals, and services provided by specific boroughs or regions have been left out for the same reason.

Editing

To aid your reading of this report, certain structures have been employed:

* quotes in italics indicate data gathered from this research
* all other quotes employ ordinary script

* text which has been left out of quotes is indicated by ... three dots
* some quotes contain words in brackets. These have been added by the researcher to clarify what is being said.

Section 1

Motives and Means

In recent years, staff at PACE observed that a significant number of those referring themselves to the organisation for counselling, would also benefit from other types of mental health care and support. They were concerned at how many of these clients seemed unwilling to access such services, or were unhappy about services they had used. Informal inquiries seemed to indicate that there were a number of possible reasons for this:

- ◊ Fears about, and experiences of, mainstream services pathologising those whose identity or behaviour is not heterosexual.
- ◊ Fears about, and experiences of, being faced with ignorance and homophobia from both staff and other users of services.
- ◊ Using services but not being 'out' could lead to inappropriate care, loneliness, isolation and possibly compound feelings of internalised homophobia.

- ◊ The services desired did not exist - for example local services specifically for LGB service users.

On the strength of this anecdotal evidence PACE successfully applied to the Department of Health to fund an 18 month research project which would ask the following question:

"What are the experiences of lesbians, gay men and bisexual people who have used, or are using, mental health services?"

PACE hoped that the answers to this question would indicate the ways in which mental health services could ensure that lesbians, gay men and bisexual people receive services which are appropriate, sensitive and safe. Developing recommendations for good practice was therefore a key aim of this report.

The organisation also wanted to continue to build its knowledge base on the mental health issues faced by lesbians and gay men, to ascertain the need for any new LGB-specific services, and to therefore inform the development of its own service.

Finally, PACE wanted to explore the extent to which LGB users of mental health services felt that LGB communities and individuals were inclusive and supportive. Findings would indicate whether work within LGB communities is needed to raise the profile of mental health issues and so encourage alliances between MH service users and non-users.

• Literature Review

A literature review was conducted prior to designing the research which emphasised the lack of research into mental health services and lesbians, gay men and bisexuals, and therefore the great need for it. In terms of British research, relevant or related studies covered four main areas:

1. Attitudes of health care workers and professional in the field of general health care

This small body of work reveals homophobia and heterosexism amongst GPs and nurses. Bhugra's 1988 study showed that 10% of GPs thought gay patients should be returned to 'normality' by therapy, and that two thirds felt uncomfortable about having gay men as patients. A 1994 study into homophobia among doctors (Rose, L.), revealed that "doctors are influenced by ideology and the values of their culture. In many instances they are blatantly homophobic." Attitudes of nurses towards lesbian nurses indicated that some lesbian nurses have not been treated with respect or dignity because of their sexual orientation (Rose, P. 1993).

2. Lesbian and gay experiences of being cared for in the context of general nursing

Research carried out by members of the RCN lesbian and gay working party (James et al, 1994, Rose and Platzer, 1993, Rose, 1993 and Platzer, 1993) drew attention to a number of areas, including:

* fearful / prejudicial staff attitudes
* inappropriate psychiatric referral
* not allowing partner to accompany / visit
* lesbians and gay men often do not reveal sexual orientation as they fear harm, unpleasantness or that confidentiality may be breached.

3. Counselling and therapy

Man (1994) discusses research findings which report that up to 50% of lesbians and gay men seeking counselling reported dissatisfaction as a result of negative attitudes and lack of understanding towards their sexual orientation. Man's own research into the coverage of lesbian and gay issues in counselling training showed that whilst counsellors had worked with, or were working with lesbian and gay clients, none had received training specific to those groups.

A study of training institutions for psychoanalysts and therapists to establish whether lesbians and gay men are excluded from training and if so, what the motives might be, revealed that openly lesbian and gay people are not accepted to train as therapists or analysts in some British training institutions (Ellis, 1994). Young (1995) describes the difficulties of getting sexual orientation onto institutional agendas - for example the British Association for Counselling (BAC) turned down a proposal for a training guide on lesbian issues, and the British Psychological Society refused to include a lesbian study group and a lesbian and gay group.

4. Lesbian and gay youth

American research on young lesbians, gay men and mental health shows high levels of attempted or successful suicide, and there is a growing body of work which suggests that the same may be true of Britain (see Bridget and Lucille, 1996,

Sanderson 1996, Willmot, 1997). A study by Rivers (1995a, 1995b) to look at the long term effects of bullying in school, found that young lesbians and gay men are more likely to be bullied and that this can often have an impact on their mental health.

Summary of literature review findings
Findings from studies done in the area of general health care, counselling, therapy and lesbian and gay youth, reveal that:

◊ Homophobia and heterosexism exist within health care professions.
◊ Lesbian and gay issues are not being addressed in training.
◊ Lesbians and gay men experience health care services negatively.
◊ Lesbian and gay youth face particular MH difficulties.
◊ There is a lack of research into bisexuals and mental health.

Since the literature review was carried out, two British studies have been published. Golding's quantitative study (1997) looks at the experiences of lesbians, gay men and bisexuals in mental health services. Koffman's report (1997) is based on a MH services needs assessment of lesbians, gay men and bisexuals. Findings from both these studies indicate that bisexuals - as well as lesbians and gay men - are subject to ignorance, discrimination and prejudice within mental health services.

• Research Methods

Pilots
Interview schedules with both service users and MH workers were piloted in October and early November 1996. After making the adjustments indicated by the pilots, interviews and focus groups were then held over the next 12 months (between late November 1996 and early November 1997).

The samples
Both LGB service users (N=35) and MH workers and professionals (N=35) were involved as participants in this research. However the desired emphasis was on the experiences of service users, and this is reflected by some differences in method which were used with each group.

◊ Thirty of the 35 service users, and 15 of the 35 MH workers were interviewed using in-depth interview techniques.
◊ For the 4 service users who wanted to take part but for whom one-to-one interviews were not feasible, a telephone questionnaire was used.
◊ Focus groups were primarily used for gathering information from professionals - 3 groups with a total of 20 participants. One group was held with 4 service users. Three of these participants later gave one-to-one interviews and have not been counted twice in the total figure.

Obviously some participants fell into both categories, having experience of working in *and* using services. Where this was the case, participants could choose the experiences they wanted to focus on, and there was opportunity to talk about both perspectives.

It would not have been possible to access random samples in these particular fields, where the stigma associated with being lesbian, gay and bisexual both for workers and users would mean that people were not necessarily out. The further stigma associated with being a MH service user added to this difficulty, so that anyone who fulfilled the criteria below and wanted to take part was interviewed.

1. Mental health service users - the sample

In terms of the sample of mental health service users, mental health services were defined as any service accessed by lesbians, gay men and bisexuals in relation to their mental health needs; however counselling or therapy alone would not have qualified for this purpose (but may have been part of a person's experience). Thus someone whose only contact with services was a referral to PACE for counselling, for example, would not be eligible. The range of services experienced by participants - voluntary, statutory and private - included residential care in psychiatric hospitals, psychiatric units, medium secure units, therapeutic communities and supported housing schemes. Non-residential care and support included the use of out-patient psychiatry and psychology, day centres, drop-ins, user groups, community psychiatric nursing, GP services, emergency clinics and crisis services, self-help groups, therapy, counselling and social services.

Leaflets, letters, visits, phone calls and advertisements were all used as ways of obtaining a sample, and were made or sent to LGB user and campaigning groups, LGB groups generally, mental health services in both the statutory and voluntary sectors, day centres, hospitals and relevant publications and conferences. Some targeting of specific groups was also done to ensure that the diversity within the LGB communities was represented.

Table 1. Demographic Breakdown of Service User Sample: N=35

	Men	Women	Other				
Gender	14	20	1				35
	Gay	Lesbian	BiMan	BiWoman	Other		
Sexuality	11	18	3	2	1		35

	16-24	25-34	35-44	45-54	55-64	65+	
Age	4	13	14	1	2	1	35

	White UK	White Irish	White Other *	Black**	Mixed Ethnicity***	Indian	
Ethnicity	20	3	4	5	2	1	35

Physically	Yes	No	Sometimes	Not Recorded			
Disabled	11	23	1	0			35
Disabled by	Yes	No	Sometimes	Not Recorded			
MH Probs	32	2	0	1			35

* Celtic-Cornish-Welsh / USA / European

** African-Caribbean English / of Mauritian Descent / British Jamaican / Anglo-Jamaican / Black British of African Extraction

*** Indian-Jewish-European / Mixed Ethnicity

The majority of participants had experiences of MH services within the last 5 years and many of those also had experiences which took place more than 5 years ago. A few had experiences which referred solely to the last 5 years.

2. Mental health workers - the sample

The main selection criteria for the professional sample was area of work. Aside from the focus groups we therefore targeted very specifically in the professional fields - MH professionals and workers acknowledged to be lesbian, gay or bisexual, who would be willing to give an overview of the issues based on their observations of LGB clients accessing services and of their personal experiences as a lesbian, gay or bisexual working in those services. However, leaflets advertising the research were also distributed at a number of relevant conferences.

In terms of focus groups, three groups of MH workers and professionals were run in conjunction with members of the RCN lesbian and gay working party, who helped with the organisation and facilitation of these groups. Notice of these were sent to several health and community care publications, and also received publicity in the Pink Paper. One was held at the Royal College of Nursing in London, and attracted a professional, multi-disciplinary group of lesbians, gay men and bisexuals. The other two were held at Southampton General Hospital. Again a number of professional areas were represented and included a small number of heterosexual workers and students. Whilst the groups were aimed at lesbians, gay men and bisexuals, these workers have remained in the sample as they were keen to contribute and did give an insight into the kinds of attitudes which may be held by heterosexual trainees, students and workers.

Table 2. Mental Health Worker Demographics: N=35

	Men	Women	Other			
Gender	13	22				35
	Gay	Lesbian	HetMan	HetWoman	Not sure	
Sexuality	10	17	3	4	1	35

	16-24	25-34	35-44	45-54	55-64	65+	Not Recorded	
Age	4	9	15	5	0	1	1	35

	White UK	White Irish	White Other *	Black **	Mixed Ethnicity***	Indian	Not Recorded	
Ethnicity	24	2	3	2	2	1	1	35

Physically	Yes	No	Not Recorded				
Disabled	1	33	1				35

* USA/European/Mixed Irish-English
** Black British/ Palestinian Origin
*** Celtic Jewish / Romany English

The following areas of work were represented by those workers and professionals taking part in one-to-one interviews and focus groups (FG). Seven people in this latter group identified as heterosexual.

Table 3. Areas of Work: N=35

Clinical Psychology	Consultant CP Clinical Psychologist Clinical Psychologist	Rehab / Continuing care Adult Mental Health Child and Adolescent MH	One-to-one One-to-one One-to-one
Psychiatry	Consultant Psych. Psychiatrist	Hospital Psychiatric Unit Acute Admissions	One-to-one FG
Social Work	Approved Social Worker Approved Social Worker Social Worker	Community Support Services Hospital Psychiatric Unit Young People's MH Service	One-to-one FG FG
Mental Health Nursing	Student Nurses, MH MH Nurse Teachers, Nurse Training MH Nurse Specialist	In Training Hospital Psychiatric Unit Mental Health Men's Health Clinic (Ex Forensic)	FG FG FG One-to-one
Counselling and Therapy	Counsellors Psychoanalytic Therapist Counsellor* / Therapist	LGB Organisations Private Practice General Practice/Private Practice	One-to-one/ FG One-to-one One-to-one
General Practice (* See above)	GP	Inner City General Practice	One-to-one
Day Care Services	Day Care Officer Day Centre Manager MH Day Centre Worker	Not Recorded Mental Health Ethnic Minorities Development	FG One-to-one One-to-one
Community Support	CS Worker Care Manager	Mental Health Housing HIV / AIDS	One-to-one One-to-one
Youth Work	LGB Worker Lesbian Youth Worker	Youth Work Prevention, MH Difficulties	FG One-to-one
Occupational Therapy	Occupational Therapist	Department of Psychiatry	FG
Research	Researcher	MH Services	FG
Gay Men	Workers	Gay Men's Health Project	FG
General Nursing	Nurse	General nursing	FG

Data collection methods

1. In-depth qualitative interviews

Semi-structured interviews were carried out using a tape recorder. Most lasted about two hours. Respondents were given the choice of being interviewed:

* at PACE
* in their own home
* at their place of work
* any other suitable location suggested by participants. These included the premises of MH services, user groups and LGB groups.

This method was chosen in order that participants could focus on those issues most important to them, and could address them in a way which did not restrict their responses.

Given that the interviews dealt with material which could be difficult or painful to talk about, we wanted to ensure that participants had some support if they felt upset or angry, or had a need to talk further about the issues raised. An arrangement was made with the Senior Counselling Practitioner at PACE whereby anyone who needed to could access the crisis service at PACE. All service users taking part were given contact details about PACE and other organisations useful in this situation. They were also given a sheet explaining the purpose of the study, what was meant by confidentiality and how that would be maintained, and thanking them for taking part. It also included the researcher's name and telephone

number at PACE, in case there were questions people wanted to raise at a later date.

'Respondent Profile Sheets' gathering demographic data, services used and when, and the level of confidentiality required, were filled in prior to the tape recorder being switched on. Service users, and the small number of workers taking part in their own time, were paid £10 plus any travelling expenses. All participants were asked if they wanted a copy of the final report. Everyone did.

Although the majority of people taking part currently live and or work in London, many participants described experiences which took place in a number of geographical areas thus the findings are not only a reflection of what is taking place in London. For our purposes it was felt that locality did not need to be made explicit. What we wanted to establish was the *range* of possible experiences and present these in terms of good and bad practice and impact on mental health. Some interviews took place further afield (Brighton, Oxford and Lancashire), as it proved cost-effective to visit user groups for example, where a number of people were willing to be interviewed.

2. Telephone questionnaires

A fraction of these were used in response to someone wanting to take part but not being easily accessible. Although they did not gather qualitative data to the same degree as the face-to face interviews, a number of open ended questions were included which provided some data of this sort.

3. Content analysis of the presenting issues brought to PACE

In order to provide additional material on lesbian and gay mental health issues which could be compared and contrasted with that provided by participants, an analysis of the presenting issues brought to the counselling service at PACE during 1996 was carried out. As it was not known if PACE counselling clients fulfilled the criteria of having used statutory mental health services, these presenting issues are not included in the data or description of demography.

4. Focus groups

These were mainly used in order to bring together MH workers and professionals to look at their observations of good and bad practice and draw out recommendations. One focus group was run with service users. This came out of a GLAMH meeting (Gay and Lesbian Action on Mental Health), when members who had seen leaflets about the research invited the researcher to run a focus group at their next meeting.

Data analysis

Analysis of the data was done on an ongoing basis, allowing the emerging patterns and themes to provide the analytic categories. Where a new theme emerged, previously analysed data was checked to ensure that it had not been missed elsewhere. Where analysis has attempted to move from description to explanation the theoretical perspectives of feminism, lesbian and gay studies and a social model of illness and disability have been applied. Collaboration in the writing up of this report was sought from the participants.

Section 2

Understanding the Mental Health Issues Specific to Lesbians, Gay Men and Bisexuals

The purpose of this section is to consider the mental health issues and distress faced or identified by the interviewees in this study, and to show how the root cause of some of these issues stemmed specifically from responses to sexual orientation.

A number of service users when asked, employed a medical model to understand their mental health difficulties, and were clear that schizophrenia or manic depression for example arose from genetic, chemical and / or biological causes. Some nevertheless indicated that factors of an environmental and or social nature may also play a part in exacerbating or causing distress, indicating that for them, different perspectives were not necessarily mutually exclusive.

However many of those interviewed talked about mental health issues in terms of the effects of difficult and traumatic life events: being HIV+, sexual abuse, physical abuse, rape, the break-up of relationships, bereavement, redundancy, unemployment, racism and family conflicts were amongst issues described. Some talked about self-harm, substance abuse, attempted suicide and eating disorders as direct responses to the above. For others those links were not necessarily as clear.

> *"For 7 years as a child I was locked in a cellar, I was sexually abused and raped ... Constantly beaten, constantly not washed, not dressed ... there's a lot of physical abuse. And what's made me ill is that I get a lot of flashbacks ... I sometimes hear voices, not voices from strangers but voices from people who have hurt me. Sometimes, occasionally I see things, like I think I'm going through it again ... And sometimes, sometimes I get so low as you can see, I've cut all me main arteries in me arm, you know, where I've felt so, where I feel so bad."*
>
> Kerry, Lesbian

> *"I was getting a lot of nightmares about my being raped, I was going through suicidal tendencies, a lot of post-traumatic stress to do with the rape came up. I was very distressed. And I was hearing voices as well, which kept telling me that I deserved what I got and so I thought I've got to go. This time it was crunch point. It was either going into the hospital or jumping off a bridge or doing something equally bad to myself."*
>
> Jason, Gay Man

What is clear is that in terms of distress we do have experiences in common with our heterosexual counterparts. This is further illustrated here by an analysis of the presenting issues of counselling clients at PACE, 1996. From a list of 42, the presenting issues most frequently identified are shown in the table below.

Table 4 : Presenting Issues Most Frequently Identified: N=93 *

Presenting Issue	Men	Women	n	%
Relationship difficulties	37	30	67	72
Family problems	28	27	55	59
Depression	18	17	35	38
Low self-esteem	18	15	33	35
Alcohol problems	14	13	27	29
Loneliness / Isolation	15	11	26	28
Ambivalence re sexuality	19	7	26	28
Suicidal thoughts	13	10	23	25

PACE, 1996 (* Excluding HIV concerns)

That some of these are MH issues shared by the population at large is confirmed by other studies. An evaluation of a women's counselling service (McFarlane, 1993) for example, showed the issues most frequently brought to that service in the two preceding years to be depression, lack of self-esteem and difficulties in personal relationships.

One or two participants in the PACE study went further however, suggesting that

> *"... at the end of the day our sexuality has nothing to do with our mental health, our state of mind. And that's certainly the case with me."*
>
> Ron, Gay Man

Indeed, this report would want to emphasise that sexual orientation *per se* is not regarded here as a mental health problem. What does emerge from the data however, is that over 60% of the service users taking part in this study identified attitudes and behaviour arising from homophobia, biphobia and heterosexism as having had some impact on their mental health. The frequency with which issues in the table above were presented also reflect points raised later in this section.

Professionals were asked if there were particular issues with which lesbians, gay men and bisexuals present. Whilst there was some reluctance to pinpoint specific issues as being more relevant to LGBs than the rest of the population, nevertheless 80% believed that discrimination, prejudice and oppression could have negative effects on mental health, and the importance of all mental health professionals being aware of and understanding these effects was emphasised.

> *"What is bound to come up at different times, is the bearing of homophobia on how they experience some of the difficulties they are having ... I am very cautious about assuming that there's a set of symptoms or pathologies or whatever ... but I think it's crucial that one takes homophobia really seriously."*
>
> Psychoanalytic Psychotherapist, Lesbian

> *"There is a sense in which attitudes in society do affect people and they end up with mental health problems, problems with relationships."*
>
> Consultant Psychiatrist, Lesbian

Whilst attention has been drawn to the different ways in which people understand their distress, it is not within the scope of this report to consider these perspectives in general. Our focus here is on mental health issues arising out of responses to sexual orientation which is not heterosexual, thus the rest of this section will consider what it means to be lesbian, gay or bisexual in a homophobic, biphobic and heterosexist society, and examine the effects on mental health.

2.1 The Impact of Homophobia, Biphobia and Heterosexism on Mental Health

To be lesbian, gay or bisexual in this society is to be a member of a minority group which is stigmatised, oppressed and discriminated against. For example:

- ◊ There are people who will hate and fear you simply on the basis of *what* you are - who you are is irrelevant.
- ◊ Up until 1992 in the UK homosexuality was classified as a mental disorder.
- ◊ Your religion if you have one is more than likely to label you a sinner.
- ◊ You do not have the same rights as the majority of your peers - sexual acts between men were criminalised for years for example, and as yet an equitable age of consent has still not been achieved.
- ◊ You are not represented by the images you see everywhere - you are not a part of the cultural 'norm'.

What this list illustrates are some of the ways in which heterosexism, biphobia and homophobia operate. But what do we mean by these terms?

Heterosexism

"The institutional and individual assumption that everyone is heterosexual and that heterosexuality is inherently superior to, and preferable to, homosexuality or bisexuality." (Rankow, 1996)

Homophobia / Biphobia

"The irrational fear or hatred of, or aversion to, homosexuals and bisexuals ...

These feelings can be

1. External - the experience of fear or hatred from another person or an institution because one is gay, lesbian or bisexual ...

2. Internal - the experience of shame, aversion or self-hatred in reaction to one's own feelings or behaviour as gay, lesbian, bisexual. This is usually referred to as 'internalised homophobia.' " (NLGHA, 1997)

Do these impact on your mental health? And if they do, does that mean you are ill? Just as it is difficult to agree on what constitutes 'mental illness', defining mental

health is also problematic. It may be seen to differ depending on the cultural and historical context, but even in this society, at the end of the 20th century, views will differ. 'Health' as defined by the World Health Organisation (WHO) is 'a state of complete physical, mental and social well-being' (OU, Module 1, 1997). How can mental health professionals hope to promote and restore the well being of lesbians, gay men and bisexuals in any sense, if they do not understand some of the fundamental difficulties these groups face? By presenting theories, experiences and observations of the impact of the above on mental health, we hope to further that understanding.

• Internalised Homophobia

Growing up gay

The experience of growing up in a society which is heterosexist, homophobic and biphobic will mean that to some extent almost all of us will have internalised negative feelings about what it is to be lesbian, gay or bisexual (Davies and Neal, 1996). Consciously or unconsciously we will take in the blatant discrimination which surrounds us, as well as the more subtle forms of exclusion or denial. This can mean that emotional growth and development may be hampered and we may feel shame, low self-esteem and inferior to those in the majority (Neisen, 1993).

> *"[Homophobia] made me feel depressed. And also having little self-esteem. For years I've had problems with my sexuality. Not the act or anything like that but people's attitudes and me taking that on board. You know - internalising it. ... Mum - mum was dodgy let's just say that. Sometimes she accepts, sometimes she doesn't. She changes her mind a lot. So that is a continual struggle with my mother and that's you know - had - I think that has had a detrimental effect on my mental health."*
>
> Ayo, Gay Man

Shernoff and Finnegan's 1991 study (cited in Anderson, 1996) suggests that growing up gay in a family that assumes heterosexuality and is homophobic is in itself a dysfunctional process. Nick, one of the participants talking about his experiences of growing up says:

> *"From day one you know my parents sort of were homophobic. They're racist, they are just everything. They don't like anyone who isn't like them. So I grew up in that environment and I couldn't wait to get out of it ... That's why I left home when I was 18 years old. I mean I am human, I don't think that I'm kind of hypersensitive or anything ... You open the paper in the morning and it's just bullshit ... I mean just everything was anti-anti-anti, all rubbish ... It makes you feel worthless really, when you are being attacked like this."*
>
> Nick, Gay Man

Dependence on drugs and alcohol

Internalised homophobia has also been identified as a risk factor for dependency (Kus, 1988, Glaus, 1988) - resorting to alcohol or drugs as a way of coping with stigma for example. For a time Nick dealt with his isolation and alienation by misusing alcohol and drugs.

> *"And I didn't really start coming out until about three years ago. Until I was about 29, 29 or 30 ... I wasn't out to anyone - and I was tormented by that, you know. It's not really something you go and talk to your GP about, being gay ...*

> *As I said, not really ill enough to go into hospital, but you know just sort of like borderline misery. And I thought that was how I was supposed to feel in life ... The alcohol again, that was like a symptom of the problems that I was having in my life and I was using alcohol just to sort of anaesthetise myself ... Not being able to come out - that had an absolutely massive effect on my mental health."* Nick, Gay Man

Davies and Neal (1996) also refer to substance misuse as a possible manifestation of internalised homophobia, and draw attention to the ways in which pubs and clubs are commonly used by LGBs as places for meeting and socialising. These issues were also raised by a number of the professionals in this study:

> *"Alcohol abuse is particularly prevalent amongst lesbians and gay men ... there's a need to understand the particular reasons for that."* Consultant Psychiatrist, Lesbian

> *"The alcohol thing is more hidden ... There's a lot of young lesbians that I know that have got serious drink problems, but if you mention it to them, they've said, 'don't be daft ... I'm just getting pissed and having a good time.' But it is actually a problem, because whilst they're turning to alcohol to deal with their emotions, they're not developing other less harmful ways of coping. So it's there ... and I found that in my research ... in terms of alcohol misuse, in any of the areas that I've highlighted, like eating disorders, depression, self harm, attempted suicide, suicide completion of course, homelessness. Any of those areas, drug misuse, then I would say that probably something like a quarter of young people would be lesbian and gay, and it would be related to their internalised homophobia."* Jan Bridget, Lesbian Information Service, Lesbian

• 'Coming Out'

What does 'coming out' mean?

Being 'in the closet 'means keeping one's sexual orientation hidden. 'Coming out', on the other hand refers to the process of

> "First recognising and acknowledging non-heterosexual orientation to one-self, and then disclosing it to others. This usually occurs in stages and is a non-linear process. An individual may be 'out' in some situations or to certain family members or associates and not others. Some may never 'come out' to anyone besides themselves." (Rankow, 1997)

The process of coming out is an extremely important step for lesbians, gay men or bisexuals and the implications, repercussions and rewards need to be thoroughly understood by mental health professionals if they are to provide appropriate and relevant help for these client groups.

Problems for young people

Whilst it is not true of all lesbians, gay men and bisexuals, many of the participants in this study began to recognise their 'difference' in their teens and early twenties. As Gochros and Bidwell (1996) point out, this realisation comes at an extremely difficult stage of development.

> "Most adolescents are just beginning to develop a sense of identity and self-esteem nurtured by identification with a reference group of peers. Most of their peers are developing heterosexual identities and communicate a preoccupation with successfully making it in a heterosexual world. This can heighten the homosexually oriented youth's sense of difference and non-conformity. It also often removes the opportunity for peer support for any difficulties the homosexually oriented youth might be encountering in her / his sexual development."

This sense of difference is described by Stephen, one of the participants:

> *"... the whole compulsive-addictive anonymous cycle of cruising and sex and cruising and sex. In my mind it would be some equivalent of heterosexual teenage sort of interaction, which of course it wasn't. I was really, really young. And I never met anyone my age. I mean I think years later when I was about 18 I met somebody who was 18 once or twice. But the norm was it was much older guys. So that kind of was very weird, being at school and having this double life from so early. And feeling very cynical and jaded ... I suppose it's like some of these kids in America, these sort of gang kids who are involved in murder and firearms and all that. I felt very kind of, well they don't know anything, even though I didn't understand what I was doing, it was sort of, they were talking about the gym teacher and 'oh I bet she's good in bed'. Or whatever. And I remember thinking, yeah, but I'm doing it with blokes, and they hadn't done anything with anyone. And so that was very weird ... I think there's kind of mental health depression involved in cruising somehow ... I felt very like a marginalised - outcast, a perpetrator from really young. You know it was kind of like having this secret of having murdered somebody or something ... I think for me cruising was about feeling bad."*
>
> Stephen, Bisexual Man

Ways of coping

Shannon and Woods (1991) suggest that compulsive patterns involving sex, alcohol or eating for example, are developed as a way of dealing with feelings of shame and anxiety and to gain some control of the environment. Two quotes from the data illustrate this point.

> *"I think a lot of my feelings were quite confused as well, about my self esteem anyway, at that time in my life. And that was my sexuality as well, the way I felt ... I started to feel angry with society in general really, because I felt, although I'd experienced abuse and whatever, my sexuality was part of - I felt, part of my anorexia ... which was about being angry ... Just with people's attitudes really and about lesbian and gay issues - I felt I'd internalised stuff and hurt myself, where it was like external stuff that was hurting me more. So I did begin to be angry with a lot of things."* CE, Lesbian

> *"I mean there was one young lesbian for example that contacted me first of all in '91. She was anorexic and she was under a psychiatrist for her anorexia. And I've had several young lesbians with anorexia and bulimia. And it all seems tied up with them coming to terms with their sexual orientation ... From what they say, there's a very clear connection ... We started giving her support, put her in contact with other young lesbians, and gradually now she hasn't got an eating problem. And her alcohol consumption's nowhere near as bad as what it used to be."* Jan Bridget, Lesbian Information Service, Lesbian

Suicide

It has been suggested that suicidal thoughts, suicide attempts and actual suicides are particularly high amongst young lesbians and gay men, resulting from the effects of both internalised homophobia, homophobia in the wider society, and feelings of extreme loneliness and isolation (Bridget and Lucille 1996, Gochros and Bidwell,1996, Golding,1997).

> *"I told my mum at 18, she banned me for a whole year and said I mustn't go to any gay pubs, so I went under, I went into loos and that, and cottages and that. At 19 I said to my mum I'm gay again, and she said to me that either I can leave home and live my life as I want to, or be straight and live with her. So I said there was no option, I had to leave home. So I left home at 19 and got this place from the council, and that's how it all started ... At the time I didn't know, what was it, looking back I can see what caused it. Because at the time in the hostel I thought I was lonely and I was gay, I wanted to try and commit suicide because I was gay."*
> Mark, Gay Man

> *"I think coming out ... is a constant kind of process, but I think it's much more acutely an issue, at that [young] age. And that's made very difficult, much more difficult, if people collude with someone's internal homophobia. The family will be doing that, and wider system may be doing that. And so if they go for help and the system that they go to it for also colludes, I think that can be devastating and no wonder that young people do think about suicide a lot, because they think 'where do I fit in, what's the future in my life?' It's all those kind of concerns that young people at that age are thinking about, that identity, that are central to issues of sexual orientation. And if they are seen as something bad, it's not surprising that thoughts of suicide come along."*
> Child and Adolescent Clinical Psychologist, Lesbian

What are the benefits of 'coming out'?

> *"I think ... what was affecting my mental health was feeling the pressure to be straight. And yeah, I think that was the main thing. It was actually quite a relief, coming out was quite a relief."*
> MH Project Worker, Lesbian

> *"I mean, I came out when I was about 19, during a bit of a calmer period in my life, and stuff. And I don't know. That helped me. Once I came out I felt a lot better, for a while ... One of the best moments in my life is when I came out. I was so much happier, now I know I'm a lesbian ... I don't see it as an issue any more, my sexuality. It was when I was coming out, but now that I've been out for about three years it's not really an issue any more. I just think well I'm a lesbian and that's it really. Sometimes I question my sexuality very slightly, but I do feel quite happy with my sexuality. It's other people that aren't so happy about it."*
> Rachel, Lesbian

A number of professionals also pointed to the importance - for lesbian, gay men and bisexual people - of coming out, and to the equally important aspect of support to do so.

> *"If you talk to a lot of older people who have got mental health problems, they'll identify, they'll go back to their adolescence when they were trying to come to terms with their homosexuality. And if they'd been given the right kind of support at the right time, it could have all been avoided. Same with alcohol. Drug problems. No question - if you give them the support like we give young lesbians now. So I'm not saying homosexuality per se is a sickness, but I'm saying homophobia creates problems amongst lesbians and gays,*

especially the ones that identify early on in their youth ... I would argue that a lot of young people that go to the doctor with mental health problems, things like that, it'll be because of homophobia. And they don't know what the hell to do. They don't even ask them about their sexual orientation, and even if they did ... they don't know anything, they don't know the effects of internalised homophobia. They don't know that by giving that young person support, by encouraging them to accept who they are, and giving them accurate information, putting them in contact with other young people of a similar age, supporting the parents etc, that you can get rid of the depression."

Jan Bridget, Lesbian Information Service, Lesbian

• Homophobia, Biphobia and Heterosexism: Further Difficulties for LGBs

Loneliness and isolation were persistent themes

"I think there are huge issues about total isolation and the oppression that they experience. So I think that in terms of lesbians and gay men's life experiences, those are likely to cause some distress and exacerbate other problems ... I think isolation is the thing that you most commonly get, and one of the problems is that that distress, because of its contact with mental health services, becomes pathologised. Whereas in fact actually what you want to do is find somewhere that someone can contact other lesbians or gay men ... You feel better about yourself if you see other people who are OK about themselves, and you discover it's a possible way of being." Rachel, Consultant Clinical Psychologist, Lesbian

"Well when I was a teenager I always thought 'what's wrong with me, why don't I fancy boys?', the usual kind of thing. And when I was 18 I moved down to London. I definitely started thinking about it a lot more, because there were lesbians, visible lesbians around me. Whereas I grew up in [place] and I never even knew what a lesbian was, hardly, until I was about 16. I certainly never met anyone who was an out lesbian. So meeting with these lesbians and stuff who were fine, they were happy, they were confident, that really sort of changed it around ... It was one of the staff at [MH organisation] ... She said, 'I've got a friend and she runs this group for young lesbians. I'll just take you along.' So she took me along there and things started happening then. Because I was with other young lesbians and young gay men who were confident and like, it's OK to be gay, and they did sort of help me and stuff." Rachel, Lesbian

70% of the lesbians who said they were isolated in Bridget's 1993 study (cited in Bridget, 1995) had attempted suicide. Support and social interaction with similarly orientated peers are clearly important in helping to reduce at least some of the distress people may experience. Bridget and Lucille (1996) also suggest that with appropriate support at the extremely vulnerable time of coming to terms with sexual orientation, some of the mental health issues experienced by young lesbians may even be avoided.

Lack of positive images

This lack of role models and positive images arising from the heterosexism and homophobia within society was clearly felt by a number of people to have contributed to their distress and mental health problems (Greene, 1994).

"If I had been a lesbian at 15, I wouldn't have ended up in hospital at the age of 22. I think that was what it was all about. It was being forced into a bloody role that totally was not me. And nobody gave me any options, nobody told me there was another way to live and another way to be, certainly not in the mental health system. I mean they don't want you living any other way. They want you to conform." Brenda, Lesbian

"I can remember when I was 10, the only person I knew that was gay was Jimmy Sommerville, and I know a lot of people hate him. But you know, I'd stick up for him, because for me I mean, I can remember people joking when we were younger about people like Larry Grayson and things like that. But to me gay was just something for gay men. I had no idea that there could be women that could fancy other women." Anne-Marie, Lesbian Orientated

Whilst a lack of positive images and role models undoubtedly has an effect, so too do abundant negative images - as is evident from the following quotes:

"I don't regard it as in any way an illness, but I am sure at that particular age when I was very confused about things, I hadn't had any positive images of lesbians given to me ever. I mean, I had pretty bad images of what a lesbian was. So I was very confused about my sexuality. Because I really didn't think I could be a lesbian because my idea of them was so terrible, that I knew I wasn't. But when I came to realise that I probably was, and because of all the bad attitudes and the bad reactions, I'm sure it did cause an awful lot of stress and I suppose I had some sort of identity crisis, because I'd got nothing to relate myself to ... Maybe if I hadn't been lesbian I wouldn't have got ill, or maybe my illness would have been different or not as bad, or would have happened later or wouldn't have been quite so, I don't know, quite so hard to get over. I don't know. It was linked definitely. But I wouldn't say that my sexuality was illness in any form, but just the attitudes surrounding it." Kari, Lesbian

"And well yeah, what's being gay about, what's being homosexual about? And I didn't know. I'd never had any education about it. A homosexual was a man who interfered with children, as you read about every week in the News of the World. And that was something I didn't want to be ... After a year or two when I found out what it was about, and I'd met more people, I wasn't alone sort of thing, then it just became part of my life and was never a problem."
David, Gay Man

Self-acceptance

Crucial to the well-being of a healthy adult is the integration of sexuality into the developing identity (Davies and Neal, 1996). For lesbians, gay men and bisexuals, the integration of an aspect of identity stigmatised by the rest of society can first of all engender issues about 'loss'- both loss of a prescribed identity linked to perceptions of the idealised self, and the real or anticipated 'loss of persons' who may react negatively to the individual's coming out (Woodman,1989). Both Woodman and Brown (1996) identify depression as being one of the possible outcomes in the face of these events. Loss of, or conflict with, identity was an issue particularly raised in relation to religious beliefs.

"Because of my cultural identity, I've been brought up, well not like fanatical, but I was brought up with a very strict Irish Catholic background. And you're taught more or less from the word go, anyone that doesn't veer to normal, which is like settling down, having umpteen kids the rest of your life, not using contraception, no sex before marriage, various abstentions on feast days, what-have-you - you're just not normal. It's just not tolerated. I can remember

discussing it with my priest at the time, and I went to confession. And he actually wasn't very helpful at all. He said to me that an inclination wasn't a sin, but an act was. And I thought well great, where does that leave me. Do you want me to be celibate for the rest of my life or something like that."

Anne-Marie, Lesbian Orientated

"I go to a gay church ... I was trying to get my homosexuality and Christianity together and live as one person. One identity. Because I thought being a homosexual and a Christian was wrong, I couldn't coincide both of them together... but I can now. I'm far more happier." Mark, Gay Man

"Being Muslim for me was a biggie and being lesbian was another. It's like committing a big sin in my life. And yes, it still is, Islam perceives that. It's having to overcome that and not feel the guilt that is still there around it."

Development Worker, Lesbian

Acceptance by others

A number of interviewees also talked about their fears of being rejected by friends and families and so losing their love and support.

"When I was about 14 or 15, I suddenly decided to come out to my mum. So I, it was very spur of the moment thing, and I took ages to get it out of my mouth, but I eventually told her. I said I thought that I was gay because I felt feelings towards girls, and she was absolutely shocked at first. Just like pure shock. And I was crying, and she could see how upset I was. And I just, in my mind, it was just like, she would hate me for it and she'd throw me out. And I said to her, 'One day I feel like, if I do become gay, I'm just going to have to leave my family and never see them again.' Which was basically me saying that I don't think they'll want me so I'll leave them. And she just said, 'Well we will never want that, you're our daughter and we love you, whatever you are.' But even though she said that sort of positive thing, she ended it by saying 'Don't worry about it, everyone goes through it, and we'll just see.' And then she said 'Do you feel worse for telling me?' And I did. And then she said, 'Well you know, we won't talk about it again.' And that wasn't what I needed. So the only person I've ever told, and she said 'We won't talk about it again.' So I just felt that I shouldn't talk about it again, and sort of suppressed it, and never mentioned it, and still haven't mentioned it to her since that day. So ... "

Justine, Lesbian

Staying in the closet

A study by Berger (cited in Lee, 1992) suggested that those who attempted to lead a 'double life' were more likely to score high on indicators of depression, interpersonal awkwardness and anxiety about their gayness and indeed, a number of participants did identify not being out as having an impact on their mental health.

"I hadn't accepted being gay myself. It was always a question mark hanging over my head, telling me I wasn't sure what was right, whether I was gay or whether I was just going through a phase ... It worried me for a while ... because you never knew who you could confide such a story in. But I didn't trust anyone basically ... I think I was afraid of their response, my long standing reputation, - I had got a good reputation in the community, - being blown out. And the biggest problem was probably my parents ... I didn't think my mother would like that you know, and I'd always done everything sort of behind her back ... I think the fact that I was trying to store so much up in my mind, without being able to let it out. It was like a kettle boiling, everything building up, steaming up in your head, and nothing can get out, unless you

take the lid off it ... I've always felt since being young, I always felt sort of - I'm in my own little corner, as far as this gay life comes. And I still do at times. Because there's not that many people to talk open to." Jaymee, Gay Man

Changing attitudes?

Phillips (1994) identifies an assumption that 'things have changed' in that there is more tolerance and acceptance towards sexual minorities. Celebrities have 'come out', MPs are 'out', we are represented in soaps and in advertisements and even mentioned in some equal opportunities policies. To some extent that is true, but do the changes really reflect a change in attitudes?

"Oh, there's still terrible isolation. The vast majority of young lesbians that contact us think that they're the only one. You know, they might see these on television, but they're on television. They don't know any other young lesbians. So that's the first thing, isolation ... Older lesbians and gays think that things have changed, that it's a lot easier. It might be for them, because they've grown up, they're adults now and they've got the skills and knowledge and confidence and what-have-you. And yes, of course there are helplines, there were no helplines when I was 15 ... But the same way that I was terrified at 15, you've still got the 15 year old terrified now. But in fact I would argue perhaps more terrified because it's much more visible now than what it was ... Because the issues are more visible, there's much more harassment, much more scape-goating, much more physical, verbal, mental abuse of lesbians and gays, and Stonewall have shown that in their survey."

Jan Bridget, Lesbian Information Service, Lesbian

Homophobic violence

Preliminary results of the Stonewall survey on homophobic violence, published in Gay Times (Powell, 1996), showed that 'one in three lesbians, gay men and bisexuals have suffered at least one physical attack in the past five years'. The figures depicting the experience of young lesbians and gay men are even worse - one in two under eighteen's have suffered at least one violent assault. This is not to suggest of course that such abuse did not exist before.

"In the 60s, I had a bad time in the 60s, because I was the other side of Quentin Crisp ... I was true butch, the old type butch. Sheer tie and everything. And the times I got beaten up for that, I got knocked about terrible. Never broke down. Didn't break down because of that." Jo, Lesbian

Impact on mental health

Professionals also expressed an awareness from their work experience of the possible effects of homophobia and biphobia and the need for mental health professionals to take these into account.

"Suicide! Attempted suicide. People who've survived their suicide ... Housing problems ... that's a big issue in this area. Homophobic neighbours. That happens all the time but we can't help any more (service cut so now only working with 'high dependency']. We used to be able to help with that. But we can't because 9 times out of 10, the person, the sort of mental illness they've had is as a result of, direct result of that social factor .... not of mental illness as such. Although sometimes they are all linked ... Here's an example of a 24 year old man who came to us. He's been experiencing homophobic abuse from the neighbours living above him. I think they put excrement through his door.

They were playing loud music, calling him fucking poof - all sorts of things going on over a long period. He took an overdose and ended up in hospital. He was in hospital as an informal patient - he went to the casualty department. Obviously a lot of that was down to being in a desperate situation. Now he could have died, but he didn't. And we couldn't give him any support with the housing issue because he didn't meet our eligibility criteria of who gets the service ... What he needed was someone to advocate for housing in a strong way." Terry, Mental Health Social Worker, Gay Man

Multiple oppression

A number of people in this study also drew attention to the issue of multiple oppression. The effects of homophobia, biphobia and heterosexism can be added to or compounded by also being a member of an ethnic minority and / or other marginalised groups (Lee, 1992, Greene, 1994).

"There was lots of family pressures on me and me knowing that I didn't want what my family wanted, knowing that I was ... well at the time I thought I was bisexual, but having all those issues going on. And the overdose actually followed my parents finding out I was having a relationship with a man at the time, and then just like throwing me out of the home ... I think in a way the second time, a lot of it had to do with really unresolved issues from then ... It was the same sort of family issues coming up really, and a few relationship issues, and a lot of confusion about sexuality really ... and confidence and that. And I lost it ... I was very, very low for months, very low. And looking back now I realise some of it was quite psychotic as well, and not reality based. It might have come from quite a real situation, like feeling quite alien in my environment and the reality was I was living [in a place] where I didn't know any of the black lesbians ... and had no links with my family, so that sort of isolation was quite reasonable to feel." MH Project Worker, Lesbian

"When I was at boarding school, black people used to call me Paki, and white people, so that's a voice in my head calling me Paki. So it's like being called a honky if you was white, or a nigger if you were black ... all the time. It's the worst thing you can be called, going on all the time ... It was just - I felt so - one of the worst times of being in boarding school was being spat on. Two people in bunk beds spitting on me and calling me Paki until I cried myself to sleep. The staff were just as bad. Racist, at school."

Lincoln, Gay/Bisexual Man

Summary

It seems clear that homophobia, biphobia and heterosexism can impact on mental health. Such oppression, discrimination and prejudice may result in our:

- ◊ Internalising negative feelings which can hamper emotional growth and development, cause feelings of shame and self-hatred, and leave us feeling alienated and isolated.
- ◊ Experiencing loss or feelings of loss - for aspects of our identity or for those who may reject us.
- ◊ Being physically, sexually or verbally abused.
- ◊ Being so affected by the above that we become depressed, self-harming, suicidal or involved in the misuse of alcohol and drugs.

We have looked at some of the ways in which the respondents in this study experienced or identified homophobia, heterosexism and biphobia and how these may have impacted on mental health. We now turn to their experiences of mental health services, and find out to whether these attitudes - of prejudice, discrimination and oppression, are also prevalent in the organisations and institutions they used, or were forced to use, because of their mental health difficulties.

Section 3

Accessing Services as Lesbians, Gay Men and Bisexuals

In attempting to draw attention to the needs of lesbians, gay men and bisexuals in mental health services, a response which is sometimes encountered is that either there are no such clients using that particular service, or only a very small percentage of clients identify as such (Rabin et al, 1986, Perkins, 1995a). From the perspective of these service providers there is no need to consider the view of such clients, but what is not being recognised is that:

◊ Whilst it may well be the case that some lesbians, gay men and bisexuals choose not to access mainstream mental health services, this should be a cause for concern rather than a justification for assuming there are no problems.

◊ Many lesbians, gay men and bisexuals *are* using services but for a variety of reasons choose not to disclose their sexual identities. Failure to do so may result in their receiving care which is not only inappropriate but may also compound difficulties they are already experiencing (Golding, 1997).

Other service providers may acknowledge that they have service users who are sexual minority clients, but to what extent are they aware of the ways in which their service is perceived or experienced by these particular groups? Until recently what little research there was on this topic, both from the US and the UK, tended to concentrate on general health care. Lucas (1993) showed that lesbians avoid or delay seeking care because of the insensitivity of health care personnel to issues of sexual preference; she also has evidence suggesting that lesbians believe disclosure of sexual preference would negatively affect the quality of health care. Some further believe that they would actually risk harm in some health care situations. Research by James et al (1994) also raised concerns about confidentiality, the keeping of records and access to information. A statement published by the Royal College of Nursing (RCN, 1994) raises these issues for nurses and outlines ways in which they could start to be addressed (see Section 5.1).

In terms of looking specifically at *mental* health services and the experiences of lesbians, gay men and bisexuals, two recent publications in this country revealed problems. One showed that 78% of participating LGB service users expressed reservations about feeling safe enough to disclose their sexual orientation in a mainstream mental health setting, and 84% feared prejudice, discrimination, or that their sexual orientation would be pathologised (Golding, 1997). The other (Koffman, 1997) suggests that experiences of isolation as a lesbian, gay man or bisexual person within mainstream mental health services renders those services inaccessible to some lesbian, gay and bisexual people.

Experiences and observations described by service users and mental health care workers in our study show that whilst there are lesbians, gay men and bisexuals

who use services and are open about their sexual orientation, there are others who are or have been reluctant to use services, or who use services but do not disclose. It is also the case that sexual orientation may be disclosed in some settings but not others. Reasons for this include:

* fears about safety
* fears about being pathologised / negatively judged / stigmatised
* worries about confidentiality
* invisibility and lack of acknowledgement of sexual orientations other than heterosexual.

For a number of participants, barriers to access were compounded by issues arising from ethnicity, disability and being HIV+. Access to therapy and counselling services was also considered to be difficult.

• Fears about safety

Physical and sexual assault

Services may be perceived as potentially dangerous and even life-threatening places to be. Whilst physical and sexual assault may arise from homophobia and can affect lesbians, gay men and bisexuals, lack of safety has been identified in other research as an issue which is of great concern to women generally (Findings, Social Care Research, 1994). For those who may be in any doubt that these fears are grounded in reality, first hand accounts of physical and sexual abuse are presented in Section 6, where the issue of safety is further discussed. There can be no doubt however that knowledge or past experience of such events can render services inaccessible.

> *"The thought of an admission ... just appalled her, she just wouldn't do it ... They would have to section her to get her in. I mean I think part of it was this stigma and that was one of the main reasons she didn't want to do it, but if there'd been a women-only, 'depressed-women-ward' she might have. If she thought there'd be a safe place she might have been coaxable in ... But if you get admitted ... as a worried, freaked out, depressive lesbian and you've got all these hulking great schizophrenic men around you - it's fucking terrifying. It's just not a safe space ... I think they need to split up wards certainly according to gender and ... possibly according to condition as well."*
>
> GP, Inner London, Lesbian

Disregarding such fears can turn what might have been a voluntary admission into a 'section', thus compounding the distress of an already vulnerable person as well as diminishing their rights, choices and trust.

> *"In the last hospital I went to, I was resisting going in. I've never gone in willingly, and they were asking me reasons for why I didn't want to go in. There were lots of reasons, but one reason I said to them was I didn't want to be with men ... I mean when I was in hospital women were raped."*
>
> Kari, Lesbian

Clinical treatment

As well as physical and sexual attacks perpetrated by individuals giving rise to many fears about safety, concern was also expressed in terms of clinical treatment.

> *"And she [the GP] said go home, pack a bag of clothes and I'm going to admit you to hospital. But I only had the visions of that information about psychiatric hospitals which I got from the media or through gossip, on the grapevine, that they beat you up and they gave you shock treatments, and they didn't tell me there was talking therapies or anything like that. But anyway after she said that I did pack a bag of clothes, but I didn't go back there. I went on the streets for about 3, 4 days. You know. Really ill and no medication or anything. Because I thought I wouldn't come out alive out of hospital."* Ayo, Gay Man

Historical context

Historically lesbians and gay men have had a very particular relationship with mental health services, and findings suggest that this history underpins some of the fears about safety, as well as those about being stigmatised, negatively judged and pathologised.

Lesbians and gay men have been pathologised by the medical, psychiatric and psychoanalytic professions for many decades. The 'medical model' started with the theories of the sexologists in the late 19th century, for whom sexuality was biologically determined and heterosexuality the norm. Anything 'other' was unnatural, abnormal, and clearly rooted in biological and genetic defects (Stevens and Hall, 1991). An alternative theoretical perspective - based on parent-child relationships and the experiences of the individual during childhood - was developed by psychoanalysts, and whilst Freud himself was not inclined to see it as a disease which could be cured, the idea of individual pathology was taken up and developed by many. A recent study of training institutions for psychoanalysts and therapists to establish whether lesbians and gay men are excluded from training, reveals that openly lesbian and gay people are not accepted to train as therapists or analysts in some British training institutions (Ellis,1994).

Just as both the medical and the psychoanalytic models pathologised homosexuality, both also saw the 'illness' as something which could be treated and cured.

Within the medical model, treatments included (Sayce, 1995):

* neurosurgery e.g. lobotomy
* aversion therapy using mild electric shocks and nausea-inducing drugs
* hormone injections
* ECT - electro convulsive therapy
* behaviour modification therapy.

The aim of each was to help the patient achieve heterosexuality. The idea of treatment is still very much in evidence in psychoanalytic practice (Limentani, 1994). It was noted with concern at a recent conference on Mental Health Issues for Lesbians and Gay Men (Royal Society of Medicine, October, 1997) that the vast majority of consultant psychotherapists within the NHS are trained in psychoanalytic institutions known to be homophobic.

Homosexuality as a mental disorder was not declassified by the WHO until 1992.

Effects

Given this oppressive and damaging history between psychiatry and lesbians and gay men, it is hardly surprising that some prefer to steer clear of mainstream services.

> *"There may be people who don't make contact, who are not using services, because of fear - fear based on psychiatry's history of pathologising homosexuality. So in that sense services are not necessarily accessible."*
>
> Consultant Psychiatrist, Lesbian

> *"I think there's bits of general practice that are still incredibly inaccessible, just because of people's you know, fear of ... being treated, which is often very justifiable. So I think lots of general practices are inaccessible to lesbians and gays still, although I also believe that things have got better ... I do think things are constantly improving. As regards psychiatric services, probably the same is true, in that because of this fear, because of what was happening to lesbians and gays with psychiatric services twenty, thirty years ago, they're still, they're understandably frightened of using mainstream services."*
>
> GP, Inner London, Lesbian

How much or how little attitudes have changed is considered in Section 5. Nevertheless, however much service providers may wish to assert that the kinds of treatment outlined above do not happen nowadays, it needs to be borne in mind that there are many people for whom being diagnosed as a 'homosexual' or 'sexual deviant' and subsequently treated as such, is a very real experience. They have suffered at the hands of psychiatry and will quite possibly have spent years struggling to overcome the effects of that abuse. Understandably they have little or no trust that services are any different nowadays, and the onus is on the providers of services not only to ensure that things *have* changed, but to then get that message across.

> *"We've got one patient who is a lesbian, she actually was a sort of victim of her time in that she's now in her forties and in her teens she was very much totally pathologised by her whole family and by psychiatrists and she never got over the process, thirty years on ... That's really tragic."* GP, Inner London, Lesbian

> *"You learn to build up an expectation of a degree of prejudice, you have to think that could be a possibility. And if there aren't very clear messages saying this is not a homophobic service, I think there are difficulties."*
>
> Child and Adolescent Clinical Psychologist, Lesbian

> *"Lesbian, gay and bisexual service users need to believe they have the right to access mental health services. People are afraid to access services because they expect to come up against judgmental attitudes."*
>
> Multi-Disciplinary Focus Group

- **Fear of being pathologised/negatively judged/stigmatised**

Effects on access

A number of service users and health care workers indicated that fear of being judged, stigmatised or having their sexual orientation pathologised meant that services were either not used or that service users were unable to be out.

> *"Well in the first encounter [with MH professionals] which was when I was a lot younger, I mean obviously I was aware that I was attracted to men but I mean I didn't, it wasn't even an issue at the time. I mean that was a drugs issue. It didn't have anything to do with my sexuality, I mean I didn't disclose that to the doctor, I wouldn't have dared anyway at that time ... I mean sort of you know, I would have been sectioned under the MH act or something ... I was just a lot younger then you know, and I was terrified."* Nick, Gay Man

> *"I wouldn't have felt happy at the hospital, I think they would have ... labelled me. And the first psychiatrist that I saw, when the anxiety attacks started ... I feel they were quite closed off and I actually wasn't out to them. It was only when I went in and saw someone completely different, when I was admitted."*
> Teresa, Lesbian

> *"I didn't come out to my GP, probably because of the worry, and probably with the relationship that I have with my GP. I wouldn't say it was something that I'd want to discuss - my personal stuff. But it would also be like a worry about attitudes and stuff like that ... I was struggling with my own sexuality, they would have seen that like an extra problem or an illness, something else that was wrong with me."* CE, Lesbian

Disclosing sexual orientation

Rabin et al (1986) suggest that service users who do feel able to come out are better satisfied with the treatment received. However a lack of continuity in terms of the mental health professional seen, compounded difficulties for some service users. As observed in Section 2, coming out is an ongoing process and clients and service users belonging to sexual minorities have to consider the pros and cons of coming out in every new encounter. Thus service users may be out in some circumstances - in some services, to some workers and / or users - but not others.

> *"I've always been suspicious of you know, different people's reactions even in health care professionals ... I had so many different people when I was there [MH centre OPD]. I mean we're only talking about a space of about 6-8 months, but they rotate those doctors really quickly ... So I mean you come every few weeks, every 8 weeks or so, and you know very likely there'd be a new face there. I mean I had 3 different doctors when I was there, and you didn't know who you were going to end up with."* Nick, Gay Man

> *"I was still seeing the psychotherapist, I was still seeing the psychiatrists, and the problem with that was that I saw them always at the out-patients clinic, and at the out-patients clinic it was registrars, so every six months they changed. So every 6 months it was the same thing again, going over my history, what it was all about, and I mean sometimes I used to go saying I'm not going to answer any of your questions because it's all there in my notes."*
> Sharon, Lesbian

Fears such as these are also apparent in issues raised about confidentiality, where breaches can come about in a number of ways.

• Worries about confidentiality

Medical records

The writing up of medical records and case notes, and access to that information, were raised as issues by a number of participants, though there were differences in the extent to which people felt they themselves had any control.

> *"With regards to the psychiatrist, I just had a new psychiatrist, so that put me in an awkward situation that I've got to go through this phase again where I've got to go and start telling more and more people that I'm gay. How's it going to look, you know. So the first appointment I just outrightly told her, I said 'Before you do anything, because you won't find this written on any document, it never will be written on any document, but I am gay. And I don't permit you to use the word gay or homosexual in any of my notes.' ... I've said that to my psychiatrist, I've said it to my community support worker, my community psychiatric nurse, my housing association staff, I forbid them to write anything down relating to my sexual life ... They've had to respect it, because I could have them up for breach of confidentiality. Because I've requested them not to put it in writing. I want the knowledge of my gay life to be kept at a minimum, for my own protection."*
>
> Jaymee, Gay Man

> *"I have actually requested what you call, access to my notes, which still hasn't come through. But I am also aware that a lot of stuff about my sexuality has been written up. The reason I know that is various staff members have said, 'Oh, you know, you're gay' and this that and the other thing, if something gay comes up. So you know they know I'm gay."*
>
> Pete, Gay Man

Defining 'confidentiality'

Collaboration in writing up notes was one strategy suggested by participants in thinking about how services for LGBs can be improved (See Section 6). In terms of helping LGB to both access services *and* feel able to come out, clarity about confidentiality was undoubtedly crucial.

> *"I think it's an issue that actually isn't very clear, and it should be much more clear. And I think that there is a lot of gossip that can happen, and you know, you do talk a lot about - social workers do talk a lot about confidentiality, but yeah, what is kept in people's records is very much up to the kind of social worker, making the notes, rather than jointly with the person who is coming to the service ... And just thinking about it, that isn't something that's discussed a lot, when people initially come out, 'Where do you want this information to go, how far do you want it to go?' Yeah, the control over that information is lost often as soon as it's spoken."*
>
> Child and Adolescent Clinical Psychologist, Lesbian

> *"People's sexuality is always asked. As I was saying before, psychiatrists in their assessment procedure, certainly in this part of London, they ask questions on people's psycho-sexual lives. And they talk about what their sexual experiences are. And these are on their medical files, it goes to their GP, it comes to us as*

are. And these are on their medical files, it goes to their GP, it comes to us as well in social services. On you know, discharge summaries. So. And it's not always used ... it's identified, but not addressed."

Terry, MH Social Worker, Gay Man

These points mirror concerns expressed in Golding's study (1997) that some workers were unaware of issues pertaining to confidentiality, particularly regarding what is written up in case notes and medical records.

Information sharing with same-sex partners

Despite work-place cultures where staff and mental health professionals felt at liberty to disclose information about sexual orientation and other 'confidential' issues, there appeared less willingness at times regarding the disclosure of information to same-sex partners, even though service users would have liked them to do so. Again, these kind of worries can affect whether someone uses a service and or chooses to come out in it.

"It totally damaged me, it ripped up my life, because after that one of my line managers rang up for some work to be delegated ... They were informed I'd been sectioned and that I was taken away by the police, so I want to know what happened to confidentiality? I was told it wasn't a member of staff that had told them, but I'm not convinced. So I was encouraged to leave my job ... I was told I was now an insurance risk and because I'd been taken on a 136 I was now a danger to the public ... And the thing that fucked my head in actually was my then partner ... as I said we'd been together 9 years ... she went to see me at [residential service] with a bunch of flowers, the day after I'd been sectioned. And they wouldn't give her any information. They turned her away and I just thought that stinks because she was my next of kin. And she was down as my next of kin."

Julie, Lesbian

"In terms of visiting, psychiatric wards are quite free really. In my experience they have visiting times but by and large they're quite free and accessible places for anybody wanting to visit. But certainly access to records is a complete no-no, consent issues, complete no-no. Because you're only seen as a friend, you're not regarded as a partner ... That would apply to information giving entirely. If the fact that somebody is distressed is automatically being equated with them being a lesbian, then the fact of another lesbian being around in any capacity will be seen as part of the problem. So it's like, we've got her now and we're going to keep her away from you lot. That's how it can work."

Peter, MH Day Centre Manager, Gay Man

The variability of practice with lesbian, gay and bisexual clients is particularly noticeable when considering access to information and issues concerning next-of-kin and nearest relative. Some users felt their requests were honoured whilst the wishes of others were clearly disregarded. Discrimination against same-sex partners is discussed in greater detail in Section 6.

Verbal disclosure of 'confidential' information

Breaches of confidentiality occurred not just through the medium of written materials, but also verbally. Some described how disclosures about sexual orientation or same-sex experiences were passed on to parents or other family members without permission. In some cases this resulted in additional problems.

"And he told my parents, which wasn't a very good idea because they're very, well they were anyway, very anti-gay ... So without my permission, he informed my parents because he thought it was important. And that's the last thing I would have done. Because they reacted very badly really ... They saw it as an illness and part of my illness ... I mean I do think you're supposed to be given confidentiality, but you're not in mental health areas. You're just not. Staff discuss you, they tell your next of kin."
Kari, Lesbian

"I was referred to a psychiatrist in the general hospital ... that was a very negative experience. He got my confidence, got me to talk about things and then told everything to my stepmother. Things ... I thought were confidential. So that was my first encounter."
David, Gay Man

There were further issues about confidentiality raised which were not to do with *disclosure* of sexual orientation, but which show how non-heterosexual orientation may be pathologised.

"And the thing was I'd - in an assessment that I'd had, I'd told all this stuff about how my stepfather had sexually abused me, and they told them, the whole lot. It was like they just didn't believe it. For whatever reason, they just weren't going to accept any of this had happened. And I think a lot of it was to do with that they assumed I would say this because I was a lesbian, but also that I could delude myself that things were really bad because I was a drug user. I mean that was always an issue ...

They told all of that to my family. Because after about 3 or 4 days of my mum coming to visit me, she suddenly came in one day - and she was coming in with my stepfather as well, and I hated this man, you know, I didn't want anything to do with him. And one day she came in on her own and she just said, you don't know what you've done, he's down there crying his eyes out, and how could you say all this stuff. And I was like, what? What are you talking about ?...

And so she just did all this stuff about I had to like not keep on saying this, and to, you know, like change and be different, and if I could do that, if I could stop telling people this was happening, she would accept me back into the family. Even though I was gay. Even though she couldn't, you know, that was a problem for her."
Sharon, Lesbian

Hearing nurses talk openly on the wards about other patients and their issues understandably made service users anxious about the status of their own details as confidential.

"I didn't feel like I could trust anybody while I was there ... the general atmosphere you used to have with nurses, chatting about other patients and making judgements on people and whatever. I could overhear those conversations, just pick up on them."
CE, Lesbian

Child custody issues

Confidentiality around sexual orientation can be an issue of particular concern for those with children.

"But for me there was also the fear of seeing somebody like that because I still had children. So there was wondering and worries about what she was going

to report back to social services about what I'd said to her. She was an analytical therapist so she didn't give any guidance about whether what you disclosed was confidential, and I was far too far gone along the line when I first saw her to ask her all the sorts of questions which I would ask nowadays. So whether or not she was keeping things confidential or whether or not she was writing reports on me were things I feared but I didn't ask her. I suppose I was always aware of the fact that I was part of the system and that she was linked into social services and social services was linked into the child welfare system."
Brenda, Lesbian

HIV status

The issue of confidentiality applies not only to sexual orientation within mental health services, but also to HIV status. Breaches of confidentiality in one area can fuel fears about what else may be disclosed by staff.

"I mean, basically I think I get what I want, what I need, from the system. Where the system has fallen down is where, and this actually came out at a seminar which the [local] Council organised last December where lesbian and gay people in the borough were invited to give their views on the various services. And one of the, well there were two areas in social services which were criticised by lesbian and gay people, and that was, one was availability of social workers to attend mentally ill people in police stations. And the second thing was confidentiality ... because of home care staff who were not sympathetic to gay people, being allocated to do home care for gay people. And so there had been breaches of confidentiality over HIV. Now ... if there's a breach of confidentiality over that, there's probably going to be a breach over mental health problems."
Ron, Gay Man

Investigating the needs of HIV+ gay men, Scott and Woods (1997) found that

"Despite the existence of much experience and excellent guidance some appalling breaches of confidentiality still occur."

The use of MH services by MH workers

A further issue of concern for those working in services was confidentiality around their own mental health problems.

"I had to use services in NE England in the past. This was difficult because it was a small place and I was concerned about confidentiality both as a lesbian and as a mental health worker with mental health problems. Although it's easier in London, confidentiality about these things is still an issue. I worry about bumping into people, and about how I might be judged."
Cathy, Lesbian

• Multi-oppression

Barriers to access went beyond the issue of sexual orientation. There were also concerns about the accessibility of services for lesbians, gay men and bisexuals who were also from other minority groups.

Black or ethnic heritage

> *"Lesbian, gay and bisexual material is needed in a range of languages. Staff need to reflect service users, for example black lesbians. There needs to be an awareness of multi-oppression and discrimination and its effects."*
>
> Multi-Disciplinary Focus Group

> *"I don't think counselling and therapy services are particularly well - I mean this is outside of London, there is more in London - but outside of London there isn't that much for lesbians, gay men, bisexuals, definitely not for black women. So if you come from one or two of those groups, it is quite difficult to access appropriate services."*
>
> MH Project Worker, Lesbian

A policy paper by MIND (1986) draws attention to mental health care for black and minority ethnic people, and it is suggested here that any policy for LGBs should also take account of such recommendations.

Disabled

> *"I refused to see the psychiatrist at [named hospital], because what was happening there was ... there's steps there. The first flight I got up, this is when I was on crutches. But I could not get up the next flight. So there was a little room at the bottom ... but in there, I can't sit on the seats. They're too low for me, I'd never get up off them. So what he used to do was come in there, pull up a chair, (saying) 'of course you can't sit down can you?' And that was me left standing. 'Well I won't keep you standing there, I have to go now. And I'll put you on this and I'll put you on that.' I said to him, 'I don't want to be put on this and I don't want to be put on that. I need help. I need to talk to somebody - And you are my psychiatrist.' Then he'd say he'd have to go because he had somebody else waiting. So this was what was happening ... It's difficult getting to the other LGB user groups. I know of others, but that's too far away for me, I'd never get there. DIAL-A-RIDE only goes around the borough, it doesn't go outside it."*
>
> Jo, Lesbian

HIV+

> *"I was organising care in the community for people with HIV related illnesses, which included people with mental health problems, either related to having HIV, like dementia, or simply because they had mental health problems in addition to HIV, or as a response to HIV ... There was a problem because the mainstream psychiatric services were not that keen really to have them as in-patients."*
>
> Community Care Manager, HIV and AIDS, Lesbian

• Accessing therapy and counselling

The difficulties of accessing psychotherapy and counselling were also raised. Barriers identified included class, cost, and the stigma of being a mental health service user. Where services are accessed, there may be other issues - for example the gender or sexual orientation of the therapist or counsellor. These are considered in section 6.

"The biggest weakness in the NHS services is that there is virtually no access to counselling through the NHS, because the funding isn't there - or this is the reason that's given."
Ron, Gay Man

"I was 10 years in the system before seeing a psychologist - that was my first access to 'talking treatment'."
Kerry, Lesbian

"They say I've got a personality disorder and they agree it's not the sort of thing I need to be locked up in hospital with. And given loads of drugs, which is good of them to admit that. But they said I needed therapy and stuff. Obviously they didn't help me to find therapy right? ... I knew about [therapy centre] and it's quite hard to get therapy there, but because I'm priority, they've got categories like if you're a lesbian, if you're ethnic minority, low income, whatever. Psychiatric patient, you get priority. You get on their waiting list basically. And I still had to wait six months on the waiting list, but it was worth it. Because now I've got a therapist that I see every week, it's very low cost, you can give however much you can afford to pay. And they're really well trained and I think that is helping me ... It's taken me ages to get this therapist. Because for a long time I've been turned away from everywhere I go, because the problem is, if you have a mental health problem and you've been in hospital, you're on medication, hardly anyone will take you on ... Like there's supposed to be services for young people in Camden and in Islington ... My GP told me to go there, because they're supposed to help all young people. I wasn't on medication but as soon as they heard me say I've had mental health problems, I've been in hospital, they were just like, no way. They just wouldn't accept it. And that makes me very angry and stuff. That places won't take you on."
Rachel, Lesbian

• The importance of physical surroundings

The physical environment gives out important messages and services may also feel inaccessible if there is no indication that the environment is intended to help or heal.

"The thing I hated about that place [day hospital] was the terrible, terrible bleakness of the Victorian building and you go in through this long corridor and the waiting room itself was just dire. And the magazines in the waiting room had been around for years. And I felt like I would never get out, you know. Just like everything in there smacked of decay and cobwebs and lack of care really. And I just felt hopeless. I felt well that's it, you know. They've sealed the tomb now. And I was in the mausoleum."
Julie, Lesbian

• Invisibility

The need for positive images

Many of the participants in this study drew attention to the invisibility of lesbians, gay men and bisexuals in services, and explained how this could affect both accessibility and coming out.

"Posters like what we were talking about would go down better in a GPs surgery than it would anywhere else. Because often the first point for people that are psychiatrically ill, unless you are taken acutely ill and you don't know what's going on, is the GP. And I've seen them advertise all kinds of help-lines

in there, and I couldn't seriously see a gay poster not going amiss in a place like that. Because I think it would get the message across. I mean, it shouldn't just be left to solely gay organisations to do all the work. That's like making you a separate community all over again, it's like them and us, them and us, and it goes on. Repetitively." Anne-Marie, Lesbian Orientated

"It felt unsafe or uncomfortable to be out in a range of services - LGB posters and gay positive images would help." Service User Focus Group

"And then I think we ought to make bloody sure that with all our information leaflets and posters and pictures and things that we have in services, that we actually see representations of lesbians and gay men. And it makes a huge difference walking into a place where you see a poster on the wall, a leaflet about some lesbian group or activity. Those kind of things in a very material way communicate that the environment is actually acknowledging, and ready to accept, lesbians and gay men."

Rachel, Consultant Clinical Psychologist, Lesbian

Policies and procedures

The importance of backing up any indication that lesbians, gay men and bisexuals are welcome in services is illustrated by the following comment, and brings us back to the issue of safety.

"I'm not sure about having gay papers and stuff around. If they was on the ward I was on, I don't think I would read it. I think I would be a bit frightened. I might try and read it privately, but I don't think somehow ... I might get a bit frightened ... of other service users ... I wouldn't feel confident that staff would interfere - they wouldn't support me. That's what I believe." Mark, Gay Man

Because of the lack of any official policy across the board regarding lesbian, gay and bisexual clients, any positive changes that are implemented by particular managers or members of staff can come to nothing as soon as that person leaves. Changes in the workforce can lead to changes in the whole culture of the service. Some people felt that a safe or appropriate service was utterly dependent on there being enough non-heterosexual staff members.

"I think that the service that I worked in that was most successful in access for gay and lesbian people was the alcohol unit. But again that was perhaps more to do with the fact that the doctors and some of the nurses were gay men and lesbians. Indeed, I think that's probably what it was."

Peter, MH Nurse, Gay Man

"Unfortunately, the accessibility of too many services is dependent on lesbian, gay and bisexual workers being employed there." Service User Focus Group

"The previous director [of MH day centre] was very supportive around issues to do with lesbians and gays, racism ... I think if you have somebody from the top sending that message down, you're more relaxed about being who you want to be ... Now we've got a new management, it seems completely different ... I find that it does actually make users vulnerable in coming out. Because a lot of the users feel, we're not sure if this is a place that welcomes that or not ... I know for a fact that I work with people who are very, very homophobic ... They used to have a support group for lesbian and gay workers ... Now none of that is

going on. We used to have a group for black workers, and there was also a support group for women workers, there was all these things before, and now we don't have any of that any more. And I actually think that does make a big difference, and you kind of feel quite, well I feel now very isolated. I mean, I also feel quite isolated when my manager says to me, I have a problem with your sexuality." Development Worker, Lesbian

Out staff

Without wishing to put undue pressure on LGB workers within services, many participants felt that having 'out' staff would help reduce invisibility and thus make a difference to the accessibility of a service. Some felt this process had already started.

"Well I think it's changed considerably over the years that I've mentioned and maybe - I don't know how relevant this is, but when I started co-ordinating at [counselling centre] I wanted to find supervisors for the counsellors, and I could actually only find 4 'out' supervisors. And now of course there are lots of 'out' lesbian and gay therapists, so I think that reflects something about accessibility in terms of professionals being able to be more open and more aware." Psychoanalytic Psychotherapist, Lesbian

"I think one of the things that's brought about the change in mental health fields probably ... is the fact that there's a lot of out lesbians and gays working in mental health services ... From consultant psychiatrists to CPNs, the lot, and I think that makes a huge difference because the professions have become more visibly represented by lesbians and gays. Inevitably then - well not inevitably, but hopefully most of the time it's ... inevitable, they're providing a lesbian and gay-friendly service but also their colleagues are learning to normalise ... our sexualities I suppose." GP, Inner London, Lesbian

Requests re workers

This issue is also raised where requests for workers who are of the same gender or sexual orientation are made. Some felt such requests were generally honoured.

"In my experience where a client does make contact and asks to be referred to a lesbian psychiatrist, this happens where possible."
Consultant Psychiatrist, Lesbian

However others experienced barriers to access due to such choices not being made available.

"Like, if I want, if I had to probably see a psychiatrist I'd try and explain that I would like a woman doctor to speak to, because I feel more comfortable. And like sometimes they go, 'well we can't do that, you just like come and see whoever's on duty', or, 'You've got to see a male doctor.' So I tend not to keep them appointments. So I don't go. So ... I'm sort of missing out on my health as well. It's like even with GPs, I mean I got a woman doctor, I'm lucky to find her actually. She understands, so we got a good relationship, so that is quite good. But with psychiatrists and that, ... I mean, they're mostly men. So. I don't hardly go ... I think there should be more like women psychiatrist doctors, and they should understand if someone's a lesbian, they should understand they are lesbian even though they had kids. And they should have more understanding as well. But most of them, they don't." TJ, Lesbian

- **Using inclusive language in interviews, assessments and official documentation**

Using language which does not encompass the experience, reality or circumstances of lesbian, gay and bisexual clients can be an indication to those clients that their sexual orientation is either being ignored or actively disapproved of. Either way, the encounter lacks any opportunity or encouragement for 'coming out'.

> *"The last time I had an interview with a psychiatrist who I didn't know, who needed to know all my personal details, all he asked me was if I was married. He didn't ask anything else you know. So ... Recently, none of it's mentioned. It hasn't been an issue at all - and I don't even know if they know I'm a lesbian. Never been asked."*
> Kari, Lesbian

> *"I think that probably most lesbian and gay clients think very long and hard and try to avoid actually being open about being lesbian or gay. Simply because it's never addressed or made possible."*
> Rachel, Consultant Clinical Psychologist, Lesbian

> *"Often I think the way that we ask questions and the way that we think about things, affects whether or not people would come out ... Things to do with being out, and being out with different people, is such an important part of lesbians and gay men and bisexuals lives, that if the services aren't really open to be able to talk about that, then it's bound to affect the service received."*
> Clinical Psychologist, Adults, Lesbian

Ways in which participants felt these and other issues could be addressed are presented in Section 6, whilst recommendations drawn from the findings are presented at the end of the report.

Summary

Lesbians, gay men and bisexuals may face a number of barriers in accessing or coming out in services. Reasons for this include:

- ◊ Fears about safety.
- ◊ Fears about being pathologised / negatively judged / stigmatised.
- ◊ Worries about confidentiality.
- ◊ Invisibility and lack of acknowledgement of sexual orientations other than heterosexual.
- ◊ Issues of multi-oppression.

The difficulties of accessing and coming out in services have been considered in this section. The following sections present the experiences of those who do come out in terms of treatment, care and diagnosis.

Section 4

Diagnosis, Treatment and Care

How did the lesbians, gay men or bisexuals in this study experience the mental health services they used or were forced to use? This section considers whether:

- ◊ Sexual orientations which are not heterosexual are still being pathologised?
- ◊ LGBs receive particular treatment because of their sexual orientation?
- ◊ The treatment received was satisfactory?

Variability of practice found within and between services

It is important to note that services were found to be variable. Examples of good practice were experienced, though there was more evidence of instances of bad practice. Findings also show that the quality of service received depends to a great extent on the prejudices, ignorance, liberalism or informed practice of individual professionals and staff members.

> *[Talking about the giving of information to same-sex partners:] "And also it depends on the individual staff member ... If you've got a gay or lesbian then that's fine, things are a bit different. But then there's shifts, and people change shifts, and you can have a good response one day and a bad response that evening."*
>
> Terry, MH Social Worker, Gay Man

> *"The problem is that services vary enormously I think, as do the attitudes of the professionals working in those services - the variability of those attitudes is mirrored in the variability of attitudes within society generally."*
>
> Consultant Psychiatrist, Lesbian

4.1 Pathologising the Sexuality of Lesbians, Gay Men and Bisexuals

There were users of services who had been treated for 'homosexuality' in the recent past who are now reluctant to access services, or who do not come out if they do use services. What treatment did a lesbian or gay man receive fifteen or twenty years ago, to result in this kind of relationship?

> *"I stayed there for quite a few months. I was on a section. And I was diagnosed at the time as probably being schizophrenic ... given depot injections and lots and lots of other tablets. I mean the whole range really of psychiatric drugs. I was also treated for my homosexuality which was seen as part of the problem. My doctor saw that as one of my main problems and one of the main causes of my illness ... And they saw sexuality as a big thing. Particularly the psychiatrist who specialised in sexual problems ... in 'sexual deviancy' as he called it.*

My sexuality was seen as something very bad that needed to be changed. So I was treated for it, and it was treatment which all the staff, all the people on the ward, knew about and had to follow. It was a system of reward and punishment with the aim of changing me into a heterosexual. And it made me more determined not to. But I think maybe with some people it would have really damaged them more than it did me. Basically there were some really horrible staff on that ward. There were some nice ones but there was one man in particular who was quite nasty. Who could physically be very rough. And he used to actually tip me out of bed in the morning, tipped the mattress up so I fell on the floor. He hit me once. And he was in charge of the ward.

What I had to do was be very sociable to the male staff ... and I felt frightened by men, I felt angry about men, I felt controlled by men and I actually wanted to have a rest from them for a bit. But in this place I was surrounded by patients and the staff, and the staff would ask me questions all the time about why I didn't like men, didn't I find them attractive, didn't I think it was abnormal? They would be trying to tell me all the time that men were all right, it was me that had got something wrong with me.

And if I didn't respond in a very nice way, like smile back and say good morning to this male nurse and others, I would actually get a punishment. Like I would have to sit in the dining room area all day by myself while all the other patients were in the sitting room, and nobody was allowed to talk to me. Staff and patients. And it was usually a 12 hour do. That sort of thing. Just for not saying good morning. But I was very stubborn at the time, and now I would just do it, because I'd just want to get out. But then I was actually quite - well I was furious and I was sticking to my way basically. And I probably hadn't got the brains to just fake it. Because I would now, I'd just say good morning and smile and get through it. But I was actually quite ill as well, and I was very paranoid, I was frightened that men were going to do things to me. Or I was frightened about my sexuality, that I was going to have some punishment for it really. And I was harassed about it ...

I'd sit and look through a magazine with one of the staff and they would - they didn't do it to anybody else on the ward at all - but they would point out men in it and say 'Isn't he attractive?' And stuff like that. And I'd always say no, whether he was or not. I would say no because I just couldn't bear it. And that usually resulted in me not being able to have a smoke all day - I was a smoker then - so no cigarettes for 12 hours. Or another punishment was, I could have my meals but I couldn't have any tea or coffee or biscuits or anything in between, like everyone else could. And you get very thirsty on psychiatric drugs. And there's always a little place where you can make tea and coffee, and there's nothing else to do, so people do that a lot and I wasn't allowed to do that ...

Or they would take all ways of amusing myself away. Books, cards, anything ... what they wanted me to do was to mix with the male patients. And learn to associate with men. They thought I'd got problems associating with men and wanted me to learn to socialise with them. So they put me with a group of men and encouraged me to chat with them. Men who were out of their heads on drugs or illness ... They weren't easy to socialise with. It was a ward where people were quite ill as well. It wasn't an admission ward. And I was supposed to make friends with these men ... And if they just saw any sign of me not liking men, not talking back or not trying my best to impress them, I'd get a punishment for 12 hours ... But the subjects they might talk about, I felt were degrading to me. You know, they would be talking about a woman they found attractive in very sexual terms, and I would feel uncomfortable. And they would think it was because I was turned on by it.

And the other thing was they wanted me to grow my hair, they wanted me to wear make up. I had one of the female nurses sitting and advising me on all this sort of stuff over and over again. I should wear lipstick, I should dress differently, how could I expect to get on if I dressed like a man myself. I can't remember everything. But basically it was several months of concerted effort of trying to make me socialise, feel attracted to, and do things with men. I mean I wasn't encouraged to talk to any of the other patients. And I was the only one that was singled out for this. Other patients if they'd got other problems, they weren't dealt with like this at all. The women were told not to talk to me for days at a time. And if they did talk to me, then they would get punished.

The female staff ... there was one nice nurse who took pity on me and she'd sneak me a cigarette on the sly now and again. But she still broadly thought that to fit into society ... I really had to learn to become heterosexual or at least act like it.

It was a set course, called behaviour modification ... My actual illness was treated with drugs, but it was seen like this was a separate thing, it was much more important, and that my main problems were that I couldn't get on in society because I didn't fit in. So they were trying to change me into something, that they considered normal. I also think that people who stick out as being a little bit different in hospital ... I don't know if this is true, but I feel they may be more liable to be given ECT. I was given an awful lot of ECT for no apparent reason. It was often used as a punishment. I was told if I didn't do this or that, I would get ECT. It wasn't treatment, it was punishment. And I feel it was used as a punishment on me, rather than treatment, because I didn't fit in, in some way which was usually to do with my sexuality. I think it is possibly used maybe more on homosexuals than other people.

And all it did was just make me extremely angry, and it didn't work. At the end I conformed, I did everything that I was supposed to do, and I actually left hospital very quickly." Kari, Lesbian

"I was fifteen when the psychiatrist diagnosed me as 'deviant'. He assumed I was sexually active and asked me intrusive questions about my sexual behaviour. I felt dirty, I just wanted to die. I was given aversion therapy. I felt I was a horrible, dirty, nasty person." Focus Group Participant, Gay Man

Recent experiences

The accounts above illustrate the types of treatment sexual minorities could expect in the past, yet there were service users and professionals with recent or current experiences of mental health services who clearly felt that sexuality may still be pathologised ...

"There is still a much held belief in mental health services that homosexuality is a mental illness." Service User Focus Group

"We put a lot of questions to him, me and the advocacy person. Why he put in my files '52 year old woman, lonely.' And why he had put down 'personality disorder.' When I had 3 other psychiatrists saying clinical depression. And he would not say. I think it was connected to my sexuality. And that's still on my files and I can't get it off. And I want to try and get that off because I am not a personality disordered woman. I've lived on my own all my life, except for my two girlfriends. They both died. One died tragically - she got murdered. And my second one died of cancer - over two years, slowly." Jo, Lesbian

"I think gay men and lesbians are much more likely to be diagnosed as personality disordered, in my experience. Which again, does have treatment implications ... the sexuality is seen as pathological, absolutely ... certain groups of health workers like psychoanalysts, psychotherapists - are quite clear that homosexuality is a pathological, abnormal state to be in. In special hospitals ... it's totally not talked about, not thought about, always seen as pathological, always seen as directly relating to the offending behaviour ... I think a lot of gay men and lesbians don't come out because of their fear of their sexuality being pathologised, or seen as directly related to the problem they have presented with."

Peter, MH Nurse, Gay Man

... and also treated.

"I think psychiatric nurses and psychiatrists would be very interested to know whether someone is gay, lesbian or bisexual. The word homosexual is a very important label to them I believe, in their notes ... And one of the treatments that I think would be high on the agenda would be treatments that dampen down people's sexuality and sexual drive, and you know sexual feelings. That would be the treatments in my opinion that would be used."

Terry, MH Social Worker, Gay Man

MIND's recent study (Golding, 1997) revealed that 51% of participating LGB service users said their sexual orientation had been inappropriately used by MH workers in order to explain the causes of their mental distress.

Psychoanalysis

Psychoanalysis was also found to have been pathologising, and it would seem that this perspective is still prevalent in some psychoanalytic circles.

"And within some psychotherapy and counselling agencies too there are still a lot of people who would see homosexuality as a symptom of pathology ... Most of the people that are trained at [major psychoanalytic training institution] - their view certainly would be that homosexuality is a pathology."

Psychoanalytic Psychotherapist, Lesbian

Treating aspects of behaviour

Even if sexual orientation per se was not pathologised, aspects of behaviour assumed to relate to that orientation were thought to play a part in diagnosis and treatment.

"By and large even in fairly liberal psychoanalytic institutions, there is a tendency to constantly refer to the homosexuality as an integral problem - the problem is homosexuality, not that homosexuality has caused a series of problems for a particular individual, which may be the case ... In psychiatry, particular modes of behaviour become pathologised. So if you're too camp or too butch, you know. Then that is the problem, that becomes the problem. That's been very common since homosexuality was taken off the list of mental illnesses. So, over-effeminate behaviour, or over butch behaviour from a woman, becomes a pathological problem."

Peter, MH Day Centre Manager, Gay Man

Multi-oppression

Reference was also made to other forms of prejudice and how these interact with each other, as well as homophobia and heterosexism.

> *"I'm not sure what was to do with me, and what was to do with race, and what was to do with sexuality as well ... And I also think - this is linked a bit to the harassment on the ward as well - that in the end, as well as the diagnosis of psychotic depression, I got a diagnosis of personality disorder, and I feel that that was quite linked. I do feel it was quite linked to issues I was bringing up about my sexuality. And people not wanting to hear that."*
>
> MH Project Worker, Lesbian

> *"In terms of psychotherapeutic encounters ... the difference is that their sexuality - or their relationship to sex - is problematised or focused on. And so that constitutes different treatment as far as I'm concerned. But as for psychiatry, well I don't know, I wouldn't have thought just because you're gay ... I mean you might get a few extra injections because you're a troublesome dyke, or you're viewed as a troublesome dyke ... I think a lot of women have to contend with that kind of stereotyping - of what a lesbian is or is going to get up to, in terms of aggressive behaviour. And therefore may be sedated more than they should be, if at all. And that goes on."*
>
> Peter, MH Day Centre Manager, Gay Man

Denial of sexual orientation

> *"Basically they didn't want to know about me being a lesbian. They just said, 'Oh, you don't know ... Because you are depressed you just think you are, you think you're depressed about this but you're depressed about something else.'"*
>
> TJ, Lesbian

Koffman (1997) has also found evidence that non-heterosexual orientations are being denied as well as treated.

Making links between sexual orientation and sexual abuse as a child

Perkins (1995b) urges practitioners to avoid even implicit assumptions that lesbianism is pathological, for example as a result of having been sexually abused as a child. Unfortunately this appears to be a link which is commonly made.

> *"I think one of the main things was the links people, the psychologist made, between the abuse that I'd experienced and ... I just don't know, I just didn't think that was really helpful at all. I think that made me feel worse about my sexuality as well. Rather than addressing the real issues of my sexuality and supporting me with that, it had become sort of more negative."* CE, Lesbian

> *"I have had people in the mental health services challenging the fact that I'm a lesbian ... When I was going to the day hospital a couple of years ago, my primary nurse was convinced that I wasn't a lesbian. She was convinced. Because, there's this weird thing, about if you've been sexually abused by a man like I have - my father ... you were just a lesbian because of that and you're not really a lesbian, you're just doing that because it's safer or whatever. That's what she had decided in her head, and I kept saying 'No, it's not true', and I got so frustrated, I said 'No, it's not because of that. I just am a lesbian.' I was really trying to get through to her and then she decided, there was this*

young doctor there that like, lots of people fancied for some reason. And he was a right idiot and stuff. And she was convinced that I fancied him. She said 'I know you fancy him, I can see it.' And I'm saying 'No I don't.' And she made me so angry because she just wasn't listening to me." Rachel, Lesbian

The minority view

There were some professionals who felt that lesbian, gay or bisexual clients were unlikely to have their sexual orientation pathologised or receive particular treatment because of it.

"It's much less likely to happen than it ever was, I think if somebody's had a ... I don't know, a bereavement or a loss of a partner or something ... there are services that take that perfectly seriously these days."
GP, Inner London, Lesbian

"I've not seen that happening."
Rachel, Consultant Clinical Psychologist, Lesbian

However as an occasional service user herself, Rachel does comment on the way in which some workers will simply ignore sexual orientation as an issue.

"My psychiatrist certainly will not discuss my being a lesbian. She simply says it doesn't matter any more ... I find ignoring to be one of her more interesting strategies." Rachel, Consultant Clinical Psychologist, Lesbian

Getting a good service

One service user experienced what he felt was a good service by being openly gay and pushing for what he wanted.

"Being open about being gay, I've found it's helped me with respect of my helping team. They've been able to help me a bit better ... When I'm in appointments with them, I've been able to talk to them openly about what's going on in my gay life and how I think they can help me. And can they find out about this centre, what information do they have about this, can they find out, so that I get them to do some work for me, which is what they're there for. And in return they equally know that I'll give them some information of centres and things like that, to help other people within the community. Because I'm not the only gay, I mean there's other lesbians, there's other gays in the community that they might be seeing, and they might have a member of staff in there that has a client that's gay. It's important that they have this information to tell people where they can get specific help ... It's only because I've made the services work for me, they wouldn't work if I didn't push. I do push for what I believe I'm entitled to. I'm very genned up on their charters and how you should be treated. And what you're entitled to. Which I often preach!"
Jaymee, Gay Man

Having an active say

However as another service users points out, having an active say in your treatment is not necessarily easily achieved.

"I think because I've learned to talk the language ... I've had a few sort of battles about being on mood stabilisers and things ... I mean it helps to come from a middle-class background. It helps to come from a medical background, which I do, and to be articulate, which not all of us are." Tom, Bisexual Queen

Problems with 'political correctness'

A reluctance to confront pathological behaviour because of misplaced notions of 'political correctness' was also taken to illustrate how homophobia can operate.

> *"I mean the problem is that aspects of behaviour can be pathology ... I had a client who, every time he had an argument with his partner, went out and had unsafe sex with somebody else. Now in a way that behaviour was a pathology - he was acting out his anger with his partner in a very dangerous way to himself ... I mean he was quite suicidal ... But then you see I think what happens with mainstream psychiatrists is that they don't always address the behaviour because they are afraid to pathologise. The psychiatrist said, about this particular man who was going off, 'Well that's what gay men do, isn't it?' I said, 'What do you mean that is what gay men do?' He said, 'Well that's how gay men behave, they're just promiscuous.', and I said 'Not necessarily, but it is not the promiscuity that is the problem, it's being unsafe that is the problem - he can have sex with as many people as he likes, as long as he is careful. The problem is he doesn't want to be careful, he wants to harm himself and this is a way of doing it, but he is not fully aware that he is doing it.' So he wouldn't address that issue with the client because 'that is what gay people do'. He was afraid to say something about that lest it be interpreted as pathologising."*
>
> Counsellor, Gay Man

4.2 Dissatisfaction with Diagnosis, Treatment and Care

Dissatisfaction expressed by LGBs about diagnosis, treatment and care in many ways mirrored the views of service users generally (Rogers, 1993, Read, 1996, Faulkner, MHF, 1997).

• Lack of information

Read (1996) identifies lack of information as a common complaint amongst service users, and this was the case for many of the participants in this study. Problems referred to included:

Lack of information about diagnosis

> *"I never had manic depression explained to me by any of the mental health establishment, in fact I don't believe they ever told me, I just sort of read it on my sick note. So anything I've learned about it, I've learned from my family or from finding out myself ... reading up on the subject. So quite unsupportive."*
>
> Tom, Bisexual Queen

Lack of information about the effects of medication

> *"I mean I was more annoyed really with sort of the way that I was lied to about the drugs I was taking at the time. They made me put on a huge amount of weight. And there's nothing on the packet that tells you about that ... I couldn't understand why after about 3 or 4 months or something of taking this particular anti-depressant - I was ballooning, I was putting on loads of weight ... I've never weighed that much in my life. And of course having put on two stone, it made me feel even more depressed."* Nick, Gay Man

A study by Rogers (1993) found that 68% of those prescribed major tranquillisers had not been informed about the expected effects.

The research by PACE also revealed instances of people suffering from the effects of drugs which should not have been prescribed simultaneously.

> *"Basically the two drugs should never be in those doses mixed together. And I found out a whole load of stuff about how the phenolzene causes depression, causes weight gain, all these things that I was having problems with. And causes insomnia, and I was just thinking what is going on? ... I decided that I didn't want to go to the hospital to have my care, I wanted my GP to do it. And that if I needed any kind of other help, that she would arrange it."*
>
> Sharon, Lesbian

• The use of physical treatments

Medication

Ways in which medication is used also came in for criticism, as some felt that prolonged treatment could be disabling rather than empowering or healing, particularly where no attention is paid to what is causing the distress.

> *"They kept giving me injections because they didn't know what else to do. They gave me Valium ... and intravenous and stuff, inter-muscular injections, and in the end I thought God, I've just got to shut up basically. And from then I, because I used to show feelings outwardly and stuff by sort of screaming and shouting, instead of that I started turning everything in. And when I managed to get out of that admission, I was only in for about 5 weeks, when I got out my self harm got very bad. And then they took me in again ... I just have no trust for anybody. I've been on medication, I've been on anti-psychotic drugs and mood stabilisers, and I'm not psychotic, and I'm not manic depressive. I just think they want to shut me up basically ... Medication can be useful, but you know, I don't think it's the be all and end all. Even if you've got schizophrenia I don't think that medication is the only way of treating it. There is other things that can be done but people aren't getting that kind of ... it's easier, it's cheaper isn't it, just to say here's a pill that'll make you feel better ... Even me, they know that medication can't cure me, but the reason they put me on anti-psychotic drugs is because it's a tranquilliser so it makes me calmer and quieter. So hopefully I'll sleep the whole day long and all night, and then I won't bother anybody."* Rachel, Lesbian

Over-dependence of MH workers on the use of medication

Although some viewed medication as being useful at times, there was nevertheless a feeling that too much dependence was placed on medication by MH workers. Opportunities for talking, counselling and therapy were valued by many.

> *"There is a lack of alternatives to medical treatment ... service users may only be offered medication - there is too much dependence on this. Self help groups are needed, as are staff who are aware of the issues."*
>
> Multi-Disciplinary Focus Group

> *"First time round the treatment mainly consisted of drugs from the GP, then hospitalisation, then more drugs - largactil, triptisol, valium. Drugs and having my sexuality questioned - that's not what I want, that is not mental health care. Just that thing about being drugged up, that whole thing about being on drugs, you can't really coherently put forward anything you feel or think ... When you are on drugs your feelings cease to matter ... The second time I was referred to an NHS psychotherapist ... Months and months of talking therapy just made such a difference to my life. It explained all the stuff that went on before, why it went on, what was wrong. She helped make sense of many things ... though she did fall down when it came to sexuality ... Now when I need care, I find myself a therapist who I can work with, and keep well away from the system. I find not only a lesbian therapist, but a lesbian therapist I can talk about certain issues with."*
>
> Brenda, Lesbian

Treatment as punishment rather than healing

> *"I have been put on a section when I've been doing me housework ... I've gone off as calm as everything, and calm in the hospital not kicking off or anything like that. And yet they still send me to a Medium Secure Unit. It has taken 10 years for them to realise that I need a psychologist. I mean, the way the system has treated me has been absolutely appalling. I went in seclusion for no apparent reason. Because I shouted, I got injected. When I absconded from (residential unit) the police took me back, I was handcuffed, me feet were cuffed, I was dragged in, I was banged into seclusion then the door was locked. Then they unlocked the door, then they injected me, and I was just left cuffed up like that. So basically I've had a right, right, rough deal of the system ... I think it's made me worse. I think it's made me hate the system, begrudge the system ... It's like you're in a Medium Secure Unit, you're locked up yeah. And you feel that you're locked up because of what's happened to you, and you feel that you're being punished because all of what's happened to you, it's your fault ... And I'm not the only one in them places (who is a victim of paedophilia) who feels like that."*
>
> Kerry, Lesbian

ECT (Electro-convulsive therapy)

ECT is a treatment used in mental health services which has caused a considerable amount of debate and controversy. Whilst there are service users who defend its use (Perkins, 1996) there are also many who would like to see it banned. Most would agree however that there needs to be better control over its use and the way in which consent to treatment is obtained (OU, Module 4, 1997).

> *"I would never go back inside. I would do anything to avoid going back into a hospital ... I felt they were not helpful at all ... I was given ECT - memory loss, I couldn't process information ... Even now I feel my mental processes have slowed down, my memory function isn't what it was, what it could be. And it went bad in another way as well. They give a combination of sedative and*

muscle relaxant - I was awake within half a minute of administering it. And I was paralysed. And I couldn't - I was there with my eyes closed, I couldn't breathe, I couldn't move, couldn't open my eyes, couldn't let them know. I could hear them treating the patient ahead of me, I knew everything that was going on and I was absolutely terrified ... And when I told the doctor he wouldn't believe me, but it happened again the second time, then the third time ... The fourth time I just walked away on the morning of the treatment and I just went for a walk in the grounds. But they wouldn't listen ... I don't think I get any help at all from psychiatrists. So I'm really anti the profession. I've quite strong views about it, maybe unreasonable, I'm sure there are some good ones around ... But generally I don't have any respect for the profession. So I wouldn't go back. I'd die rather than go back in." David, Gay Man

The way ECT is administered does not necessarily adhere to required standards of practice. A recent survey by the Royal College of Psychiatrists (Pippard, 1992), looked at the ways ECT is used, and revealed considerable differences between hospitals in two NHS regions. As well as a wide variation in frequency of use, there were also differences in what was thought to be effective ECT, and between routine instrument settings. Where older models of apparatus were in use, 'missed' fits and under-treatment were frequent.

• Feelings about diagnoses

How a diagnosis is made

A number of participants were unhappy with the way in which diagnoses are made.

"I mean it only takes one prejudiced person in a mental health team I think to swing somebody's treatment. It only takes one person to label them as sort of dysfunctional or whatever they label them as. And I think where the service user loses out is probably not enough attention is paid to some of the root causes of their difficulty." GP Counsellor/ Psychotherapist, Lesbian

Schizophrenia

Schizophrenia gave rise for concern in a number of ways: over-diagnosis amongst black people, and a lack of clarity about the criteria for diagnosis, were amongst concerns expressed.

"The diagnosis of schizophrenia? No I don't like it. Because the way I identify is as a black gay man. As a black person, which is part of my identity, I feel that too many black people have been diagnosed as schizophrenic. And I would want another assessment, a proper assessment, not a rushed assessment like the psychiatrists go through now. I want to be assessed properly. And have a second opinion. I would ideally like that. But on the other hand I can't be bothered, because I just live my life ... I don't live the diagnosis. I use the services when I need them, or the services that I've agreed to use."

Ayo, Gay Man

"And then it was a few days after that [slashed his wrists] I went back to the health centre and saw these two psychiatrists who were Asian guys in maybe their fifties ... I didn't realise if you're meant to hear voices you'll actually hear it like a radio, well that's what somebody said, I didn't realise it was like that. I thought it was kind of to do with an internal struggle of voices. And it wasn't

until years later somebody said 'No, they actually report it to be like the television or the radio.' I thought, no-one told me that. So these guys were saying 'Do you hear voices?' and I said, 'Yes.' Thinking they meant this kind of internal thing ... They said 'Why did you cut your wrists?', and I said - 'Well I don't know, I suppose part of me wanted to and part of me didn't.' So then they said 'Well you're obviously schizophrenic', and this didn't kind of worry me because I thought they must know. Now I'd be really worried, but then I didn't understand all the implications of what I was involved in ... So then they said 'Well you have to have depot and this will stop the voices.' Which of course I didn't have. And they gave it to me then and there - they got the injection out - dropped me trousers, bent over, had it in the arse ... I think it's outrageous. And completely unfounded and just negligent, completely negligent ... But again, you know, Afro-Caribbean men and schizophrenia, there's a huge belief that they're inextricably linked somehow. And lots of men of colour you know, African Caribbean type men ... do get diagnosed ... And that, with homophobia ... I think in the mental health system that sort of comes into play. Because you're on this list of schizophrenic violent people because you're a mixed race man, obviously you're in that category. And then you say you're in the category of handbag, effeminate, you know, wanting to be a woman, make-up, and they're like, it doesn't blend in their mind that there's a mixed race athletic man who is bisexual ... and that spends a lot of time being out and gay as well."

Stephen, Bisexual Man

Findings from other studies do suggest that African-Caribbean and African people are given particular diagnoses, particularly schizophrenia, more often than whites (OU, Module 2, 1997).

Treating schizophrenia

Where a diagnosis of schizophrenia has been accepted, nevertheless there may be dissatisfaction with the way in which it is treated.

"Before last year I'd never taken any psychotic medication, I'd always refused it, because even though my episodes had been disturbing they were always kind of like interesting. It was very sort of like, well this is really trippy and so was a bit freaky but wasn't that scary ... But then last year got much, much more frightening ... I'm much more inclined to go along with like the Laingian, mystical, oh this is a journey into the self and you know, you're finding out that this is a useful process ... But last summer it just felt, no, this is scary, I'm not learning anything ... So then I took anti-psychotics. And I'd always assumed that it would be like being wrapped up in cotton wool and you wouldn't be able to function but I found them really useful - completely. They just nipped out the part that was scaring me and I could think clearly again and felt very lucid - and so I think the medication can be useful at times, although the psychiatrist that I see now is always pushing me to be on medication all the time, which seems unnecessary. But even though the medication can be useful, I don't like all the baggage that goes with it. I'm very interested in the content of what my hallucinations are and is this telling me anything about myself ... and psychiatry's just not remotely interested in that. It's just a bit too important to me to allow it to be ... somehow so trivialised or just removed quite as easily as that, although at times that's very much what I want. Does that make sense?"

Russell, Gay Man

In 'Schizophrenia Re-evaluated' Boyle (1996) considers why little attention is paid to the content of 'hallucinations' and 'delusions'. Within the medical model 'content' tends to be viewed as "symptoms which the person suffers from, rather than

meaningful experiences which they might, at least in part, actively construct." A further suggestion is that for psychiatrists to pay attention to content would indicate the policing of belief systems. Disregarding these beliefs has been challenged in recent years, particularly in regard to people from minority ethnic groups. Littlewood and Lipsedge (1989) have written about the relationship between the personal and the cultural and how that can be understood historically: "with a sympathetic knowledge of another's culture and their personal experience it is possible to understand much of what otherwise appears an inexplicable irrationality". It could also be suggested that 'sympathetic knowledge' would go a long way in helping MH professionals understand lesbians, gay men and bisexuals.

Labelling

Some felt that workers within MH services tend to relate to 'labels' rather than individuals, and may hold judgmental attitudes towards that label.

> *"Mainstream services are dismissive in attitude towards the person, the individual. You are not related to as a person but as a label - the schizophrenic, the psychotic. All individuality is taken away."*
>
> Service User Focus Group

> *"My experience in hospital - I don't know what words to use. But I didn't feel I was getting supported. I didn't feel like there was support or care or anything like that. I felt it was mostly quite negative and people didn't treat you as a person I suppose. You were a patient on a psychiatric ward and there was a stigma attached to it and stuff ... Yes, and sort of ... comments about what are you doing starving yourself when there's people starving across the world and stuff like that (CE was suffering from an eating disorder). Which I was like probably feeling guilty about anyway. But it was intensified, like self-hatred I suppose at that time. I felt angry about attitudes and probably watching the way other people were treated as well. Because a lot of people weren't well at the time and probably being sectioned and stuff, and just the way people were treated in general."*
>
> CE, Lesbian

Dementia

There was also some indication that misdiagnosis of dementia can occur in people with HIV and AIDS:

> *"Like one chap I remember went completely manic and was going round buying businesses in [town] and hadn't got any money and I mean, they said it was dementia, but it wasn't dementia because it actually went away again and dementia doesn't go away again. And apparently he had had breakdowns like that in the past ... The problem was that the psychiatrist kept saying he had dementia. That was the problem, everything gets lumped under dementia once you've got HIV, if people are not careful."*
>
> Community Care Manager, HIV/AIDS, Lesbian

Summary

- ◊ Diagnosis, treatment and care of LGBs is variable and depends on the prejudices, ignorance, liberalism or informed practice of individual workers.
- ◊ Some workers still pathologise, ignore or deny non-heterosexual orientation. Such perspectives can affect diagnosis and treatment.
- ◊ Some of the dissatisfaction with diagnosis and treatment mirrored that expressed elsewhere by service users generally:
  - * lack of information on diagnosis and medication
  - * too much dependence on medication - more 'talking treatments' needed
  - * sense that MH care is punishing and disabling, rather than healing and empowering
  - * lack of respect for individuals - service users treated as labels.

We have looked at the issues raised by LGBs in relation to diagnosis and treatment, and seen how attitudes held by health care workers can affect the care received. The next section examines some of these attitudes in greater detail and shows the range of ways in which the heterosexism and homophobia of both workers and other service users can affect how LGBs experience a service. The section also considers the attitudes held by health care workers and the LGB communities towards people with mental health difficulties.

Section 5

Thinking About Attitudes

Findings from this research show that the attitudes towards us of those we turn to for help and support can affect not only how we experience services, but also how we feel about ourselves - both as members of sexual minority groups and as users of mental health services. The attitudes of other service users also affect how we experience the service environment, whilst our relationships with other lesbians, gay men and bisexuals can be affected by the attitudes they hold towards people with mental health difficulties. This section looks at each of these sets of relationships in turn.

5.1 Attitudes Held By Mental Health Workers Towards Lesbians, Gay Men and Bisexuals

Perhaps the most blatant evidence of the existence of homophobia, biphobia and heterosexism in mental health services can be found in the attitudes experienced first-hand by lesbian, gay and bisexual service users. Few mental health workers have been trained to overcome the anti-gay attitudes which they share with the mainstream culture (Sayce, 1995), and indeed there are staff working in services who have actually been trained to think of homosexuality as a mental illness (Willmot, 1997). Studies carried out to ascertain the beliefs and attitudes held by doctors towards sexual minority groups showed that :

- ◊ Ten per cent of GPs think gay patients should be returned to normality by therapy and two thirds feel uncomfortable having gay men as patients (Bhugra, 1988).
- ◊ Doctors are influenced by the values of their culture and in many instances are blatantly homophobic (Rose, L., 1994)

Findings from a study of nurses' attitudes in the UK and USA (Taylor and Robertson 1994) showed that:

- ◊ Forty per cent would not condone homosexuality.
- ◊ A minority claim the right not to treat gay patients.
- ◊ Some see AIDS as a divine punishment.

Such attitudes prevail despite a statement from the Royal College of Nursing (RCN, 1994) which draws attention to the fact that lesbians and gay men have specific health care needs and concerns. Suggested ways in which nurses can address these include:

- ◊ Nurses in clinical practice examining their own attitudes and exploring all possible ways of assisting lesbians and gay men using the service.
- ◊ Nurses undertaking research to develop studies of lesbian and gay health care experiences and establish how nurses can best meet their needs.
- ◊ Nurses in education designing training strategies which recognise the need to be better informed.
- ◊ Nurses in management to ensure equal opportunities are adequately addressed.
- ◊ All nurses to challenge homophobia and prejudice in the workplace.

Discriminatory attitudes and practices against lesbians and gay men are also found in mental health training institutions. For example Ellis (1994) found that openly lesbian and gay people are not accepted to train as therapists or analysts in some British training institutions for psychoanalysts and therapists.

These negative attitudes and practices have a direct impact on how lesbians, gay men and bisexuals experience mental health services. Golding (1997) revealed that 73% of service users participating in her study (N=55) experienced some form of prejudice or discrimination in connection with their sexual orientation within mainstream mental health services.

PACE research

Findings from our study reveal that attitudes towards, and strategies for dealing with, lesbianism, homosexuality and bisexuality, reflect the range of ways in which homophobia, biphobia and heterosexism operate. Participants experienced:

- * physical abuse
- * verbal abuse and ridicule
- * ignorance and lack of awareness
- * stereotyping
- * voyeurism and inappropriate questioning
- * being silenced
- * judgmental attitudes

as well as having their sexual orientation pathologised, denied, discouraged, devalued and ignored, and their relationships trivialised.

Such negative experiences were more commonplace than positive. Nevertheless some people felt they did receive appropriate responses as part of their experience within MH services.

• Positive experiences

Sexual orientation recognised and accepted

> *"So. I told the psychiatric social worker, obviously I was crying, it was a massive thing for me to tell her. And she was just so nice about it. Just didn't ... it was important, very important, but she said there's nothing wrong with it whatsoever - she was completely good about it."* Justine, Lesbian

Being given appropriate help and information

> *"They knew I was gay and I mentioned it a couple of times to nurses and one nurse said 'Why don't you go and get counselling, why don't you go out?' and he was trying to like give me advice, and saying I need to go out and get counselling, accept being gay - and he was trying to help me ... The ward manager was quite openly gay and people didn't mind ... And even my CPN knows I'm gay and I have talked to him about my sexuality and he actually tried to arrange for me to get counselling - which I did last year ... when I was trying to come to terms with my sexuality."* Mark, Gay Man

Relationships / friendships respected

> *"We went for counselling to [marriage guidance organisation] and they told us we would get a psycho-sexual counsellor, not because there was a problem about our sexuality but because that person is more likely to have more training, so is more likely to deal with lesbian and gay issues and that would be fair to us ... She's been okay ... When we talk about relationship problems, she talks about relationships and partnerships and people with children, not men and women with children, not men and women in relationships ... I am quite pleased with how our sexuality's dealt with."* Teresa, Lesbian

Information being passed on to friends / partners as requested

> *"There was one occasion when I thought there was an example of something good being done ... I have two very close friends who live in [place] and my sister telephoned them, and told them that I'd been sectioned. And one of them was very upset and started ringing the hospital and saying 'What's going on, what are you doing?', and at first he wasn't getting any answers. But when I got better - compos mentis, that's the only phrase I can think of, when I was compos mentis enough to actually speak up for myself, I had to sign consent for them to give information to him. I couldn't really describe it myself, because my memory for about a month in 94 is gone blank. I can't remember anything about it. So I asked the nurses to tell him. I said 'He's a gay friend of mine, I'm a gay man.' I explained it to my key nurse. And I said, 'I'd like him to receive information about my treatment'."* Ayo, Gay Man

• Experiencing both positive and negative attitudes

It is also possible for people to experience positive and negative attitudes simultaneously within the same service.

> *"A nurse befriended me in the hospital ... and she was actually very kind to me. All the other staff were actually pretty horrible, they were quite cruel. She told me she was lesbian ... And she was the first woman that I'd ever known who definitely was lesbian. And she was absolutely brilliant ... She was telling me all these good things about being lesbian and not to be ashamed and not to be worried ... So I actually talked about it. Which I'd never done before because in fact when I was 17 or 18 ... my idea of what lesbians were like was pretty awful, so I didn't reckon I could be one. I just knew I wasn't heterosexual. But my friendship with this nurse was noticed by other nurses and the doctors and really looked down upon. And I did talk about her. I told*

people that she was lesbian, I told my parents to show them that proper people with proper jobs and everything could be lesbian. But that was a big mistake because she was actually - I don't know if she was either sacked or just moved to another place. But I never saw her again. She was seen to be a bad influence. But she was the only person who was kind and I don't know what would have happened if I hadn't met her."
Kari, Lesbian

• Observations and experiences of mental health workers

In terms of working in services, LGB workers are in a more powerful position than users of services so their observations in this context differed to some extent to the attitudes experienced by service users.

"I am out at a professional level, my colleagues would all know that I am a lesbian. In this particular institution it is very easy to be out as a lesbian or gay man. But then this place has a reputation for being a friendly place for lesbians and gay men to work. It's one of the few places that I guess has lesbians and gay men on the board ... I don't think it's actually affected my career in any way, but then I haven't been in a position yet of being in a marginal position where those kind of issues may be more noticeable."
Rachel, Consultant Clinical Psychologist, Lesbian

Nevertheless, the experiences of some workers did confirm that attitudes of a heterosexist, homophobic and biphobic nature exist and can affect the quality of services received. More optimism was expressed however that attitudes are gradually changing, though such changes tended to be expressed in terms of it being easier to be out to colleagues. Being out to service users appeared to be more complex.

"The level of professional awareness is variable. In my own field I am also responsible for training doctors, so I do raise questions which would address lesbian and gay issues and would challenge homophobia and attitudes which pathologise. There's a need to do this not just for clients but for young doctors, so that they as gay people can also feel comfortable. I do feel there are MH professionals who have a very good awareness and understanding of multi-oppression, but the opposite is also true. It's the same for staff attitudes ... For a long period I felt very comfortable being out - I wore a labyris to work so that I could be identified by patients and staff who recognised it - but round the time of Clause 28 I felt less confident and actually became quite nervous. That feeling has changed again ... of course there is still a long way to go but you know, I was recently asked to review an American book about lesbian and gay mental health issues for the British Journal of Psychiatry. Now 5 years ago that would not have happened."
Consultant Psychiatrist, Lesbian

"I'm out to fellow professionals as much as possible and I'm in the closet to my patients. Unless they're obviously lesbian or gay ... part of that is to do with pure physical protection and ... part of it is some belief that even if I was heterosexual I don't think GPs should be parading their nuclear families and pictures of themselves looking happy with their partners all over the walls, which they do."
GP, Inner London, Lesbian

- **Safety**

The physical safety of those using services is a fundamental issue and is dealt with in greater detail in Section 6. As described here however, lesbian, gay and bisexual service users may be in danger not only from other service users (see Section 5.2) but also from staff.

> *"When I was in the hospital and when I was in the crisis centre, attitudes towards my sexuality caused me a lot of problems ... In hospital the male staff used to 'pop in' to the room when I was being visited by my partner - it felt totally voyeuristic ... I also got beaten up at one point by male staff and I do believe it was about anti-lesbianism."* Tina, Lesbian

- **Homophobic abuse**

Homophobic abuse, whether directed at oneself or at someone else, can be extremely upsetting for service users. It can also affect whether someone decides to come out and - if they have a choice - to what extent they continue to use that service.

> *"I went on to another ward, an acute ward, and I didn't come out at all there. We had a male nurse there that was reported to be gay, and everyone just took the piss out of him ... The staff were worst, particularly the male nurses on the ward: 'So-and-so, he's a real faggot, look at him, the way he acts, the way he walks' and everything like that. And someone even shouted out 'cock-sucker' after him once, it was really revolting. I don't know if it was why he left, but he did leave. Not long after."* Anne-Marie, Lesbian Orientated

> *"I think it hasn't really begun, the support that's necessary. There's this user-led day centre. And the experience of this one lesbian woman and this one gay man I key work for is very negative. They do use the service, they do attend, I think some good things have been done for them, with them, by them as well, but when it hurts them, it really does. And it's more than remarks, or notions, it's actually, you know, words like 'abomination'. "*
> Peter, Community Support Worker, Gay Man

Ridicule

Homophobic abuse was also experienced by participants in the form of ridicule or anti-gay jokes.

> *"I was working in a halfway house for MH service users ... but I couldn't come out because I overheard conversations ... then the staff meetings - the jokes about poofs, and all the jokes were homophobic type jokes. Also one of the workers, he was very, very anti-homosexuality. And I used to want to bring the subject up because I knew that if people living in this place were homosexual, who on earth could they talk to? Would they try and convert them, or would they see it as an illness. I actually was very upset by the attitudes of the staff. I never did come out though, I think it's wise that I didn't ... the atmosphere was so oppressive, it was obvious that if any one of those people had been gay they'd keep it to themselves, because you heard - if people made really bad comments about gays - the staff laugh. They didn't say you shouldn't say that or anything. The staff were as bad. "* Kari, Lesbian

• Ignorance and lack of awareness

Effect on quality of service

There may be workers who do not hold attitudes which are blatantly homophobic, but ignorance and lack of awareness arising out of heterosexism also affect the help and support someone receives.

> *"On a scale of 1 to 10 I'd say the level of professional awareness is 2 ... there's complete ignorance about the needs ... I mean one or two individuals may know of lesbian and gay services and point them in that direction, but in a hospital, at a ward based level, there's no knowledge of anything."*
>
> Peter, MH Day Centre Manager, Gay Man

Effect on service users

Even where a service user has felt able to come out, inability on the part of health care workers to meet their specific health, information and / or support needs can compound the sense of isolation and loneliness they may be feeling.

> *"It's just they are so unaware in [the day] hospital of basic issues ... and they look so surprised. When you turn round and tell them things like, for example, I'm gay. It's not on the agenda, it's just not something they have thought of ... you are just met with stunned looks. What do we do with this person? Perhaps it's just that particular hospital, but they have just not got a clue around other issues, around gender, sexuality, ethnicity, anything. It is absolutely a disgrace. I mean, this is supposed to be a place for people - well people are often troubled about things that are deep to them. For example, sexuality. And there is no outlet for that at all. I mean my psychiatrist didn't respond at all. She just looked at me, wrote it down on my file, ended the meeting and that was that ... It would be inappropriate for me to bring it up because she never asks questions around it ... I could just happily turn round and scream sometimes. There is no account made for anybody that - I was going to say 'differs from the norm' but then I don't see why you should say that gay differs from the norm anyway - it's as valid as being straight. But it's not - it's like being isolated even more. Because bearing in mind I've explained what my home life is like and everything like that - on top of that I'm supposed to go to a place 5 days a week for help - and you just don't get any."*
>
> Anne-Marie, Lesbian Orientated

Golding (1977) found that of those service users taking part in her study who wanted information about LGB organisations and / or support services, 70% did not receive any.

• Stereotyping

Stereotypical attitudes arose for participants in the PACE study in a number of ways, and confirm Koffman's point (1977) that ignorance and lack of awareness not only leave needs unmet, but help to uphold myths about lesbian, gay and bisexual people. Stereotyping experienced by participants in our study included:

The political, man-hating, butch or femme lesbian

"And she [psychiatrist at out-patients] got kind of really patronising to the point of you know, 'Aren't you being really kind of too political about being gay?', and actually I wasn't political at all. I was just stating the fact that I was a lesbian. And that's who I was at that time ... They were saying that I must hate men because of what had been happening. But I wasn't saying that at all. I was just like, 'No, actually I don't hate men, and I have very good relationships with men, straight or gay - relationships are based on who the people are, underneath what their sexuality is, not what they are to begin with.' But they couldn't see that. They thought that I was just deluding them and deluding myself and actually I was a separatist and you know, they did see it all in a very butch/femme way. And I was like, you're imposing things on me that I don't actually believe in."
Sharon, Lesbian

The belief that lesbians do not have children

"One of the psychiatrist consultants on the ward said to me, 'Do you not think that your parents want to be grandparents and how are you ever going to enable them to be that if you're totally rejecting the fact of being a real woman.' And I said 'I can have children if I want children, what are you talking about? Because I've said I'm a lesbian doesn't mean that my genetic make-up has changed.' And I remember this doctor telling me that I was being sarcastic, and I said 'No I'm not, I'm just being completely truthful that I can have children if that's what I choose to do.' But it was this idea that I couldn't be a real woman unless I did want to have a child - and wanting to have a child would mean I shouldn't be a lesbian."
Sharon, Lesbian

"Then he assessed me, which was the only thing that stuck in my mind as being really interesting. He assessed me and said, 'How would you describe your sexuality?' and I said, 'A lesbian', and he said, 'Oh really? When was your last sexual experience with a man?' And I said, 'Six years ago I suppose', because my child was five. So he said, 'Oh right, so you're bisexual.' So I said, 'So how do you figure that one then?' So he said, 'Well you are.' I said 'No! - I'm not actually.' And I remember I was lying on the bed and he was sitting next to me and I turned round and I sat up and said, 'No, look, I'm telling you, I'm a lesbian and don't try and confuse me, because if I felt like I was a bisexual I would be able to tell you.' And then he sort of laughed it off a bit."
Teresa, Lesbian

The belief that lesbians are not at risk from HIV infection

"I think also social workers they don't understand if you're lesbian and how come you're HIV positive, so they need to be learned about that as well. Which is sort of hard sitting down telling them that you got this problem, and then they shout out and say 'How come you've got that, because you've been a lesbian for the last five or six years?' They don't understand that either. So it's like ... I don't know. I just feel like standing up and telling them they fucking know nothing and just walk out. But I can't do that because I got to sit down and got to talk about the kids and that as well."
TJ, Lesbian

The belief that all gay men are HIV+

"Being out as a gay man has been an extremely varied experience. But I kind of decided at the start of my training that I would be. At all times. My first experience of that was when I was training in Leicester and I went into work with a cold and the ward sister said to me, 'we don't want HIV, you'd better get out of the office if you're going to be sneezing.' Which kind of set the tone really."
Peter, MH Nurse, Gay Man

The idea that there is a link between sexual orientation and having been sexually abused as a child

"The psychologist made a very big fuss and very big thing about saying that I was an abused patient - someone who's got mixed up because I was abused as a young child. Which was ridiculous because everything that I can remember, even as a young boy, I've always felt gay and that was the only way to be. I mean heterosexuality just did not appeal to me."
Pete, Gay Man

Gender and cultural stereotypes

"I have known in mental hospitals, particularly in special hospitals which I'm also connected with ... there are things that one's had to fight all the time. I think some of them are improving ... it's said that women patients, they don't take any interest in their appearance because they don't use make-up or they don't want fancy hair-dos or they don't want feminine clothes or things like this. And a lot of the so-called rehab work is sort of getting make-up people in - they think this is nice. Or trying to get them frilly clothes, or the sort of hairdresser that only does sort of Margaret Thatcher hair-dos, you know. And doesn't do a shaved head or something like this, which is what they might want. I've had somebody coming out ... who was a cross dresser. Now that ward had men in it, who looked as if they'd slept in their suits, who had egg all down their ties, who looked really scruffy like this. Now to me she was extremely smart in the fact that she always had beautiful white shirts and nice ties and pressed suits and things like this on. But she was said to take no interest in her appearance."
Jay, Lesbian

"I think even in terms of sexuality - it was like I was an Asian looking woman on a ward with really long black hair and for a start to be assertive seemed to be quite shocking to people. To be talking about sexuality definitely seemed to be really quite unusual. I was just perceived as really quite strange I think, and I think in some ways I was, because I was losing it a bit. But then a lot of it was - like assertion wasn't seen as culturally appropriate for me."
MH Project Worker, Lesbian

"She (the psychologist) brought her preconceived prejudices and ideas about what an Asian is. About the ideas of arranged marriages, she was talking about did my parents pressurise me into an arranged marriage ... none of that has happened in my family ... I mean it was something that she had brought from the media - it wasn't me she was talking about ... It was a long fight for me to establish that in her mind. That she has to deal with me as an individual."
Pete, Gay Man

- **Voyeurism and inappropriate questioning**

Pressure to conform to received ideas about what is appropriate in terms of gender, culture and sexuality also played a part in service users feeling subjected to inappropriate questioning about their lifestyles.

> *"There's a lot of like innuendo on the wards ... Staff - I'm sure they speak this way to everybody - but it just seemed a bit, I wasn't being paranoid or anything, I just found their questions quite offensive and very inappropriate. I mean, I could laugh and joke with the best of them, but I think there are certain things, things like, 'What will you be doing tonight?', - heavy innuendo - and 'What clubs do you go to?', and 'You should look this way, and I'd rather you didn't look that way' or, 'You look very obvious' and things like that. It was just so uncalled for."* Anne-Marie, Lesbian Orientated

> *"Unfortunately for me my consultant has changed, he's of Asian origin, and also the psychologist, who's a resident doctor at the day centre, he's also Asian. And first he started saying do I attend temples, do I pray, and all that rubbish about religion and so on. And I'm not religious at the best of times. So he was trying to hammer that into me, you know, about coming from a good Asian family you must go to the temple on a regular basis, and all that. And you know, what would your mother think, that you're gay and all that. Which was none of his business. And the same thing, my first CPA with the new Asian consultant, the first thing he started saying, 'Oh well, your major problem stems from the fact that you're gay'."* Pete, Gay Man

- **Being silenced**

Lack of understanding and awareness about the significance of coming out, and the crucial part it plays in developing a healthy identity (Davies, 1996) can sometimes lead MH care workers to advise users to be silent on the subject.

> *"What I was trying to explain was that there was a lot of issues about my sexuality that were coming up for me, because my family had rejected me because of it. So I was trying to explain that and she [psychiatric nurse] was saying that maybe if I'd looked at it on another level, and didn't throw it in my family's face then they wouldn't reject me ... And then the first time I saw the consultant in the ward round, I asked him when I was going home ... he started to talk to me about my family, about my parents and who they were, and why I didn't see them and what the problem was and couldn't I just compromise and not be so out about things and I kept saying to him 'You just don't understand. This is my life, I can't shut off my life just to suit people'."*
> Sharon, Lesbian

The on-going nature of this process is illustrated by Jaymee, a participant in this study, who gained help and support from some workers and silencing and rejection by others.

> *"I actually started by telling my last psychiatrist, who's now retired, so that she could help me. Because if you are hiding something in your mind, the idea for them is to try and get it out. And if you keep it locked up there, they can't help you. And it wasn't helping me to keep it locked up there, because I knew I had to tell someone some day ... She said 'It doesn't matter whether you are gay or not. I still treat you as you. And whether you like to go to bed with men or you*

like to go to bed with women, it doesn't worry me.' That was the first good reaction ... I'd told somebody so that now I knew if anything happened to me, someone would be able to say 'well he did lead another life'.'

I told the psychiatrist because I felt I had to, in order to help myself. Then I felt I'd try talking to somebody else, and this gay member of staff came along, and had worked out that I was gay from the way I acted and the way I'd pass comments. And he said 'There's no need to be worried about it. Just tell me who you are, and I'll help you out.' So I did. Which then led to another member of staff knowing. I went on and told a third person and she helped me an awful lot. I started to open up about 6 months ago and started to tell more and more people.

I started to tell members of staff at the drop-in and I got a very negative response from a good majority of them. One of them said 'Don't talk to me about being gay because I don't want to hear.' There was one member of staff that I could speak to occasionally, but the leader of the group said that it's best you don't talk about gay activities within this centre. Yet it is one of their policies that they respect all nationalities or whatever - sexual preferences - in a document ... there is a piece of paper that's documented that they should treat everybody equal.

Well it made me cross the fact that I couldn't talk about it, because they were the very centre, the people that I needed to talk to, to help myself. I'd come open about it and I'd started to tell people about it, and it was by telling more and more people that I was beginning to get strength. Until I got sort of punched in the face by this member of staff saying don't talk about gay business here. It's not wanted. So yes - I feel very uncomfortable, and I don't find the centre to be of any benefit to me.

I mean I know there's an awful lot of people within the community that are gay or lesbian and they too need help if they've got MH problems ... I mean I'm always on the phone to somebody who's got MH problems and has recently come forward and told me they were gay. So I'm obviously there for them. Because there is nothing for them. Like there's nothing for me. So we are supportive to each other. But not within the drop-in. There you feel negativeness ... 'Oh look out, he's here' you know, 'The gay's here.' It's the label I've been branded with. Other than mental health." Jaymee, Gay Man

• Attitudes of authority

Attitudes which pathologise

Attitudes which pathologise have been identified elsewhere in this report, and by other research (Golding, 1997). Nevertheless it feels necessary to keep stressing how damaging they can be in the hope that steps will be taken to ensure they are eradicated.

"[My sexual orientation] was received very negatively ... but I had to accept it because it came from a psychiatrist, it came from a professional, and they're obviously supposed to know more than the person involved ... I've only sat with him for say five minutes, and yet he's come up with this conclusion that my sexuality is the problem ... I'd just come to terms with my sexuality, before this happened, so I actually got more doubts and more angry about this 'being gay' thing. I mean, I had a boyfriend at the time, we'd been together for about two years. And I actually split up with him because I thought I was doing something wrong, I thought I shouldn't be sleeping with this man. It's wrong, I shouldn't be gay. And I went through that for about a year. Then I met up with

some gay friends of mine that I'd actually blocked off, don't want to know you, you're all perverts, you're all dirty people. I don't want to know you.

And luckily they seemed to understand, because we actually sat down one night and had a talk about how people perceive things. And when I explained what had happened with the psychiatrist ... they was very accepting that I hadn't pushed them away deliberately, it was because I was going through something that I couldn't really tell them about ...

I just started crying ... and one of the people actually came over and said 'Come on Jason, cheer up, at least you know you've still got us.' Which made me feel something inside, because my parents had rejected me for two years, because I came out when I was 16, and in fact it was so strange to have somebody that cared ... And he said 'Jason, you need to get to see somebody that is gay and lesbian themselves, that will understand.' And it was them that contacted (voluntary organisation) for me, as well. And when I actually went over and spoke to the bloke ... it was like, thank God, I'm not the only person that's been through this. And I actually left there and it was like a great weight had been lifted off my shoulders. I thought I can do anything now." Jason, Gay Man

Judgmental attitudes

Even where a worker may not actually pathologise sexual orientation, judgmental attitudes about that orientation can still affect the service received.

"I've encountered dysfunction in my sexuality due to taking medication and so ... when I went in and complained that I am having erectile dysfunction, then he said 'But does it really matter? I mean it's not as though you're going to produce kids.' And I was flabbergasted, I really was flabbergasted ... these are the stupid prejudices that the providers are still holding in 1997. It's very unacceptable ... I'm not talking about something that happened five, ten, twenty years ago, no. I'm talking about current service providers ... And it just doesn't help. In fact I think a lot of these service providers are more detrimental to our health than a help, really." Pete, Gay Man

• Denial, discouragement and the devaluing of LGB orientation

Some participants experienced both attitudes of denial - intended to reassure, and encouragement to be heterosexual.

"My first experience of being a mental health service user ... was having psychotherapy for 18 months ... And I still look back and think, my God! The woman who I saw, the therapist I saw, totally challenged the fact that I was gay and would say things like, 'You're not gay, what you need to do is go out with a woman' ... When you're in that process the kinds of messages that come through are so powerful, and because everything else in that relationship seems to be helpful and moving in the right direction, it's like it's almost slipped in subliminally ... and I can remember actually going out on a date with a woman because this is what the therapist was saying to me. And you know I was absolutely flummoxed by it really." Peter, MH Nurse, Gay Man

"I went from talking about not wanting to be with men and choosing celibacy - which she [NHS psychotherapist] felt was an understandable response to sexual abuse in childhood - to talking about wanting to be with women and foregoing celibacy - then she said that I was not struggling hard enough for my heterosexuality." Brenda, Lesbian

LGB youth

"What I felt was that I was labelled as having this problem because of my sexuality ... that I had never been in long term relationships so therefore I wasn't a committed person and maybe it wasn't women that I wanted to have relationships with, and how could I know because I hadn't had sex with men - I was too young to decide - that sort of attitude." Sharon, Lesbian

Perkins (1995a) suggests that reassurance by denial is particularly common with younger women, and that mental health workers like to feel that all routes to heterosexuality have been explored.

Ignoring sexual orientation

Another attitude which can be experienced as completely unhelpful is that of simply ignoring assertions by a service user that he or she is lesbian, gay or bisexual.

"There was one particular nurse that I really got on well with. And I did try to talk to him about it [sexual orientation]. But it was a sort of issue he avoided, because I'd been seeing a man up till my admission ... that was the tail end of things. And it was always like the enforcement that that [relationship] should have been working and how could that work, or if that relationship hadn't worked, why? I shouldn't be lesbian because of a reaction from that. And that wasn't what [my being a lesbian] was about. But that was definitely what was said to me. Like by him. And he was gay himself. And my actual key worker, who was a woman, she was totally homophobic when I think about it. Because it was just devaluing [my sexual orientation], ignoring it"

MH Project Worker, Lesbian

• The treatment of same-sex partners and friends

A combination of many of these attitudes - pathologising, judgmental, unaware, trivialising - plays a part in the ways same-sex partners and friends may be treated. Issues raised included:

* lack of information sharing and the need for guidelines
* lack of privacy
* lack of support
* significance of relationships / friendships not acknowledged
* difficulties compounded if service user feels unable to be out.

As highlighted earlier however, there were some service users who felt relationships with partners and friends were respected.

" I had my boyfriend visiting me when I was in hospital and everyone was just fine about it. I never got any shit off other patients, off the doctors or anything."
Russell, Gay Man

This mixture of positive and negative again draws attention to the variability of attitudes and thus the service received. Other service users experienced worry, confusion or uncertainty due to lack of clarity and again confirmed the need for guidelines to good practice and positive legislation. In terms of the Mental Health Act, same-sex partners are not recognised as 'nearest relative' unless they have been living together for five years. For heterosexuals, being married automatically confers the status of 'nearest relative'; for those cohabiting, 'nearest relative' is possible after six months of living together. Such discrepancies clearly constitute discrimination.

Lack of information-sharing

"My view is that in the legal sense, next of kin is defined as a member of the family or a married partner so in that sense lesbian and gay partners are not treated the same. In terms of visiting, I do feel LGB partners are treated just the same as straight. Where differentiation may occur and where staff may well err, is in terms of giving information out to those who ring. I thinks mistakes have been made and can be made because staff are reluctant to give out information and this may mean that partners don't get certain information. The problem is that staff feel they are only trying to protect patient confidentiality ... A possible recommendation would be for patients to be asked to whom information can be given or not given. Then staff would have a list to refer to when a request for information is made."
Consultant Psychiatrist, Lesbian

Need for guidelines and positive legislation

"There are particular problems in terms of next-of-kin acknowledgement. Under MH legislation a relative - whom you may have fallen out with - may have more powers over you than a lover." Multi-Disciplinary Focus Group

"Well the thing is I've never taken a partner along for my CP at all. I know that they do have a policy of inviting someone along if you requested it ... But again it's a funny area in a sense that I would have expected either initially, when you first went, or subsequently - that if you have that right, that a patient would have been informed of that. In my case I wasn't. Even though I'm aware of it. I wasn't told by staff or anyone like that, I'm only aware of it because I'm a member of the forum, the users' forum, that's why I know. If I wasn't a member there, then I wouldn't have known of it, no. So there is a lack of information."
Pete, Gay Man

Lack of support for partners / friends

"What they always said in the NHS was we treat everybody the same - and of course while they didn't treat everybody the same, the truth is everybody is not the same ... I have seen it in the HIV field, I've seen partners been together for years and then the person is dying and the family appears and suddenly come in and arrange the whole funeral and the partner is totally excluded and that's devastating. It is appalling - so I think this is a major issue."
Counsellor, Gay Man

"I think that for gay people there is a problem of the attitude of families and professionals, towards partners. Because they're not involved in decisions that are being taken like medication, hospitalisation, and so on. And although my partner at the time tried to cope, it was impossible ... And he was sort of caught in a, I think he probably felt like the rope in a tug of war. Between my family, me, and his family ... And I think you know, people forget the effect that mental illness has on partners, and when a partner is a gay partner, there isn't very much support for that person."
Ron, Gay Man

Lack of privacy

"I mean there's always issues around what happens at visiting time ... I think [gay service users] felt that they weren't given enough privacy. And staff I think were kind of fairly jokey about them, you know, behind their backs, to me, because I was a fellow professional, they'd ... not take them seriously, you know, assuming that I would agree with them, sort of make jokey comments. But again, that was very variable, some might have been fine."
Community Care Manager HIV/AIDS, Lesbian

Significance of relationships not acknowledged

"[How partners are treated) ... varies tremendously, depending upon the role and status of the partners and the attitudes and beliefs of the staff ... In respect of the MH Act, they are clearly not - and they can't be - treated the same, because legislation doesn't actually permit them to be treated on an equal footing, but in other respects again, I would suspect they are simply treated as friends who visit. And I don't think in many ways they're treated differently from other friends, but the significance of the relationships I don't think is very often acknowledged." Rachel, Consultant Clinical Psychologist, Lesbian

"It depends on who's dealing with them, very much. ... and what type of service it is. But from my own experience a few years ago of being an in-patient, and my mental health problem was very much related to the end of a relationship, of a long term relationship. I almost kind of didn't want to say that because there's this thing about having to justify relationships by saying how long they are, because we can't get married ... My experience of that was that my partner was completely excluded ... was very much discouraged from coming up, from having anything to do with what was going on ... I think it comes back to the kind of status of relationship. And it's not seen as legitimate in some way, because there's no legal piece of paper ... it's seen as a kind of informal thing ... it felt as if everything that was being looked at was being looked at from a heterosexual model. So that the relationship wasn't seen as particularly valuable, because you know, it had no social status, and ... I feel that if I'd been married to a woman and become depressed because of the break-up of that, the response may have been completely different. It was almost kind of like, 'Oh well you know, it's OK, there's plenty more people out there.' That was generally the kind of approach from the nurses. And I was trying to look at it in terms of a bereavement, a grief kind of process."
Peter, MH Nurse, Gay Man

Significance of friendships not acknowledged

> *"I think it would be better to do away with these sort of niceties of next of kin and say that where the person is capable of stating a next of kin, that person ... should be taken above everybody else ... Because lots of people have friends who aren't partners who don't live with them. I mean there's another peculiar thing about this next of kin thing. Which seems to say that the only relationships that matter are either blood or sex ... that these are the only things that actually bind people together, whereas there are some people who don't have either blood or sex, who have a close friend as the person that they want ... and the other thing is, this thing about living under the same roof. They may not live under the same roof, but they may be their prime person that they want to be their next of kin."*
>
> Jay, Lesbian

Further difficulties if not 'out'

> *"I think this is a big issue in general in the whole medical world ... nurses are sort of trained with this paranoia of only talking to the immediate family ... and if someone comes up and says well actually I live with the person you know - and that depends if the person's out as well and feels comfortable with that. They will only give information out to immediate family. Things are changing ... but that's up to the individual person to actually write when they are being admitted ... they have to say 'Yes, my next of kin is so and so and I want my information to be shared with this person' ... But if they are not out, they don't stand a chance. I think if you are out and you say it, you are going to get hurt. But if you are not, and then your partner comes along ... you are going to be denied all information until you kick up a stink, really. I think that's generally the situation. They are completely paranoid about that side."*
>
> Terry, MH Social Worker, Gay Man

The ways in which homophobic and heterosexist attitudes of MH workers can affect how service users experience services, and how they might feel about themselves, have been presented. We now turn to the attitudes of other service users, with whom LGBs must share some service environments and whose attitudes they also have to cope with.

5.2 Attitudes of Service Users

As indicated elsewhere in this report, the attitudes of heterosexual service users towards those from sexual minority groups can affect both the accessibility of services and whether or not lesbian, gay and bisexual users feel safe enough to be 'out'. Fear of, or actual experiences of homophobic attitudes, may also result in LGB service users feeling lonely, isolated and unsupported within the service. Negative consequences are further compounded by lack of staff intervention and / or active collusion towards such attitudes and behaviour.

Findings revealed:

- ◊ There were fears about physical safety and experiences of sexual harassment.
- ◊ Women experienced sexism as well as homophobia and biphobia.
- ◊ Verbal abuse and ridicule were experienced.
- ◊ These experiences affected use of services, prevented people from coming out and led to feelings of isolation and loneliness.
- ◊ Non-intervention and collusion by staff compounded fears about coming out, feelings about lack of safety and managing the difficulties of being so abused.
- ◊ The 'user movement' was perceived as not taking lesbian, gay and bisexual issues on board.

Previous studies mirror these findings in that 78% of service user participants in Golding's study would not feel safe disclosing their sexual orientation to other service users, and a main finding in Koffman's report (1997) was that 'direct and indirect anti-lesbian, anti-gay and anti-bisexual comments from other service users results in reducing safety and increases fear and reluctance to use services.'

Positive comments

A small number of people did feel that their experiences had been mainly positive however, and that coming out was respected by other users.

> *"But again I've been quite clear about who I am, you know, and I think in a way people respect the fact that you've said - for example, people talking about girlfriends and all that sort of thing. I think it's better to say your partner or your boyfriend or whatever, or say I don't have a boyfriend at the moment, and then it's up to them whether they say 'oh are you gay then?' And I mean I did talk about all this with patients when I was in hospital. And I think the attitude of staff gives, can give a lead, as well, you know."* Ron, Gay Man

• Physical safety

Fears about physical safety and experiences of sexual harassment have already been identified as issues of great concern, particularly for the women taking part in this study. This is discussed in greater detail in Section 6, but here we look specifically at the ways in which other service users are involved in creating an environment in which lesbians, gay men and bisexuals feel unsafe and possibly at risk from sexual harassment.

Risk to lesbians

As well as physical attacks fuelled by homophobia, lesbians are at risk from male service users who hold the stereotypical belief that 'what they need is a man.'

> *"I mean there's something about male psychiatric patients anyway, they think women love them to death ... 'Why don't you go out with me?' ... I just can't, it's not on the cards ... 'does that mean you're a lesbian then?' So you try and lie around it, because it's the sort of thing you have your face kicked in for at the hospital. We've got this one bloke at the [day] hospital, he's only young, and he is obsessed by homophobia, he really is. And oh god, it is so offensive, some of the things he comes out with. I mean I have to lie every day. I go in*

there, I have to pretend to go out with a bloke. I have to pretend to like so-and-so. I can't be myself. It's like a major strain, because you can't open up and talk to anyone. The nurses don't really want to know, and I wouldn't feel comfortable, because it would be all around the hospital and people would be taking the piss ... But I mean I came off the rehab ward, people in general there were just very supportive. But I can remember there was one guy on the rehab ward that just wouldn't take no for an answer, and he actually indecently assaulted me and thought that what I really wanted was a man. But apart from that, I mean, no-one ever said, people actually gave me a lot of respect because I was just myself."
Anne-Marie, Lesbian Orientated

"I mean, as an in-patient in the hospital most of the women there are a lot older and quite prejudiced unfortunately. And the guys of course, there's loads of sleazy guys anyway, who keep coming on to me. And if they found out I was a lesbian, it didn't make any difference to be honest. They'd just hassle me anyway. And you know, they just come out with all that stereotypical crap that heterosexual men come out with when they meet a woman that they like who's a lesbian. They're like, sleep with me, I'll change you, I can convert you. They just thought I was a challenge. They thought it was great, or they get really excited over it. It was terrible ... I've never known a single sex ward to be honest. I don't think there are many around are there, really? You don't get a choice. You just have to be on these mixed wards with guys basically."
Rachel, Lesbian

Risk to those who are HIV+

Service users who are HIV+ were identified as possibly being at risk from attack.

"What happens on one of our wards ... you get somebody who identifies as gay, identifies as being HIV+ as well, they will very quickly get them off the ward. And that's not done on clinical grounds. That's done on, this is not a safe place for them."
Terry, MH Social Worker, Gay Man

• Being out - or not

Non-disclosure of sexual orientation due to fear

Fears for personal safety also prevented people from coming out.

"[As an in-patient] I didn't feel able to come out to them. I wasn't able to say at all to any of the patients, because I was fearful of their reaction."
Peter, MH Nurse, Gay Man

"I have often thought if I tell the wrong people I might come under threat. As previously stated , I have been assaulted several times within London, but not as yet locally. But yes, I would fear a risk, I'm very pickative who I tell."
Jaymee, Gay Man

Effects of non-disclosure

The consequences of not coming out due to fear of reprisals can result in feeling extreme distress and isolation.

"So I was telling my [art] therapist [at the day hospital] that I'd been to a Pride march. And this woman picked up on it, and the next thing we know ... she started crying so we asked what was up. And luckily there was just the three of

us in there, and she said 'I feel so isolated, I'm a lesbian, I didn't know if there were any gay people here.' And she was so grateful to know that there was someone else who was gay, just like her ... So that's where I think gays are very much isolated in this, and that is the reason I've been pushing to create some kind of space. She has always felt very, very threatened ...she runs a mile from the women [users] ... because a lot of the women have made very funny comments about lesbians - not gays, but lesbians. Because apparently one of them is always going on and on about how there used to be a Portuguese girl, who no longer attends, having made passes at her and attempted to go to bed with her and all that. So all the women have made very, very anti-lesbian comments and so on. So this has completely frightened this woman ... And rightly so. I mean ... if I was in her shoes I would be as well." Pete, Gay Man

Some consequences of coming out

Unfortunately being out can also mean being subjected to verbal abuse, the threat of physical abuse and ridicule, particularly where there is no commitment from staff to intervene (see also 'Collusion by staff' below).

"They [other service users] asked me where I'd been and when I said I'd gone to see a lesbian film, they started going on about 'perverts' ... After my partner had been to visit I overheard another user saying he'd been physically sick when he heard us kissing." Viv, Androgynous Transgender Person

Such attitudes may lead users to use a service less frequently ...

"I still get different reactions to my sexuality. Like I go to the centre sometimes, I used to go quite a lot. But I only go sometimes now. People's reactions are different. Some are really bad. And I've agreed with another gay man that we're not going to go there so much. And I tell you I feel better for it. Most of the homophobia or heterosexism - I don't know what you want to call it, bad vibes I'll just call it, comes from the users or clients of services." Ayo, Gay Man

"... there were a couple of other people who were very, very homophobic and said you know, one of them actually threatened to punch me in the nose if I ever said 'Hi' to him or whatever. ... I don't want a situation where my care is hampered in any way. So I just try to keep well away ... I generally go to the day hospital when I'm supposed to go, finish off what I'm supposed to do, and out I go. I don't hang around having endless cups of tea and chatting with everyone, though I'm friendly with a lot of people ... Nor do I attend the social, they hold a social once a week on a Wednesday morning. But I don't bother with all that because I know that the situation, I mean, I find that there's an atmosphere ... the only way I could be interested in it would be if the situation was friendly despite the fact of my sexuality - then I would be more than happy to go. Otherwise I'm just not interested." Pete, Gay Man

... or even not use it at all.

"I can recall a couple of users that were bisexual who came to the service [MH day centre]. And they weren't really welcomed well ... I felt that made them run away from the service, because we never saw them again ... they got picked on, they really got driven away from the service, by other users."
Development Worker, Lesbian

Positive effects of coming out

However being out can mean other LGB users having a greater sense of safety and support.

> *"I think one of the main things for me on the ward, one of the main things that helped me, was contact with other women users. And a number of them were lesbian and were out on the ward, and that was quite a learning thing for me. But then in a sense it wasn't an issue for them as well, because they were quite comfortable with their sexuality and they saw the mental health issue separately. But I just felt a lot safer just in being with them really - there was a group of us really that was always quite close to each other and that was really important to me. It created some sort of safety really."*
>
> MH Project Worker, Lesbian

> *[On the rehab ward] "They were quite supportive actually. They were very helpful ... there was one girl there that was bisexual, and another girl later on, she was bisexual as well. But like the rest of the patients, the nurses, don't really acknowledge anything other than 'the norm'."*
>
> Anne-Marie, Lesbian Orientated

• Collusion by staff

It was also the experience of some LGBs that homophobic and heterosexist behaviour by other service users was condoned or ignored by members of staff. Non-intervention and collusion by staff undoubtedly compound feelings of fear, isolation and of being unsupported.

> *"When I was in hospital there was another resident of the unit, she was on another ward. Every time she saw me she called me 'homosexual beast' at the top of her voice ... Nobody intervened. I complained to my key nurse, and that happened like, for about four weeks, so it would be breakfast, lunch and tea, I'd see her. Three times a day. And every time, three times a day I'd get it, 'homosexual beast!' and she'd scream. And there was a friend of mine who was an older gay man. And he says, she never says anything to me. And I goes are you out, and he goes, not really, no. And I can't remember now, whether I said I'm gay. To them, to her. I was out to most of the staff."* Ayo, Gay Man

> *[At a day centre] ... "I've had a few name callings, like 'dyke', and I just said to them look, I know you've got a problem, but it's your problem and you have to deal with it ... the staff just let it go on. So in the end I left."* Kate, Lesbian

> *"Homophobia was experienced and observed within MH services from other service users, also sexual harassment. The latter was allowed by staff because it was seen as 'normal'."*
>
> Service User Focus Group

• Attitudes within the user movement

In just over ten years, the user movement has grown and developed enormously: from less than 12 independent user/ survivor groups in 1985, to roughly 350 local, regional and national groups by 1995 (Campbell, 1996). It was observed however

that the issues of lesbian, gay and bisexual service users are not usually taken on board.

> *"Because I do a lot of work in mental health I spend a lot of time in the user movement ... and sexuality is low on user agendas. I always find it really, really difficult because for me it's not just something that I chose to do one day - it is a way of life, my sexuality, and that is how I can be mentally healthy. You take that away from me and you take away my whole being really, the happy side of me, the together side of me - so when I go into groups who are survivors, I can't leave that behind, but it is never an issue for anybody else, because they are nearly always all heterosexual and I feel like a whole area of my life is ignored unless I push like hell to get it brought up."* Brenda, Lesbian

5.3 Attitudes of MH Workers Towards Mental Health Services Users

In the interview schedule used in this research, no question was actually asked about the attitudes of mental health workers towards service users generally, regardless of sexual orientation. However, as it was an issue which participants nevertheless raised, it felt important to include the findings here. By drawing attention to experiences which did not necessarily arise out of attitudes towards sexual orientation, it is hoped that issues will be addressed which will ultimately improve services for all.

Participants identified the following as attitudes held against them as service users:

* stereotyping
* stigmatising
* patronising
* discriminatory.

These attitudes, alone or in combination, could affect access, treatment, the quality or relevance of the service received and the hopes and aspirations of service users.

• Attitudes which stereotype, stigmatise and patronise

Invalidating

Attitudes held by mental health workers which stigmatised and stereotyped those in their care confirm Wallcraft's reference (1996) to 'the routine invalidation as self-determining human beings of those labelled mentally ill'.

> *"I mean my psychiatrist, I just take her with a pinch of salt. If I listened to her all day long she'd drive me more loopy than anything else ... for example, I want to do a job that my psychiatrist tells me I'm totally at odds with doing. She says she thinks it would be too stressful, and I don't think they'll give me a chance anyway because I've got mental health problems. I want to be a fire fighter at an airport ... 'I think it's too stressful', she says to me ... but on the*

other hand she turned round and said 'why don't you stack shelves in a supermarket ?' ... Well, I'm not being funny, I've got O and A levels up to the end of my whatever ... I wouldn't get any satisfaction out of it whatsoever, and it would drive me mentally loopy. Because it is so unchallenging. But this is how you get to ghettoise people with mental health problems ... you do what you're told - you don't do anything, and that's what I mean by saying that you have to learn to start fighting back very early - saying, yes I've been ill, I may require medication for the rest of my life, but I'm certainly not going to be a psychiatric patient for the rest of my life." Anne-Marie, Lesbian Orientated

"What your psychiatrist says, and what your nurse says, goes. What you say and put in there [eg your version of events in your hospital notes], the attitude is you weren't in you right mind when you were saying it ... how would you know? ... that sort of thing." Jo, Lesbian

Effects on quality of service

Such attitudes mean that service users may receive help and support which is irrelevant or inappropriate.

"I remember when I was getting a bath [in psychiatric unit] ... I had a bath, I think I had a meal ... and people queuing up for pills off a trolley - that seemed horrible. But one of the overall things was this kind of jolly/brusque type of - I mean the nurses, the female nurses who were white and youngish ... it felt like that kind of, 'Oh he's doing ever so well, isn't he?' I was thinking, I went to the best dance schools in England. I'm in a West End show at the moment which is selling out. And it's like they were treating me as if I were a kid, not knowing whether I wanted tea, coffee or hot chocolate ... There's certainly a mental health system thing I think which permeates everything, which is a sort of 'Ah bless, he's a homosexual type' ... as if you're less cognitive, less sentient ... and that was certainly acted out in the hospital I remember. It was like, give him a bath and 'Finished your bath now Mr S?' And it's like 'help' is classes in how to give the nice lady at the checkout the right money. Fuck off, you know! " Stephen, Bisexual Man

"I think the medical people assume massive, massive inadequacy. They assume you need so much support, but it's never appropriate support. Not at all." Kari, Lesbian

Effects on access

For some service users, stereotyped ideas about who services users are and how they look or behave, meant they had difficulty in actually accessing services.

"I said to her [behaviour modification therapist], this is how bad my anxiety is, and my doctor had written to them and said, this young woman has these problems. But I don't think she believed me, because I didn't sound like a gibbering wreck ... She really treated me like a lot of people treat me, 'Well come on now, dear, you're quite capable, you can do it, you're quite confident, I have every trust in you,' and they don't know who they're talking to. Because I've got my education when I'm older. Because I've been able to think clearly and talk properly and talk in their language, and I used to be a nurse, so I even use the right language, they don't see past it, or they choose not to ... a year ago I had been to my GP and said, 'Look I'm not managing my stress very well', and she referred me to a stress project. So I went along there to fill in the forms and the same thing happened to me. It was assumed that I wasn't the client. 'S' had come with me because I was really scared and we walked in and sat down and I asked for the forms. I asked for the forms, went and sat down and they

came over and assumed that 'S' was the client and that I was her carer or social worker or something ...In the mental health field you start to feel, well ... do I have to shake or look a bit strange or something?" Teresa, Lesbian

Gender stereotypes

Gender-specific stereotypes may result in users feeling patronised and not really listened to by health care workers.

"It is an issue of gender, because I don't think depression in men is taken seriously at all amongst GPs, especially by male GPs. I've always had male doctors ... not through choice it just ended up that way ... I mean I can't prove it but I have very strong feelings about that. It was basically 'pull yourself together'. And you know, I guess unless you are sort of like completely foaming at the mouth they are not interested. I was given vitamin pills, I mean I could have bought them! It would have been a lot cheaper than a prescription. So you know, they said no we don't give out tranquillisers, but I wasn't asking for that, I was just asking like, if you can't help me, who can? ... But it was all very dismissive ... As a man I do think that perhaps I am treated differently, and have been in the past. It is very much that dismissive attitude and 'really got to get a grip' and all this kind of thing ... I am just generalising, but I don't think that women would perhaps be treated that way. I don't know. I definitely thought I was being fobbed off ... and sometimes I was really quite upset. And miserable. And apparently they didn't pick up on that." Nick, Gay Man

• Discriminatory attitudes

Employment in MH services

Some felt that they were discriminated against as past users of services, in terms of their employment *within MH services.*

[Kari worked for some time at a half way house for MH service users] "... to get the job, I lied about myself ... I didn't mention my psychiatric history, nothing. At the end they found out about it and I had to go ... partly because of that, and partly because I couldn't stand the homophobia any more."

Kari, Lesbian

"I think it was all complicated because of the fact that I was also a mental health worker. And that's another big taboo for MH workers. To admit that they have crossed the line at some point. I mean I felt that I handled the whole thing completely appropriately ... people who I was working with at the time or people in the same hospital at the time, who were experiencing really quite major mental health problems, were still working. And I feel that's extremely irresponsible. It's not taking your responsibilities towards clients at all seriously. So I felt that I'd take some time off work, I was off work for three months, and when I came back, everything had changed. People's attitudes towards me had completely changed in very, very demonstrable ways ... At the time I went back to work the practical arrangements of things had changed and I would have been very clearly the next person to take the acting up job, to oversee the ward move and set up the new service. And my manager said

'Oh well you know, you've been in, and so we can't actually do that. You're going to have to take a back seat.'

And I actually challenged that ... and through challenging them it worked a bit better, but there was still this kind of, once you've seen a psychiatrist and been in hospital, it's like, you are now a lifetime member of the mental defectives league. And it really, really feels like that as well." Peter, MH Nurse, Gay Man

Up until very recently there was no legislation to prevent discrimination against those with mental health problems. The implementation of the Disability Discrimination Act in 1995 has brought about some improvements but for many in the user movement the feeling is that it does not ensure rights for all those who need it (OU, Module 3, 1997).

Drug users and attempted suicides

Discrimination was also seen to come into play against particular groups of service users - for example those who had attempted suicide, or who were known to be drug users.

"When you go up to Casualty, they don't like suicides or ODs or anything like that, in fact they ignore you ... You can hear them talk about them - 'their own fault, shouldn't have done it' ... things like that ... I'd like to see the attitude of the Casualty staff change towards people. I mean the reason why people attempt suicide ... if they don't know, they've got to show some compassion and find out the reason why they've done it. They're not interested - it's 'you can wait, we'll see somebody else'." Victor, Gay Man

"And I think at the general hospital, a lot of gay men felt they were treated quite badly by general nursing staff ... Treated badly at the GU clinic ... I mean I certainly witnessed people who were treated badly at casualty, but that ... was because they were drug users. Being treated quite rudely. Abruptly. And nastily, really." Community Care Manager, HIV/AIDS, Lesbian

• The need for respect

Ideas about self-determination and self-direction are underpinned by respect - respect being the foundation for ethically responsible practice. (OU, Module 2, 1997). That this can be missing from practice was revealed by the frequency with which participants identified it as something they would like to receive from mental health workers.

"As a patient, they treat you as someone to be controlled and contained. Not to be informed or empowered. You know nothing." Tom, Bisexual Queen

5.4 Attitudes Held by Lesbians, Gay Men and Bisexuals Towards LGB Mental Health Service Users

Participants were asked if they felt comfortable 'coming out' to other lesbians, gay men and bisexuals as users of MH services, and if they felt there was support and understanding within the LGB communities. These were questions which provoked an overwhelmingly negative response, though some people did have good experiences and others experienced both negative and positive reactions. Responses to a similar question put to professionals - 'Do you think there is support and understanding for lesbian, gay and bisexual people with mental health problems, from within the lesbian, gay and bisexual communities?' mirrored those of service users.

• Positive responses

In terms of positive responses, findings showed that a small number of people speculated that belonging to a sexual minority group in a heterosexist society helped lesbian, gay and bisexual people to be more understanding and sensitive to those suffering mental distress.

> *"I think in coming out a lot of lesbians and gay men have had to really reflect on themselves and their lives and separate from their families in order to take that kind of step. So. It may be, it could be argued that there might be more sensitivity to those kinds of struggles or to personal struggles."*
>
> Psychoanalytic Psychotherapist, Lesbian

> *"I think on the whole they're more understanding than most of the heterosexual people I know. I don't know why, but there seems to be a lot of gay men and lesbians who suffer mental health problems. And they're a lot more open about it. Like nearly all my friends, they've had - they haven't been in hospital like me, usually - but they have had some problems. Because coming out and all that business is stressful, and then just being gay is stressful because of other people's attitudes and stuff. So I think usually they has been a lot more understanding. It's really good actually. I've had a quite OK response about it. From all the people I've met."*
>
> Rachel, Lesbian

• Negative responses

However the majority of participants were not impressed by the attitudes of their peers and a small number of people also questioned the concept of 'community'.

> *"I don't think there is such a thing as a lesbian and gay community ... What do you call a community - a gay village? That's not a community. That's a place where gay men can go and drink and meet other gay men. Where do women go? So. There isn't a community. Number one. Number two there's no support in the main for young people, for young lesbians and gay. Number three - there's no support for lesbians and gays with mental health problems. So add them together, and you have zilch. Apart from one or two organisations ...*

there is no support ... we don't want to acknowledge that there's young people, we certainly don't want to acknowledge mental health problems."

Jan Bridget, Lesbian Information Service, Lesbian

Participants observed or experienced:

* fear and prejudice
* ridicule
* marginalisation and exclusion
* multi-oppression.

Failure to demonstrate understanding and support was identified not only in individuals but also within LGB organisations, in the gay media and on the commercial scene.

• Fear and prejudice

A result of being an oppressed minority

Negative attitudes expressed towards LGBs as MH service users included fear and prejudice. Some saw this as a response to the experience of being an oppressed minority ...

"I think a lot of it is people being afraid of mental health. They've got this image of the asylum. And the strait jackets being plugged into the national grid for treatment ... all these things generate fear and people don't want to think about that. And I think that one of the big issues for me is that the gay and lesbian community is an oppressed group - an oppressed group trying to be positive under that oppression, and mental health issues are the negative, downside of that oppression ... they don't want to think about it."

Terry, MH Social Worker, Gay Man

... and / or a result of being pathologised.

"With being pathologised so much, there is this, 'oh my god, that's nothing to do with me, we're all much more super-sane than the rest of the world.' And there is a danger of that ... we want to all be mainstream and we all want to be acceptable and anything that will kind of feed in to us not being seen as mainstream, could be dangerous for some people."

Child and Adolescent Clinical Psychologist, Lesbian

"I think lesbian communities struggle with ideas of distress and disability ... they can cope with transient distress if it appears understandable. If they can't attribute it to something that makes sense to them, then I think they tend to ignore it, and certainly my own experience, and that of other lesbians I know who have had more serious mental health problems, is that by and large lesbian communities don't know how to think about madness and really would rather not think about madness. I think that's partly because lesbians have been defined as mad per se, there's been a tendency to do this sort of 'we're not mad, we're angry' kind of line ... And I think that access to lesbian communities is absolutely appalling for lesbians who experience more serious difficulties. I think our communities are not dealing with distress, we're de-skilling ourselves terribly. There's a notion at the moment that you can't offer help to someone unless you're properly trained. That you might do something wrong. You might say the wrong thing. And I think that is a very, very dangerous position to come to ... You know, a community isn't just the three people you know or the six

people you know. It's actually a whole set of other people to whom we have responsibilities."

Rachel, Consultant Clinical Psychologist, Lesbian

Result of mass-media influence

For others, it simply mirrored responses from the public generally, provoked by stereotypical media images.

"I think that the way that things are at the moment, because of the homicides and the climate, mental illness and mental health problems are kind of automatically linked with violence and homicide, and serious, serious stuff. And my experience is that that's only a very small proportion of people. And I think that the gay community is as open to that message about the serious violence and homicide as any other part of the community. I don't think that gay men are particularly aware about mental health problems."

Peter, MH Nurse, Gay Man

• Ridicule

Prejudice and fear can also be expressed by the use of ridicule

"I said I had schizophrenia to a good friend of mine and some of his friends ... And I said, 'But that's only been recently diagnosed and I'm not comfortable with that' ... They thought that when I said schizophrenia, they thought - 'Have you got a split personality then?' And I've never heard of schizophrenia meaning split personality. I don't think so anyway. But I'm not an expert. And they kept on making remarks 'Oh, it's not that one, no, it's the other one. It's not that one, no it's the other one.' They kept on saying that to me. And I felt very wound up over that."

Ayo, Gay Man

Such attitudes can lead to people feeling unsupported ...

"I got support from individual dyke friends. I think that's to do with them being my friends, rather than being part of the lesbian community, you know. But from queens in general - no. Very little support and enormous amounts of fear, in fact. And I didn't have a choice in coming out. I mean I disappeared off the scene for three months and everyone knew by the time I'd come back what had happened. And I wasn't going to pretend that it hadn't."

Tom, Bisexual Queen

... rejected and hurt

"I think if you're talking mental health, everybody doesn't want to know about it. I'll just take for an instance, I was in a gay pub in London, they're doing a collection for one of the Trusts. I went round with them, helped them collect, and they raised a fair bit of money through it. A week later I'm in the pub again and this chap comes in for mental health week. I put my money in and stated that I was a sufferer myself ... And the reaction from a lot of the people in that pub was 'I don't want to know if you're mental.' And I felt that was very, very hurtful. Because the next day they could be in that situation."

Jaymee, Gay Man

"People are bigoted about mental health service users. They have the image of the 'mad' lesbian. It hurts to be rejected by your chosen peer group - straight

friends are often more supportive. Some lesbians have forgotten about support for sisters, they don't have any time, they just want to get on with their own lives."
Tina, Lesbian

"I do know I had the experience when I was in hospital of my friends deserting me."
Jo, Lesbian

- **Marginalisation and exclusion**

"I heard people talk about me as the nutter and the loony. I was in various women's groups ... usually a lot of lesbians in each group. And the attitude towards me from some of them ... was that I wasn't to be taken that seriously, I wasn't reliable, I was looked down upon by a lot of people. A lot of them didn't want to know me as a person, or socialise with me."
Kari, Lesbian

"Well, it's very difficult ... you don't get sort of immediate reaction but people don't phone you back. If you meet somebody for a drink or whatever, and this comes up, well you never hear from them again. My boyfriend walked out nearly two and a half years ago and I haven't had a relationship since then. And I'm certain that's partly because ... I don't hide my mental health history. I don't tell everybody my life story, but I do have to take medication, and I do have to go to the hospital and to counselling and so it's quite a large part of my life ... staying well. And in a way it's very similar to being HIV ... do you tell people about your status or don't you. And people don't really understand, they think if they get into a relationship with you, that you're going to go mad or that you are mad, or that you'll go into hospital, or that you'll need looking after, and that you will be dependent on them. And so that's when they will head for the door, you know. And it is, it really is a problem."
Ron, Gay Man

Multi-oppression

Such feelings can also arise from attitudes towards difference.

"You know how young gay men are anyway ... you've got to be white or black and body beautiful to be chic ... And as I looked Asian I didn't really fit into that crowd. And I didn't really wear the right clothes. I was more of an individual, wearing what I wanted to wear. And I wasn't ready to be manipulated as much as the other people, to fit in with them. As much."
Lincoln, Gay / Bisexual Man

"I mean I suppose the other issue that comes into this is disability. That's another one you can't combine with sexuality and mental health. You don't get those three words together, and I find in disabled circles I usually talk about being a survivor because I'm usually there to represent the mental health field. ... But the one big question that still doesn't get covered in relation to lesbians and mental health is disability - it is not addressed. I mean [counselling organisation] is accessible but that is about all. There is no information, there is nowhere those words are seen together so I think that's something that is missing and needs to be addressed ... I've been disabled from birth and I talk about disability, and I don't ever go to talk about disability but I end up talking about it ... It has fed into problems that I have had and yet never, outside of the therapist, has that been addressed."
Brenda, Lesbian

• LGB organisations and media

LGB organisations

The failure of organisations to demonstrate understanding and support was criticised

> *"[Lesbian and Gay Organisation] offers social groups to help combat isolation but the facilitators become quite scared when they come up against mental health issues."* Multi-Disciplinary Focus Group

> *"There's a few people at [LG Teenage Group] that have mental health problems, and I've actually been asked to do a mental health talk with another girl there, which we're going to do. We're just trying to structure it at the moment. But there's another group I go to, it would just not be the topic to bring up at all. You must have heard of [group]' ... it's terrible there. I mean there are people that are sexist, there are people that are racist, it is absolutely dreadful. They were asking us things that we'd like to see on the agenda, and I said to my friend, 'Do you think I should put something down about mental health issues?' And she said 'I wouldn't do if I were you'."*
>
> Anne-Marie, Lesbian Orientated

LGB service user groups

LGB service users' groups were seen as a vital source of support where it seemed that access to other LGB sources was unavailable.

> *"Quite often, if I didn't have the lesbian and gay user groups, I wouldn't think there was support. But I think it's because I go to these groups, it feels like there's some kind of support ... I've got more in common with gay patients that are mentally ill, like."* Mark, Gay Man

The media

The gay media was criticised for not fulfilling a role in raising awareness and educating the community in MH issues.

> *"I mean, the gay press isn't terribly sympathetic to mental health issues. I think their attitude is, God, that's a bit of a downer, and most of their revenue comes from advertising, which is about people having a good time ... we don't want our readers to be depressed, they must keep enjoying themselves. So that's something that should be looked at ... also they have a role to play in general education, about accessing mental health services and about negotiating with professionals, you know, what do you do if your boyfriend ends up in a psychiatric hospital, do you have the right to visit, and that sort of thing."*
>
> Ron, Gay Man

> *"Well I've been reading the lesbian and gay press addictively for the last ten years and I've probably seen about five articles in that time. It's incredible. Incredible when it's such a widespread experience ... it's massively unaddressed."* Tom, Bisexual Queen

However one or two did feel that there are indications that MH issues are starting to be addressed.

> *"What support? Well actually I mean, things are changing because actually there was a two page spread in [LG paper] on mental health just last week. And*

I was so amazed to see that ... And it was the only thing worth reading in the whole rag. So that is an indicator to me that times they are a-changing."
Julie, Lesbian

• The commercial 'scene'

Values on the commercial 'scene' may be felt to be unhelpful

"I think the gay scene very much revolves around alcohol and also to some extent - in London - on drugs. And those are both things which people with mental health problems have to be careful about, you know. And like the sort of culture of body beautiful. If you're on anti-depressants ... they can make you put on weight. And I've found that people will say, 'Why, you've put on an awful lot of weight', or 'You're overweight, why don't you do something about it?' sort of thing. Or 'Why don't you go on a diet?' And if you explain that you're on medication they think you're HIV positive, and if you explain that it's anti-depressants ... it just opens up sort of a Pandora's box of attitudes ... Gay people are just as capable of discrimination as the general population."
Ron, Gay Man

"I go on the scene quite a bit but not as much as I used to. Their whole focus is about youth and fame and it's all about trivial things ... it's sort of all about the feel-good factor, not about the reality of life. And I think that's because gay people are suppressed in every aspect of their life, so when they go on the scene they want to depart from reality ... I think mental issues and mental health is too much like a wake-up call for them." Lincoln, Gay/Bisexual Man

Local pubs

However away from the commercialism of city centres, local pubs were identified as possibly being more accepting of people with mental health problems.

"I'd like to sort of qualify what I'm saying about the commercial gay scene ... out of the West End there are quite local gay pubs which serve the local gay community and there are people who use those places who've got mental health problems - and people know it and it's quite all right."
Peter, MH Day Centre Manager, Gay Man

• Raising awareness in LGB communities

The findings above substantiate Golding's claim (1997) that LGB communities are 'no more enlightened about MH issues than the rest of the population', and the feeling from many of the participants in this study is that work needs to be done to raise awareness and understanding within LGB communities. This could start with both LGB organisations of all types, and the gay media, taking responsibility for addressing issues of mental health. The suggestion was also made that awareness raising could be modelled on the response of our communities to HIV and AIDS.

"But I think we can actually learn a lot from the whole campaign around raising awareness of HIV and AIDS issues, and people with AIDS. And the whole creation of buddy systems and networking that has really worked quite well in support of people with AIDS or people who are HIV positive."
Julie, Lesbian

Summary

Findings show that attitudes towards LGBs can affect not only how MH services are experienced, but also how we feel about ourselves as LGBs and service users.

Attitudes of MH workers and service users towards LGB orientation

Some service users experienced positive attitudes, for example:

◊ Having their sexual orientation recognised and accepted positively and openly.
◊ Being given appropriate help and information.
◊ Relationships and friendships respected and information being passed on to them as requested.
◊ Being respected for having 'come out'.

However negative attitudes were more common and reflected the range of ways in which homophobia, biphobia and heterosexism operate. Such attitudes could affect:

◊ Safety.
◊ Disclosure of sexual orientation.
◊ Whether or not a service was used and to what extent.
◊ The type and quality of help and support received.
◊ The levels of loneliness and isolation experienced.

Attitudes of MH workers and LGBs towards MH service users

A small number of participants felt that the experience of being LGB in a heterosexist society enabled LGBs to be more understanding of those suffering mental distress. However experience of negative attitudes was far more in evidence. In terms of mental health services, attitudes which stereotyped, stigmatised, patronised and discriminated against could affect:

◊ Access.
◊ Treatment.
◊ The quality or relevance of the service received.
◊ The hopes and aspirations of service users.
◊ Employment opportunities within MH services.

LGB individuals, organisations, media and the gay 'scene' were all criticised for contributing to the marginalisation and exclusion of LGB service users from LGB communities. Participants also observed or experienced ridicule, prejudiec and fear. Evidence suggests that work needs to be done within LGB communities to raise awareness of mental health issues.

So far the report has outlined the difficulties which lesbian, gay and bisexual MH service users face. The next section looks at ways in which participants would like to see some of these difficulties addressed, within both mainstream mental health services and specialist LGB services.

Section 6

Achieving Appropriate and Quality Services for Lesbians, Gay Men and Bisexuals

A main aim of this research was to discover what constitutes appropriate, quality mental health services for lesbians, gay men and bisexuals. In order to address this, we invited respondents to consider:

◊ Ways in which mainstream services could be improved (6.1).
◊ The role of specialist lesbian, gay and bisexual services (6.2).

• The Need For Choice

By asking these questions it emerged that the majority of participants felt that opportunity for choice was a key issue. The demand is for access to a range of mainstream and specialist LGB services; simply developing specialist services as an alternative to improvement within the mainstream was deemed unsatisfactory.

> *"I think there should be a choice of services ... I mean I think there should be vast changes to the services that actually exist at the moment. But there actually should be separatist provision ... I do think it should be on offer."* Julie, Lesbian

The majority of service users want to use both specialist *and* mainstream services, but mainstream services which are safe, sensitive to their issues and lifestyles, and relevant to their specific mental health needs.

> *"There is a role for both ... it's good to know I'll be received by a specialist organisation in a very positive way as a lesbian woman, but I also think it's important for me to be able to go my GP and feel OK about that."*
> Child and Adolescent Clinical Psychologist, Lesbian

For some, delivery of appropriate, quality services within mainstream provision was seen to be a long way off, thus specialist services are considered to be vital in the meantime.

> *"I definitely think we're at a point where we need specialist services. Eventually, it's something which might happen ... they could be integrated. But I think there's definitely a need for our own services because we've had a pretty bad lot. So far."* MH Project Worker, Lesbian

• Minority Views

Using specialist services only

A minority of participants expressed views contrary to those outlined above. Doubts about mainstream services ever being of any use to lesbians, gay men and

bisexuals, meant that some preferred to concentrate on developing a range of services aimed specifically at sexual minorities.

> *"My aim really is to avoid mainstream services as much as possible, so improving them is neither here nor there ... except that it might help other people who haven't escaped them ... I think what we [LGB MH user group] get most excited about is queer support happening from other queers and stuff like ... openly lesbian and gay advocates, working with lesbian and gay people. Or crisis centres or phone lines, stuff like that ... which I mean really are about rescuing people in the system rather than supporting the system or helping them to change their language ... Separatist stuff really. I think it's needed."*
>
> Tom, Bisexual Queen

Worries about specialist services

Although the majority of participants clearly envisaged a role for specialist LGB services, several participants nevertheless had worries. There were fears that the existence of LGB services would:

* increase reluctance on the part of mainstream services to implement improvements
* be precarious in the face of funding crises
* feed into the view that if sexual orientation is the focus it must therefore be the problem
* promote a ghetto mentality
* undermine solidarity amongst service users.

One person felt that specialist services increased the potential for abuse, but that 'they should be there so people have the option.'

6.1 Improving Mainstream Services

Eight key ways of improving mainstream services for lesbians, gay men and bisexuals were identified by participants. These follow from some of the issues already raised in Section 3 regarding the accessibility of services, as well as introducing new areas of concern. Methods identified were:

1. Ensuring physical safety.
2. Actively tackling homophobia.
3. Offering choice in terms of worker.
4. Raising the visibility of lesbians, gay men and bisexuals - including supporting workers to be 'out'.
5. Indicating acknowledgement and acceptance of sexual minorities, inherent within which is an assurance that non-heterosexual identification and behaviour is not pathologised.
6. Promoting mental health and creating a healing environment for all.
7. Increasing staff knowledge and awareness.
8. Training.

As pointed out elsewhere in this report, it is felt that the implementation of these points would not only benefit lesbians, gay men and bisexuals but everyone who uses or works in mental health services.

• Ensuring Physical Safety

As this was an area identified as being fundamental to improving services, an appropriate amount of space has been devoted to it.

Findings revealed that:

◊ Whilst safety was a crucial issue for the majority of participants, the inter-relationships of gender and sexual orientation meant that the threat or actual experience of physical or sexual harm could arise for different reasons.
◊ One consequence of this is that what constitutes a safe environment for women paradoxically creates an environment in which men may feel unsafe and unsupported.
◊ Women were almost unanimously in favour of single-sex wards, and were also far keener on other types of single-sex space: women-only rooms, groups and meetings for example. As we shall also see in the next section, more women than men raised the question of same-sex workers.

Safety for women
For women, the case for single-sex accommodation rests on:

* the sexist behaviour of male service users and staff
* the homophobic, biphobic and heterosexist behaviour of male service users and staff
* the ways in which staff respond to that behaviour

Previous research has shown that the issue of safety is pertinent to *all women who use services* (Findings, Social Care Research, 1994), but findings from this research also show (see Section 5.2) how knowledge about the sexual orientation of lesbian or bisexual women users can bring additional threats from male service users and staff, either as a result of physical attacks fuelled by biphobia and homophobia, or as sexual attacks based on heterosexism.

Situations which women found distressing and /or physically unsafe were numerous:

* knowledge / experience of physical assault, sexual assault, rape
* being subjected to, or observing, sexual comments, sexual harassment and homophobic abuse
* having to listen to misogynist conversations between men
* observing / experiencing aggression / threatening behaviour from men
* men being sexually disinhibited /running around naked
* men climbing into women's beds.

Risks from staff

Findings show that staff do not necessarily support women in trying to deal with such behaviour. Not only that, where fears about safety affected the behaviour of some women as well as their emotional well-being, it was felt that staff pathologised women's responses and their requests for women-only space, rather than addressing the real problems. Lack of staff attention to safety, dismissive attitudes and physical assault by male staff were also issues raised.

Women's views and experiences

> *"I really, really hate mixed wards. And I really don't think women should be made to be on mixed wards unless they want to be ... I mean I've been in wards where men have been running around naked, they've been offensive basically in a way that maybe they wouldn't be when they were well ... It can be so intimidating hearing them talk about women and sex ... then even if they don't do anything you know that they think about it, or they have done it ... I had men get into my bed countless times when I was in, countless times. Naked men ... I was usually too drugged physically to be able to have much energy, I had got this man in my bed and I felt so drained of energy, it was so hard to get out and try and find someone to move him ... That's the only thing I liked about the old fashioned hospitals, they locked single sex wards. I felt safe sleeping at night ...*
>
> *In the last hospital I went to, I was resisting going in, I've never gone in willingly. And they were asking me reasons for why I didn't want to go in. There were lots of reasons, and one reason I said to them was I didn't want to be with men. And their explanation was that it's a normalising influence. Women together get hysterical, and you've got to live in a world with men, so you've got to accept them. Well I suppose in some ways of course you have to, but not when you're mentally ill with mentally ill men ... I mean when I was in hospital women were raped. There might well have been women who didn't mind a mixed ward or would prefer a mixed ward. But I really don't think it should be allowed. Not at all. I mean, you don't know what a man's going to do when they are like that. ... It should never, ever be allowed to happen. That's the main thing. If they do nothing else, they should do that."* Kari, Lesbian
>
> *"I didn't feel safe on a mixed ward because you know, one of my friends actually got raped on that ward, on the ward I was on in [hospital] by a guy there. And I just think to myself, it could have been me ... And in the end she was totally drugged up to her eyeballs at night-time, so she couldn't stop him, because she was on too much medication to know what was going on. And she wasn't sure if it was rape or not, and I said look, you said no and he carried on. So it is.*
>
> *And she said to her primary nurse that she wasn't sure, and the primary nurse tried to make her play it down. And nothing happened to this guy who raped her. He was just moved to another ward, another acute ward not a secure ward, for three weeks and then he came back again into our ward. And this woman was still there. And this woman, she just wanted to forget about it, because that's what the staff told her to do of course. And they just played it down so much it made me really angry. If it had been me, I would have got the police in. Because this guy was under Section 3, I don't think that the police could have done much, this is what happens on wards. You get attacked by some nutter and because they're on section 3, they're not responsible for their actions apparently ... They just say, oh they can't help it. Yet if I'm really angry and start chucking plates around, which is what I do sometimes, they never say that to me. They say you've got to take responsibility ... It really bothered me being on a mixed ward a lot of the time. I never felt safe at night. I just wore*

loads of clothes at night, like my swimming costume in bed and stuff, so if he did try to attack me he'd never get in there because I've got all these clothes on. I know a lot of other young women on there felt the same. Because there weren't many young women, and we all felt like we were prime targets, not just from the other patients but from the staff. One of my friends there she was only like 16, 17, when she was on the wards, and she said she was sexually abused by one of the male workers there ... I didn't feel safe at all there. I was glad to get out of there. I was so glad to be away from there." Rachel, Lesbian

"I used to get lots of harassment on the wards from male patients ... like we had these big dormitories and this man came and got into bed with me. And all sorts of things happened. And all my key worker ever said to me was, 'You are a really beautiful woman, so things are going to happen.' And that was, she wasn't the only person to say it. There were quite a few staff on the ward would say that, 'Oh you're really attractive', or 'No wonder you get the attention.' Yeah. I mean I had people, male clients come up and just really push themselves up against me or kiss me, or whatever, and no-one would ever intervene. And on one occasion I slapped one of the men that did this, and that is something that's been in my discharge summary ever since, was that I'd been violent and antagonistic with other people on the ward. It really makes me furious." MH Project Worker, Lesbian

"When I have been in hospital it's been mixed wards ... I don't want to stay there, I'd rather say look I'm better, and have them think I'm better. But I'm not. I just go home. And then I end up back in there .... Which I hate because of the mixed wards ... I don't feel safe on a mixed ward. If I'm in hospital I just sort of stay in my room ... I don't hardly come out ... I would prefer to have women only space." TJ, Lesbian

"A woman was raped on a mixed ward by a patient that I had admitted ... I don't think I've ever got over the feeling that somehow I was responsible. There were some people who almost treated me like I was. It was just awful, absolutely awful." GP, Inner London, Lesbian

"I feel very strongly that women in hospital should have women only wards, both from the physical safety aspect and to be free from other types of harassment. Having to be on a mixed ward in hospital can feel very unhelpful for a lesbian, apart from the safety aspect which is an issue in itself. For example being put into situations which you have steered clear of for years, and having to deal with this at a time when you feel particularly vulnerable, only makes matters worse. In hospital I was beaten up by male ward staff, which I do feel was about anti-lesbianism." Tina, Lesbian

"But another thing we had, was because there was this thing in the special hospitals, where it was thought ever so good, I think this is a bit like secondary schools, where it was thought ever so good to have mixed wards for men and women. Now this is a bit like secondary schools where the girls do best in single sex and the boys do best in mixed, you know. It was awfully good for the men, for they're a far larger quantity in special hospitals. But even for heterosexual women, it wasn't good, because a larger proportion of women in special hospitals, even heterosexual women, have suffered violence and abuse from men than even in the general population, and that's large enough, God only knows. But the last people they want to mix with are the sort of men who are in special hospitals, a large percentage of those are in for rape, violence and murder towards women ... but it's seen as a good thing. And if women refuse to go on mixed wards, they're held back from getting out, they're not taking part in the sort of 'rehabilitative' programme. Now this may be excellent for the men, but it's not excellent for the women." Jay, Lesbian

Minority views

Whilst the above descriptions reflect the majority of women's experiences and views, a small minority stated that they did not mind whether wards were mixed or single-sex.

> *"When I've been in hospital, MSU's or whatever, the wards have been mixed - that felt all right, I didn't mind ... I wouldn't mind a woman only space or woman only ward. Don't mind that. But having male patients around me, it doesn't bother me."* Kerry, Lesbian

NHS policy

There is a move within the NHS to provide single-sex accommodation (DoH, 1997) but progress is slow and many women are still currently affected.

Safety for men

Attention has already been drawn (see Section 5.2) to the homophobic and biphobic abuse feared and / or experienced by bisexual and gay men in this study. In general however, men tended not to want single-sex accommodation and space, with both male workers and service users expressing a preference for mixed-sex environments. Amongst service users, findings showed three reasons for this:

◊ Gay and bisexual men feel safer and more comfortable when women are present.
◊ Women play a substantial role in providing gay and bisexual men with friendship and support.

> *"I do think that problems might arise if mixed wards are abolished. I mean there's pressure to have single sex wards at [named hospital], and I think in a way that actually will make it more difficult for gay people ... with mixed wards, where you have men and women, it is much easier to be yourself ... I think this is more of a problem for men. I don't think it would affect women so much. I think also that having mixed wards probably helps recovery more, because you have a variety of people you can talk to ... women are better at talking, men aren't ... women are much better at opening up, and so segregating men and women means that people will talk less about their experiences. And so it may hold them back from getting ideas about recovery, about accessing services, about standing up for themselves in the system."*
> Ron, Gay Man

> *"I think I prefer mixed wards ... I don't think I could feel comfortable in a single sex ward ... to me it would be a little bit odd. ... I would be worried about straight men. And I think generally women are a bit more easy to talk to. And most of my friends are women. So. I think I'd miss that."* Mark, Gay Man

> *"Men-only space wouldn't interest me at all ... I prefer a mixed environment ... most of my friends are dykes and nearly all the support I've had, the mental health stuff, has come from dyke friends. So that's what I prefer as my background."* Tom, Bisexual Queen

◊ A small minority of workers expressed the view that segregated environments do not reflect the wider society and are therefore unhelpful to service users.

> *"I think that it doesn't reflect society at all to have segregated ward environments. However, I do think that one of the ways that I tried to deal with*

this in the past ... was to have men only and women only spaces. And I found that to work really well ... I think there needs to be a self contained space that's private and with a door and you know, a cut off point. And some of the women on that ward I worked on, some of the women used that space a lot."

Peter, MH Nurse, Gay Man

Resulting dilemma

There can be no doubt that for women, single-sex accommodation would ensure a degree of safety which they are not currently experiencing. As has been shown however, gay and bisexual men experience mixed environments differently, thus some thought needs to be given as to how they could best be accommodated.

• Actively Tackling Homophobia

Two strands to this issue - which would also feed into the aim of ensuring safety - were identified.

Disciplinary and complaints procedures

Both service users and workers felt strongly that homophobic behaviour by individuals - whether staff or other service users - must be confronted and challenged. Some felt that homophobic behaviour by staff should be a disciplinary matter, if not a case for dismissal.

"I'd like homophobic behaviour in health workers to be a disciplinary matter in the same way that it is about racist behaviour." Peter, MH Nurse, Gay Man

"And if you have mental health workers who are homophobic, then they should be booted out frankly. They shouldn't be there."

Jan Bridget, Lesbian Information Service, Lesbian

Clear statements about unacceptable behaviour should be displayed and effective complaints procedures in place.

"I think there has to be a notice on the walls saying we don't tolerate homophobic or racist behaviour or whatever, and a lot of people would have to have that explained to them - what they mustn't do." Kari, Lesbian

"People need contact numbers so they can complain if they do have problems with services." MH Workers Focus Group

Equal opportunities policies

EOPs which include sexual orientation were seen as an important way of tackling homophobia and heterosexism at an institutional level.

"There needs to be equal opportunities policies and they need to be enforced ... at [named hospital] for instance, there's nothing about sexual orientation in the nursing philosophy. Despite the fact that a great deal of the senior nurses are gay men." Peter, MH Nurse, Gay Man

"I think it's an equal opportunities direct action moment, when you actually decide: we will hire lesbians and gay men. And bisexuals."

Peter, Community Support Worker, Gay Man

"NHS pensions are not equitable for lesbians and gay men, as far as partners are concerned." Clinical Psychologist, Adults, Lesbian

"Individual and institutional homophobia ... the whole system is homophobic. So you have to change the procedures, the policies ... that needs to be changed as well as challenging individual workers as well. Phenomenal, phenomenal task to be honest. But it needs to come from the top and the bottom and the middle. You can't just do it from one way."
Jan Bridget, Lesbian Information Service

- **Offering Choice In Terms of Worker**

Gender

Choice of worker was raised more frequently by service users than by workers, and appeared to be based on fears about safety, homophobia, lack of understanding and empathy. Having a worker of the same gender was extremely important to many women. However gender as an issue was raised less frequently by men.

"There are things like rights to a member of your own sex in all sorts of ways, like doctors, key workers ... And there's also, now they've got in prison, they have sort of key workers, they're 'personal officers', and well my friend's had male personal officers foisted on her, and she doesn't talk to men, can't talk to men. This sort of thing. There should be a right across the board ... people should have the right to say they want a member of their own sex if they want to ... Somewhere you've got to establish a relationship of trust and confidence, and it's quite obvious that this person can't do it with a member of the opposite sex - they should have a right to say I'm sorry, I can't talk like that to that person." Jay, Lesbian

"I asked for a woman therapist but was given a man." Tina, Lesbian

"I always prefer a female worker, I don't want male. They gave me a chap [key worker in hospital] - he is a gay boy but he is a gay boy that does not like butch lessies. So we never got on, and they never changed him. I wanted to be changed but they wouldn't." Jo, Lesbian

"I always pick a woman. I was fortunate with [S] because she was gay, so she understood where I was coming from. But my counsellor at the moment, she hasn't got a problem with my sexuality. And I haven't got a problem with hers." Kate, Lesbian

"It would help a lot if there was a member of staff who was gay and who was also out. That would really, really help. But the major problem is, never mind having a gay role model as such, we had a major problem having no male ... So I mean there's also the gender issue that comes in, because sometimes you know, there are certain things that you cannot, or would not want to share to a woman, you know, especially the explicit side of yourself. Which you wouldn't mind telling a bloke ... I mean, one thing I've always found, I don't know whether it's gay specific or not, but the fact is that there are many, many times they'll say you have a choice, what you say matters, what you feel matters, yet it doesn't. Whatever you say, whatever you do, is completely ignored. And that can be very, very frustrating." Pete, Gay Man

Other grounds for choice

Requests for workers were also made on other grounds - sexual orientation, age and ethnicity - by both women and men.

"Individual needs are not taken into account in my borough. I was told the CPN for my area was a man, I could take it or leave it, so in the end I left it ... I felt he had a problem with me being a lesbian ... Psychotherapy on the NHS also lacked any choice in terms of therapist and I do feel there should be choice in terms of worker's gender ... I went to an alcohol agency which was good at attempting to 'match' people with a counsellor. My counsellor was a lesbian and I felt this made a huge difference - it was easier for me to talk to her, and my lesbianism was never made an issue unless I felt it was an issue. Really I felt comfortable with my identity and it was like ... the cultural aspects of my lesbian lifestyle were not judged in a way they had been in other services."

Cathy, Lesbian

"I don't know if it should be compulsory that if you're a lesbian you see a lesbian psychiatrist, because there's other things to do with you. I mean if you're black and they're white, you might prefer to see a black man than a white woman. I don't know. But I think the option should be there and you should be offered a leaflet when you go in, saying would you rather see a man or a woman doctor, or if you are gay would you rather have a counsellor who is gay. I mean I know they couldn't have staff in every hospital, to provide for everyone, but I think there should be something, some way ... I have a feeling that the nurses are too young on the whole. They're usually students, almost everywhere I've been the majority of the staff have been young boys or young girls ... but I really think they should have a good age ratio on a ward because even an older person who isn't a lesbian will probably have met a couple by then. Or at least read about it or formed an adult opinion of it. I also think your key worker or your CPN or your psychiatrist should be of the same sex ... I mean try and get everything else, race and everything else right, but definitely the same sex, because you haven't got that power thing in the same way."

Kari, Lesbian

Work already carried out with minority ethnic groups to consider what makes a service appropriate, reveals similar requests. Bhugra (1993) points out that for services like counselling to be appropriate, considerations other than whether the counsellor is black need to be made, and may include class, race, religion and gender issues.

• Raising the Visibility of Lesbians, Gay Men and Bisexuals

Positive images

That services positively welcome lesbians, gay men and bisexuals can be indicated by making these groups more visible. Participants felt that having visual images, notices, leaflets, newspapers and magazines on display would help a great deal. Reception areas in services were considered important sites for such material, as well as within the service environment generally. GP surgeries, day centres and hospitals were particularly mentioned.

"I mean they've got posters all over the walls for people with drugs problems, drinks problems, people that have been raped, women that have been battered within marriage. Whatever. Child abuse. But yet there is nothing relating to sexuality at all ... that's the whole point of making literature of a helping nature accessible, to say to people you're not alone, there are people you can talk to. The very fact that it's obvious is a help. It's not like having to go to a library and sit away in a secluded corner and look up an address and make sure no-one's looking. It should be approached in that way."

Anne - Marie, Lesbian Orientated

"It's a real priority that mainstream services, whatever they might be ... have visible lesbian images, visible lesbian mentions in their leaflets."
GP, Inner London, Lesbian

Out staff

Creating an environment where staff are able to be 'out' would also help visibility, indicate acceptance of non-heterosexual identities and provide positive role-models.

"It would help in mainstream services if lesbian and gay staff were out."
Tina, Lesbian

"I think in the mental health field that if more nurses and doctors were able to feel safe about coming out, then maybe gay people would be able to use the mental health system more ... I think that it's a real shame that they can't feel safe enough in that environment to say they're gay, so how are you supposed to feel safe enough?" Sharon, Lesbian

"I think that it would make a huge difference if it was known that someone was lesbian or gay on the staff - that they were out and were a positive role model." CE, Lesbian

LGB space

Also creating lesbian, gay and bisexual spaces within mainstream provision was seen by some as another way of raising visibility - letting others know that there are 'out' lesbians, gay men and bisexuals using services, thus possibly cutting down on loneliness and isolation and again, providing positive role models.

"I think within mainstream services there certainly still is the need for things like lesbian and gay patients' groups." Psychoanalytic Psychotherapist, Lesbian

Procedures for dealing with homophobia

As highlighted elsewhere however, such initiatives need to have the support of staff who would challenge any homophobia aimed at people known to attend such a group.

"But would people feel safe in the mainstream services, going to a lesbian and gay meeting in a building where the majority of the users and staff are heterosexual. That's the difficult question that needs answering. Because you know some people may not wish to be that out. For me, I'm out but sometimes even I feel uncomfortable going in ... If I had the choice and the money to pay for a cab, I'd rather have it at [a lesbian and gay organisation]." Ayo, Gay Man

• Promoting Mental Health and Creating a Healing Environment for All Service Users

Areas which were not necessarily to do with sexual orientation specifically but were nevertheless identified by service users as ways of improving services, included greater availability of talking treatments, less dependence by professionals on medication, and the *promotion* of mental health. (See also Section 4).

The demand for 'talking treatments'

> *"And undoubtedly there is far more progress made by people who have access to regular professional counselling, compared to people who are simply dependent on medication."* Ron, Gay Man

> *"Well if I got ill again, as they think I'm getting ill again, I hope that I'd be given the chance to stay in the open hospital, not in the locked hospital. And be given more time. I mean in hospital, the majority of the staff are in the office, they are not with the patients. It is the patients who get themselves well, or the medication. Because the staff are in the office."* Kerry, Lesbian

Kerry spent ten years moving in and out of MH services before she received an appointment for 'talking treatment'. As Faulkner (Mental Health Foundation, 1997) points out, resources for counselling and therapy on the NHS do not meet demand, thus access to treatment is unequal. Lack of choice may be specific to particular groups and indeed a report by the NHS Executive (1996) suggests that black and ethnic minority people, older people, those with chronic illness, and lesbians and gay men, may all be discriminated against in just this way.

The quality of 'talk' between staff and service users

The suggestion that MH workers could spend more time with service users, particularly in ward situations, was made a number of times.

> *"I'm with the patients council and I do voluntary work ... and I found even as a patients council, the nurses ... most of the nurses are in the office ... We go into the wards and we spend hours there, to get the feeling of what's going on ... So what we have noticed is that there's no communication, proper communication, between the patients and the nurses, because the nurses are in the office ... And there's sort of commotions going on, and of course it has erupted before the nurses can get there. Whereas if the nurses were amongst the patients and properly doing their job, eruptions wouldn't happen. Nobody would get hurt. ... The only ward that contradicts that is [named] ward, we can't complain about that ward, because that should be a demonstration to all the other wards. Of how they should be working. Because the staff sit with the patients, they talk to them, they mingle. That is the only ward that communicates with their patients."* Jo, Lesbian

Involving service users

Collaboration with service users in writing up notes and medical records was another improvement which many would like to see.

> *"Patient and clients should be able to work with professionals in deciding what is written up. What is written in medical records can have huge consequences and follow a person round for the rest of their lives - yet the patients voice is never heard giving their perspective or opinion - users should be involved and able to participate throughout MH services. At the very least they should be able to read each note taking and sign or not depending on whether they agree with what has been written."* Service User Focus Group

Promoting mental health

A role identified for mental health services but considered neglected, was that of the promotion of mental health.

"If we're going to have good mental health services, I think they should be actively promoting what good mental health is. And providing explanations to the people that need them ... taking away a lot of the fear, because we only actually attack what we fear, what we don't understand."

Gina, Bisexual Woman

• Indicating Acknowledgement and Acceptance

'Naming' LGBs

Acknowledgement and acceptance of sexual minorities can be further indicated by including those groups in statements about the service, and by using inclusive language on forms and in assessments.

"I do wish they would put in their day centres the fact that they accept lesbians and gays ... Because when you walk into these day centres ... you suddenly realise they are all straight and you are apparently the only one there ... And they suddenly realise 'oh, we've got a lesbian in here.' And it's a bit uneven ... you kind of walk out, because you don't want to upset them." Jo, Lesbian

LGB orientation not pathologised

Inherent within such actions is the understanding that non-heterosexual behaviour and identities would not be pathologised.

"Another issue would be to make initial assessments more friendly. Getting rid of those kinds of things about always asking about marital status, and assuming that partners are heterosexual and so on and so forth. And assuming that families and partners are the most important people in people's lives, because it could be that there's another group of people that are more important."

Clinical Psychologist, Adults, Lesbian

Diversity

Indicating acknowledgement and acceptance of all cultural groups for whom the service exists is crucial, and also acknowledges diversity amongst lesbians, gay men and bisexuals.

"It should be made very clear that it's an organisation that is positive about it ... there does need to be positive statements ... statements on the wall saying that we try and offer a service that is sensitive to race, gender, sexual orientation and disability. That kind of thing. To be very up front."

Child and Adolescent Clinical Psychologist, Lesbian

"Ten years ago this service [MH day centre] decided to employ a black worker to do research around the needs of black and ethnic minority groups ... and the researcher discovered that over 60% of in-patients in the local psychiatric hospital were from Afro-Caribbean and Asian communities. But only 20% were using day services - so it was really a huge gap ... When I started here we had a women's day on a Monday and I was gob-smacked to see that it was so pure white and not even a soul of a black woman in there."

Development Worker, Lesbian

• Increasing Staff Knowledge and Awareness

Training was identified by both users and workers as being a major strategy for increasing staff knowledge and awareness, and as such is dealt with in a separate section below. However other ways forward were also suggested:

Creating and sustaining information resources

> *"Heterosexual workers should be able to find lesbian and gay professionals whom they can contact for advice."* Service User Focus Group

Referrals to LGB groups

Identifying LGB (or LGB friendly) organisations with which to network and possibly refer would be useful.

> *"What I'd like to see most of all is lesbian, gay and bisexual mental health support groups better publicised ... and used by professionals for referrals."*
> Ayo, Gay Man

> *"Mainstream services should have information about local LGB services. Improving knowledge should improve intervention."*
> Multi-Disciplinary Focus Group

Supervision, study and discussion groups

Improved supervision and allocation of time for team discussion and staff-led study groups. Some indicated that strategies such as these could be employed to deal with a range of issues, not just those arising from sexual orientation.

> *"They could learn how to be more tolerant towards other issues, not just homophobia, but racial issues and ageist issues as well."*
> Lincoln, Gay/Bisexual Man

> *"I think it needs something very basic actually. It needs the dialogue to start happening within teams. And it's interesting because you know ... I found using the word lesbian in a child mental health setting really embarrassing at first. What was this about? And I think it's because that conversation hadn't been had in that setting. So I think it's really important for people to start talking, and to start thinking about the issues, and start understanding that young people do exist, lesbian, gay, bisexual - and that there are lesbian and gay parents out there, as well ... and I think there needs to be a lot of information ... it is helpful to know about lesbian and gay youth groups for instance, I think that should be part of a mental health child and adolescent service, to know where the local groups are, and to positively say that to the young people."*
> Child and Adolescent Clinical Psychologist, Lesbian

• Training

MH workers

Mental health workers were asked a number of questions on training:

* was there a need for training?

* how could it best be satisfied if such a need was identified?
* what were the possible obstacles to training delivery and uptake?

Service users
Service users were not asked about training. However it was one of the ways most frequently identified by them as having the potential to bring about improvements in mainstream services.

Shared views
Training for students and workers across disciplines and service sectors, was identified by both workers and service users as having a key role to play in improving mental health services for lesbians, gay men and bisexuals, but it was also made clear that training needs in this area were not being addressed. That such training is vital to delivery of an appropriate service for lesbian, gay and bisexual service users has also been identified elsewhere (Murphy, 1992, Greene, 1994).

Rationale
Participants expressed views on why this training is necessary, to whom it should be delivered, what the content should be, how it should structured and who might deliver it. Professionals also commented on what they felt the obstacles to training might be. Only one person expressed strong doubts about the utility of training.

• Why Training?

Both service users and professionals identified training as a way of improving services, but service users in particular drew attention to *'why?'*.

To eradicate attitudes which pathologise
Whilst mental health workers are just as likely to hold the same anti-gay attitudes as those held by the mainstream culture, there are also professionals still working in the field of mental health who have actually been trained to think of homosexuality as an illness. Textbooks currently in use with some students still consider causes of homosexuality and pathologise certain homosexual 'types' (Sayce, 1995).

> *"Current training still pathologises homosexuality. Training needs to be reviewed and the content updated and developed. Updated training should be given to all people involved with service delivery."* Service User Focus Group

To combat ignorance, prejudice and discrimination

> *"The strange heterosexist crap and anti-lesbian crap that comes out ... I actually think it's about hatred and ignorance and prejudice. And that needs training to go right back into the fundamentals of every counselling practice there is ... not just counselling and therapy but nurses, GPs, right across the board."* Julie, Lesbian

> *"And I just think there should be something done along those lines that you know, not every gay man that they're going to be caring for is HIV positive. Not every lesbian that comes through the door is going to be a separatist and not like male children ... there's all these assumption made that you're going to be*

this particular person. And I think there needs to be recognition of the diversity within those groups."
Sharon, Lesbian

"[We need] training in terms of building awareness and also, looking at over-representation of certain groups in services, and what that's about, why that is."
MH Project Worker, Lesbian

To educate about lesbian, gay and bisexual issues and lifestyles

"I suppose the best way forward would be for them to understand what it is to be lesbian or gay. I mean if the service providers are influenced by the gutter press, the media or anti-gay legislation and so forth - society's attitudes. If they bring those along into their profession then that is really very, very unacceptable...If service providers are not educated about homosexuality, and what makes us tick, then they will never be able to provide us with a good service."
Pete, Gay Man

• Who Needs Training?

Staff already in the field

Training needs were identified across the board: across all sectors, including provision in special hospitals ...

"I think there should be a structured sort of retrain across the board ... what we need to do is raise the profile of the issues in discrimination against lesbians and gay men in mental health services. And that means raising the profile across the community sector, the private sector ... and in the statutory services."
Julie, Lesbian

"We need to also acknowledge lesbian and gay clients in special hospitals ... and we're talking here about institutional practices from staff, whose practices are such that you haven't got a hope in hell, they can't even meet people's basic needs really ... so how are they going to meet people's needs when you bring in a sexuality component. And lifestyle. It's not going to be met at all. Because of that institutionalisation. Lack of training, lack of awareness, and also in a lot of these hostel accommodations, the staff are getting paid £3 an hour ... you're getting unprofessional staff, most of the time ... What I'm saying is that it's not professionalised, the system, there's not enough basic training ... it's not there. Not there at all."
Terry, MH Social Worker

... and from top to bottom in hierarchical institutions:

"Definitely from the psychiatrists and the junior doctors, to the registrars, right down to the nurses and the nursing assistants on the floor ... people that worked within that profession ... educated from the top to the bottom."
Anne-Marie, Lesbian Orientated

Students

Training for students, as well as for those already working in and providing services, was seen to be necessary throughout professions and within particular areas.

"I don't think there is really any LGB content in student training in psychiatry."
Consultant Psychiatrist, Lesbian

"Unless I raise it or force the issue LGB issues don't come up in GP training."
GP, Inner London, Lesbian

"I think for counsellors the issues need to be raised at the training level ... Any organisations I'm involved in, I'm very active in ensuring that issues of anti-discrimination get fed in right at the start, they're in the code of ethics ... I'm involved in an accrediting body at the moment ... and I feed information into that through my training organisation ... trying to be really clear that yes, in order to be accredited through this body you have to have done some training on anti-discriminatory practice."
General Practice Counsellor, Inner London, Lesbian

"There needs to be training for those people who work in casualty - it's really important that our response to deliberate self-harm in young people includes an awareness of lesbian and gay issues."
Child and Adolescent Clinical Psychologist, Lesbian

"LGB issues are not taken into account in the training of student nurses. Also, some people have not come across it in social work training, though bear in mind that colleges differ tremendously in the content of curricula."
Multi-Disciplinary Focus Group

Auditing the training curricula of professional bodies for LGB content, and including LGB issues in curriculum guidelines, were suggested by the multi-disciplinary focus group as steps towards bringing about standardised training in this area.

• Thinking About the Content of Training

Cultural awareness

Many of the areas identified as needing to be addressed within training sprang from a desire to increase understanding and awareness of the lives of lesbians, gay men and bisexuals.

"I think the first thing that you need to do when considering cultural awareness training is to look at the lives of lesbians and gay men in the same way as one would ... Bengali communities, Hindi communities. I think we actually need to include it in professional training and see it as being part of our necessary knowledge and understanding of lesbian and gay communities."
Rachel, Consultant Clinical Psychologist, Lesbian

Coming out

Consideration of conditions unique to LGBs was regarded as an important educational objective and has also been identified by others (Forrister, 1992, Lee, 1992).

"Whenever I give lectures on working with lesbians, one of the things professionals never understand is the significance and importance of coming out in lesbian communities. And one of the things I always tell them to do is go off and read coming out stories, because that actually gives you an understanding of a hugely important part of lesbian culture. But it doesn't have a parallel in heterosexual culture. So I think people need training in understanding lesbian and gay communities."
Rachel, Consultant Clinical Psychologist, Lesbian

Difference and diversity

> *"When I'm doing training on this issue, I always talk about 'lesbians' and 'gay men', and you invariably find that someone in the group starts talking about 'gay women'. And I say 'actually, I don't wish to be referred to like that'. And going into some of the differences that exist within lesbian and gay communities, and the importance of those differences to the individuals concerned. You know, whether someone believes they were born that way or made an active choice. Whether they see themselves as gay and part of the gay community, or lesbian and part of the feminist community, whether they choose to call themselves dyke or whatever. All of these actually have a huge amount of political meaning within a lesbian community which is completely lost ... I think you also need to have an understanding of the resources available within L and G communities."*
>
> Rachel, Consultant Clinical Psychologist, Lesbian

> *"I always bring sexuality into training wherever possible just to get them to think about differences and I do it as a matter of course re disability ... so it depends on the setting but I set scenarios, for example a gay man with a hearing impairment ... and ask them to consider these."* Brenda, Lesbian

Anti-heterosexism training

Some further identified a need for training about homophobia and heterosexism and how they operate, and how homophobia can be confronted.

> *"Nothing is done about homophobic comments. People need training to challenge homophobia as they do not know how to do it. This may change the work culture more effectively."* MH Workers Focus Group

> *We did a questionnaire [at the day centre] for the users to fill in confidentially ...one of the things they said about how they would like us to improve services was about the lack of training around issues like homophobia, sexuality, racism - all the 'isms' ... users felt there was a lack of training and awareness around things like that ... that was a year and a half ago and we are still waiting."*
>
> Development Worker, Lesbian

• How Should Training be Structured?

Integrated training

It would seem that student training which *has* included LGB content, tends to have been delivered as a separate section 'added on' to the main body of the course. Most people however had a preference for the integration of such content throughout the course.

> *"Having a special slot on sexuality seems to differentiate 'homosexuality' yet again. There is also the concern that students are already overloaded. I think the best way of implementing it would be to insert LGB content into each section as you go along - but again, I wonder how realistic this really is. I would be interested in developing training but thing like how, for whom and by whom all need to be given a lot of thought. Forming a group to tackle some of these issues might be the next step."* Consultant Psychiatrist, Lesbian

Top-up training

One-off days or a number of hours devoted to LGB issues over a few weeks, were nevertheless seen as important in the delivery of training to staff already working in the field. This approach was also identified as perhaps being a necessary part of student training whilst *trainers* underwent training themselves.

> *"I think it would be quite an uphill struggle to suddenly expect all people coming to teach about different aspects to then think about lesbian and gay issues, particularly if they haven't had training themselves. So it's sort of a stepping stone, having one day or one day a year or something, specifically devoted to raising lesbian and gay issues and those kinds of perspectives. And then encouraging trainees to keep on asking people that come to teach them ... to include or consider issues of sexuality and issues of race and so on ... One day kind of sits a bit uneasily, really - well today we're going to talk about black people and then later today we're going to talk about lesbians. But otherwise I think it can end up by being completely hidden and not covered at all. So starting off with a bit that's separate, and then moving into being able to integrate it."* Clinical Psychologist, Adults, Lesbian

Should training be compulsory?

In thinking about training for staff already working in the field, the question arose as to whether such training should be made compulsory. Several people observed that training available on a voluntary basis tends to be taken up by those least in need of it, yet there did seem to be some reluctance about forcing people to attend. Some of the issues involved are further raised under '*Obstacles*'.

> *"There's issues about, do you give training to people who are interested in it, or do you make everybody do it. And I can never decide really. Because obviously you want to get to those people who don't want to be there, and maybe you do need to make them be there, but ... they can be really disruptive. I guess they're also raising lots of issues that means you can have a discussion ... But I find it difficult to say you've got to turn up. I think even people who might otherwise have wanted to go, sometimes don't want to turn up if it's compulsory."* Clinical Psychologist, Adults, Lesbian

> *"I think it should be that everybody has to go on the course. Because young people that I'm working with, sexuality is part of everybody's identity and it's so important."* CE, Lesbian

• Who Should Deliver Training?

This brings us to the question of *who* would be best placed to develop and deliver training, and although it would seem that this very much depends on context, many would like to see training delivered by:

LGB service users and workers

> *"... go in there with quality training packages with a whole team of trainers who happen to be lesbian, gay, transsexual, bisexual - whatever ... I think it needs to be a mixed team. I think if you have people who have been professionals, either professional trainers and still are professionals in the mental health services, their experience is equally valid and equally important. But to actually combine that with the power of having users and survivors on that team of trainers, I think is crucial. How else can you actually start to address the dynamics of power and powerlessness and the experience of abuse*

at the receiving end of the system, than actually have it from the horse's mouth." Julie, Lesbian

"I think it helps also if there are out lesbians and gays on the training staff as well. Because that gives permission to people to be out, to think about the issues." Child and Adolescent Clinical Psychologist, Lesbian

LGB organisations (see also 6.2 below)

"Once again I think a specialist LGB organisation having outside facilitators and trainers who can come in and do a training programme - I think that's important." Terry, MH Social Worker, Gay Man

"There should be a strong element of user involvement in training courses, both in developing course content and in delivery of training. LGB organisations should recognise that there are a lot of users with skills and training who could be considered as trainers for MH professionals."
Service User Focus Group

• Obstacles to Training

A number of obstacles to training were observed:

Unrealistic assessment of what is needed

"Ignorance. And by that I mean there is a tendency for most liberal, well-meaning professionals to say being lesbian or gay is no different from anything else. And once you start from that premise you don't need to do anything else ... I think there's a huge amount of people assuming that they already know all about gay men ... and in fact actually the number of heterosexuals who I know who have the faintest clue about lesbian or gay communities is tiny ... I've actually heard professionals say 'are you butch or femme?' as if this was the most obvious thing you had to ask someone!"
Rachel, Consultant Clinical Psychologist, Lesbian

Lack of resources

"There are several obstacles. One, - just people's homophobia, full stop. But also ... mainstream services are extremely depleted, everybody's knackered, it's as much to go to work never mind to go on a training course as well. In their self-interest they look after themselves so ... that's another obstacle, resources."
Peter, MH Day Centre Manager, Gay Man

Insufficient co-ordination and standardisation

"Training for all health professionals seems to be so patchy, so piecemeal, so uncoordinated ... it's just anarchic, there's no sort of proper framework, there's no proper thing of putting together portfolios of what each person's training needs are ... If you decide to run a course, you just decide to run a course ... Anybody can run a course and try and get it accredited - so it's very, very unplanned and whether things have lesbian gay and bisexual issues on the agendas of their training just totally depends on the desires of the people who are providing the training. So if the people who provide the training are kind of

aware people who've got that as part of their ... issue - it gets on - and if they haven't, it doesn't." GP, Inner London, Lesbian

Defensiveness

"I'd say a lot of people get very twitchy and nervous about it - defensive. They think they are in some way lacking because they don't know how to do this thing called anti-discriminatory practice, they think somebody's going to turn round and point a finger at them and tell them they're racist, or homophobic. If somebody says to them you need to do training in this, that means that you think that they're lacking. Well that is true. But at the same time it is met with defensiveness. For the most part. Rather than, 'you're right, this is a gap. This is something I'd like to learn' ... But - 'no, I don't want to do anything on anti-discriminatory practice ... no-one's going to call me a racist.' ... I think that is the response for a lot of people." General Practice Counsellor, Lesbian

Homophobia

"I think some people would think that training about lesbian and gay men is a good idea ... they'd see a need for it. But I think there'd be quite a lot of people that would probably be quite resistant to it as well. Particularly thinking of my own line manager. Who doesn't think that young lesbian and gay people should have support in a sense, or be supported in going along to young lesbian or gay youth groups ... Don't do anything that promotes their sexuality ... So with those kinds of attitudes around ... I think it's probably a lot of the management who sort of uphold those attitudes as well, management who's been there for some time." CE, Lesbian

Backlash against equal opportunities

"But also I think there's a sort of backlash against ... what's been perceived to be an over-equal opportunities environment, and there's a sort of 'oh no, not lesbians and gays as well as Blacks and Asians and Jews.' "
Peter, MH Day Centre Manager, Gay Man

6.2 The Role of Specialist LGB Services

As stated at the beginning of this section, the majority of participants identified a need for both mainstream and specialist LGB services, with only a minority expressing doubts about either. Of the majority, many talked passionately about why they wanted specialist services, the types of services they felt there was a particular need for, and how they would like to see those delivered. Roles for specialist services identified by MH workers in particular, were the development and delivery of training, providing information resources and advocacy, and acting in a 'watchdog' capacity to ensure that mainstream services improved. Service users were more inclined to want hands-on treatment and care.

• Why Do We Want Specialist LGB Services?

There were a number of reasons why participants felt specialist services were necessary:

* not wishing to be on the receiving end of homophobia and heterosexism
* more likely to receive empathy, understanding and rapport
* would not have to educate
* sexual orientation would not be pathologised
* opportunity to meet people with positive sexual identities
* loneliness and isolation would reduced.

Not wishing to be on the receiving end of homophobia and heterosexism

> *"I took part in group work at the day hospital, but I think there is a problem with group therapy or group counselling for lesbian and gay people in a mixed context. Because there is a tendency - I think there is a tendency no matter how tolerant people may be, I think there's still a tendency to gang up on say, if there is only one lesbian in a group, or one gay man, or even a couple of lesbians or whatever. I think there's a tendency to gang up or pick out those people ... I think gay people, I can't speak for lesbians at all, but I think a lot of gay people, if they're put into group contexts which are mixed, they will drop out after a few sessions, they'll drop out, because they feel a bit uncomfortable."*
>
> Ron, Gay Man

> *"So you can't just say well, we've got an equal opportunities policy and lesbians and gays are welcome here, which a lot of services are doing I might add ... They just say, we welcome lesbians and gays and are doing nothing whatsoever about it. So a lesbian and gay will go along and experience horrendous homophobia ... So meantime there is a need for separate provision."*
>
> Jan Bridget, Lesbian Information Service, Lesbian

More likely to receive empathy, understanding and rapport

> *"I go to ordinary groups but going to a lesbian and gay user group is an added bonus. I have something more in common ... having more in common means you can help each other, that's what I believe."* Mark, Gay Man

> *"I mean when I came to [specialist LGB service] it was very much about the sort of sexual side of being a lesbian and trying to understand myself. I couldn't get that out of going to a straight counsellor, I don't think they'd really know the sort of technicalities or anything of it. And really understand what it's like to be a lesbian. And I think that's what, I know that's what I wanted, I wanted someone who really understood what it's like to be a lesbian, who could share my experiences ... That's why I came to [specialist service]. To strictly deal with being gay. Instead of all the years I've been dealing with being religious, being from a strict family, being a bit of a worrier, being a bit neurotic. All the rest. I just wanted to deal with being gay ... and I wouldn't have gone to a straight place to deal with that."* Justine, Lesbian

> *"I think there is an absolute role for specialist services ... there's a whole lot of bullshit that you can then just step over. A lot of it is around language ... the words you use, the experiences you have. A lot of it is around empathy. And*

givens, things that are given and understood, and things that are not. And a kind of cultural rapport, if you like, that's kind of in place."

Peter, Community Support Worker, Gay Man

Would not have to educate

"Well I personally like the idea that there should be or could be something along the lines of specialist services - I would be much happier. ... You'd then have caring, knowledgeable staff and you wouldn't have to spend your time educating them before you get through the door. It takes a lot of energy to fight that kind of ignorance and discrimination, so yes I would be on for specialist services."

Brenda, Lesbian

Sexual orientation would not be pathologised

"I think I probably would have felt more comfortable [with a specialist LGB service]. It would have been sort of more normalised I suppose. And I just felt that when I was in hospital ... that I was struggling with my own sexuality and they would have seen that like an extra problem or an illness, something else that was wrong with me. Rather than something that I needed to feel ... deal with and learn to feel good about. It would have been the opposite, I would have got the opposite."

CE,Lesbian

Opportunity to meet people with positive sexual identities

"If for example I want to have a partner, and not everybody does want to have a partner, but if you do want that ... you find there are no rules and each couple has to create its own, and there is nothing to fall back on, nothing to refer to. We can't go to our mammies and say what is it like to be a lesbian, how do I deal with this, like you could if you were heterosexual and you were having a baby or having problems with your husband ... So I mean there is no- one to turn to, no-one older, unless you have older lesbian and gay friends and not many people have. I mean older lesbians and gays kind of disappear - we don't have a network of older, wiser lesbians and gays, which may be why services like these are so important actually, like a substitute family thing, extended family, where you can go and see more experienced people who have a positive identity."

Counsellor, Gay Man

Loneliness and isolation would be reduced

"There's not many places in [London Borough] that take on lesbians and gays coming out of mental health situations. We don't have that ... It would be lovely for me to go into a day centre that's mixed gays and lesbians, I'd love that ... I would, because I am the only lesbian in [day centre]. And they got a shock when they found out I was lesbian ... they kept asking me about my husband and I had to make it clear to them there's no way I'm married, and I said whether you like it or not, I am a butch lesbian. And the shock on their faces ...so not to have people being shocked when you do come in. But I do feel a bit out of it ... I do love it there, because of the arts, the crafts and everything ... It's therapeutic to me, very therapeutic. Because if I didn't have that, I would go insane. But the point is, it would be nice if there was a few lesbians, a few gays ... so that I could have better communication ... Because what you hear about is their husbands, their children and all this and really, it's not your conversation,

because you don't live that way ... And you tend to get negative about things because you can't join in ... So in that respect you feel a bit left out. So I think it would be lovely if they had, ah, wouldn't it be lovely, I'd be in my glory if they had places like that."
Jo, Lesbian

• Range of Services Desired

Difference in emphasis
Findings showed some differences in the roles service users and professionals thought specialist LGB services should play:

◊ Workers tended to consider the major role for specialist services to be in training, information provision, advocacy and being a 'watchdog'.
◊ Service users identified a number of areas in which they would like to receive care and treatment from specialist services, as well as support and advice. Of these the most frequently mentioned were:

* crisis services, particularly crisis and longer term housing
* counselling and therapy
* LGB MH service user groups
* groups with awareness of MH problems for young LGBs
* self-help and facilitated groups with a particular focus
* befriending services.
* prevention.

Service delivery
Participants also drew attention to some of the ways in which they would like these services to be delivered:

◊ In terms of time and place for example, people wanted local services, available often and with a wide range of opening hours.
◊ Services need to be well advertised and that providers should be knowledgeable about them.

• Training, Information Provision, Advocacy and 'Watchdog'

Being a resource for mainstream providers was identified by some workers as a key role for specialist LGB services. This was partly to do with the convenience of having 'experts' on hand when specific needs arose, and partly to do with ensuring that lesbians, gay men and bisexuals had access to the same range of services available to service users generally.

"Whilst mainstream services are not able to actually address the needs of lesbians and gay men, obviously it is very tempting to set up specialist services. But those specialist services can never offer the range that mainstream services can offer ... I would have thought that a role of any specialist service should be not only to offer a direct service, but should be to work via mainstream organisations. To actually improve and change the sorts of care that they receive, so I'd actually prefer to see specialist agencies doing training, as much as they are doing individual work."
Rachel, Consultant Clinical Psychologist, Lesbian

"I see a need for an organisation on similar lines to the Afro-Caribbean MH Association. I can see that there is a real need for a place where people can go where barristers and solicitors can actually be accessed, and also trainers and many things ... One of the things that comes to my mind is how many advocates have you seen for patients on mental health wards? ... So it's for all professionals to access, it's for users to access ... I think that's the way forward, the vision we must stick to ... It's about having a professional force that psychiatrists would know ... They could say, this person's needs are not being met on the ward, I wonder if this organisation could help with some input. And outreach work ... our staff have got a bad attitude, maybe we need a trainer from there to come and do some training." Terry, MH Social Worker, Gay Man

"I rang up about a year ago for signers for a conference we were having and they couldn't tell me about a lesbian or gay signer - they didn't keep that kind of information. I could get a black signer but they didn't know whether they had any lesbian signers. Now to have a specialist service means that you don't have to bother with all that ... it saves so much time and effort ... For me it is about having a network of information from which I can make a choice according to what I need at that particular time. I need different things at different times. Sometimes I just need a telephone conversation, and sometimes I need a certain number of weeks a month and sometimes I need a one-to-one, sometimes I just want to talk to somebody ... there can be a range of things I need at any particular time.....For me its about having that range of needs met."
Brenda, Lesbian

• Crisis Services and Housing

For LGBs, by LGBs

Crisis services, crisis housing and longer-term supported housing were mentioned frequently by service users as particular services they would like to see being provided, and are not dissimilar to findings from consultations with service users generally (Sayce et al, 1996). Here however desired services such as crisis housing, longer term supported housing and out-of-hours drop-ins, would be specifically *for* lesbians, gay men and bisexuals and for many, *by* lesbians, gay men and bisexuals. Having women-only space was also seen as crucial. Having these workers available in a crisis, and being able to work with them on a longer term basis, was seen by most as very important and stemmed from feelings of being understood and empathised with, as well as not having to deal with homophobia (see above). The lack of hostel accommodation specifically for women and those with MH difficulties was also raised, as was the difficulty of being discharged from hospital as a homeless person.

Crisis housing

Provision of crisis housing was identified by many as a specialist service they would like to see given priority.

"It would be important to have separate provision, a crisis house, crisis houses ... maybe gay men want to meet separately from lesbian women I don't know. But there should be a choice. And I do think it's important to have crisis houses because there are times when actually we do need respite care or residential care, I'm not denying the level of distress that I can get into.

If you had a choice of crisis houses you might have one that was a kind of half way house when you're actually coming back into the community, rebuilding

your life and going back home. And that one would actually just be a network of the clients in that house, with staff that don't live-in but actually come in maybe three times a week to run groups. See how the houses go, see how the individuals within the house are doing, etc, etc, but for the most part that group living in that house actually run it for themselves. So that's your kind of halfway house. But that's a step back into the community.

But a crisis house that's offering respite care, I think should be staffed round the clock. And I think the staff don't necessarily need to be lesbian and gay, but they certainly have to be pretty shit hot on all the issues ... the discrimination that we face. And the fear and hatred we face on an every moment level. Out here in the wilderness. And I would expect that to be quite well structured, I think when people are in crisis they need a lot of support. And I'd expect there to be somebody who offers a kind of casual counselling role who you could come and talk to at any time really. Now that would need to be rotated because you couldn't have one person trying to carry that on their shoulders. But otherwise there should be structured meetings so that you meet at least three times a week. So that you know there's going to be a time that's just for you and you can just let off steam just talk, or whatever. And then activities like art therapies and music and all that stuff. Or just sitting round writing together, and you know, starting to structure your thoughts and engage in activities outside of yourself, I mean I can get lost up me own arse, you know. When I'm in crisis."
Julie, Lesbian

"I think that specialist services are very important. I would like to see a crisis house and long-term supported housing for lesbians, but because of previous experiences in places like that, I'd want a clear staff structure - some professional support provided for those using the services." Tina, Lesbian

"A crisis house for LGBs would be excellent, yeah. Definitely."
Stephen, Bisexual Man

Longer term supported housing was also an important issue

"Speaking in terms of women I definitely think in terms of more sort of long-term residential projects, there need to be more women only projects ... I think in a way it would be good to have lesbian only projects, but there's always the issue then about how much people want to be identified in that way I suppose. At least have women only projects that are more open to the idea of different sexual orientations - not just assuming heterosexuality. But yeah I think definitely residential and long stay places for women who have been abused over quite a long period." MH Project Worker, Lesbian

"I don't think they should do what they're doing to me, and put people from hospital into bed and breakfast. Nobody should ever have to leave hospital and go to bed and breakfast, I mean bed and breakfast is appalling for anybody to go, it doesn't matter who they are. Whether they're ill or not. It's enough to make you ill.

Because what they do to me is, I leave hospital and I have to leave with no address, and I have to go to the homeless persons unit that day and get somewhere to live. So I'm leaving hospital to no fixed abode ... I think there needs to be better housing, because there's not enough hostel vacancies for mentally ill people as it is, and the standard of hostels is quite dodgy ... I think there needs to be a lot more housing, a lot more choice, like different kinds of housing, not just traditional hostels. Stuck in a dormitory and stuff with loads of strange people and everything. I heard about this scheme where you have a

flat in a block, a nice flat, and there's a warden there who's on call all the time. So if you have a problem there's somebody there. Yet you're still independent.

You need lots of different stages of accommodation for people to move through. Because that's what I found for me, you know, there's very little choice when it comes to accommodation. And there maybe should be a lesbian and gay place like a hostel. For people with mental health problems. And there should be women-only ones, because there's quite a few men-only ones I found out in [London borough]. Because I'm under [London borough], and I found that there's like men-only projects, there isn't any woman-only projects. And that doesn't seem right to me. The women need the projects more than the men in a way, and all the mixed ones are male dominated, so the men are getting all the housing practically ... I don't know what they expect women to do, probably go back to their families and stuff. But what about women like me who haven't got anywhere to go?"
Rachel, Lesbian

"Community houses would be very, very desirable - because when we had this new consultant, when I first went to my CPA with him, he said my being at home is detrimental to my health, because my family do not understand my sexuality ... and so he suggested that I move out double quick. And my financial situation is such that I said I couldn't really move straight away ... He suggested some kind of hostel, and he said there are Asian hostels ... And this is when it came up, and I said, 'But are there any gay hostels?' and he went very, very apologetic, he just looked down he didn't even say yes or no. And I said 'Yes, I would be more than happy to move out if there was a gay community home' ... that would be very important to have."
Pete, Gay Man

Out-of-hours drop-in

"What I'd find useful now is a LGB befriending service [see also below], some sort of crisis service. Where you can be with people, it might be for an hour, it might be for a few days ... just to be somewhere else with people who understand and help you through that crisis. These are the sort of services I felt I needed and they weren't there. I would prefer a lesbian and gay specific service - already we have a small network of drop-ins or social groups around London. If that could be expanded and built upon, into a full-scale service ... there would always be somewhere open you can go to in a crisis. And know that there would be somebody there you could talk to ... and I think lesbian and gay facilitators, I think that would be an essential part of that."
David, Gay Man

• Counselling and Therapy Services

Counselling and therapy services specifically for sexual minorities were frequently referred to.

Building trust

In order to use counselling and psychotherapy effectively, to be able to discuss intimate and difficult topics, any client has to feel confident that they will receive respect, understanding and empathy.

"I mean it was always an issue, it was something people wanted ... We happened to have a woman heterosexual counsellor and gay men were constantly saying to me she doesn't understand what it's like to be gay. And it's definitely something that gay men wanted, they felt it would be better if they had someone who was gay who would understand them, I mean I don't know

whether she could understand them in the same way as another gay man could. And I think they felt that, and they used to get quite angry. And say to her you don't know what you're talking about, you're not gay, you don't know what it feels like. You don't know what it feels like to be rejected and be marginal ... I think that is an issue. I think there does need to be more gay counsellors or psychotherapists, or whatever you like to call them ... I think that is a big issue actually, having gay staff. Which certainly in social services is not likely to be, because obviously they don't employ people on that basis."

Community Care Manager HIV/AIDS, Lesbian

Finding a counsellor who will not pathologise LGB orientation

Lesbian, gay and bisexual clients have the added difficulty of not knowing how their sexual orientation will be received, and many are fearful that it will be pathologised.

"I've often thought that I want to sort of understand more about the gay life. I've always had a thing in my mind about why am I gay. Why, what happened? ... I need to learn a lot more about myself, and I need to learn it more or less sooner rather than later. Because at the moment I don't properly understand my sexuality although I know I'm gay. Coming to terms with it is a separate issue. And obviously getting the right help on that side of things. Because there's no gay counsellors that you can get free. When you're on benefit. It's much harder to get help, because you haven't got the money. They don't seem to provide enough services of gay counselling, for people on benefits. And that's nation-wide. It's always something you've got to pay out for." Jaymee, Gay Man

"I don't think we're at the point, because there are still people who approach specialist counselling services - presumably they feel strongly that unless they see a lesbian or gay counsellor, they can't trust that their experience is going to be taken seriously. Now you know, that may not always be true, but if that's the experiences they've had - it's led them to believe that that is the only place their needs are going to be taken seriously, then I think that has to be respected and worked with. Because it's a kind of symptom of the culture we're in."

Psychoanalytic Psychotherapist, Lesbian

Therapy on the NHS

Given that the vast majority of consultant psychotherapists within the NHS are trained in institutions which are known to be homophobic, it is hardly surprising that many participants highlighted LGB specific counselling services as being of the utmost importance.

"I'm not sure if you know but consultant therapists in the National Health Service are required on the whole to have trained in one of the psychoanalytic organisations, which belong to the British Confederation of Psychotherapists. And they are the most conventional in terms of how they see psychoanalysis, and certainly in terms of how they see homosexuality. So their attitudes are likely to be pathologising." Psychoanalytic Psychotherapist, Lesbian

Access to counselling

It was also emphasised that LGB organisations which provide counselling have a role to play in addressing the counselling and therapeutic needs of those lesbians, gay men and bisexuals with more serious mental health problems.

"What I think needs developing, and shouldn't be difficult to do, is a more concerted effort to provide shorter term counselling ... for lesbians and gays who would normally be regarded as being very distressed. Or have severe, chronic mental health problems. I think they get overlooked, I think they get passed on to specialist mental health agencies, without regard to their needs as lesbians or gay men, or their need to go to a lesbian or gay service ... I think that these organisations ought to develop strategies and ways of being able to work with people. It's partly an attitude thing - it's probably mostly an attitude thing - so lesbian and gay institutions and counselling services need more mental health training." Peter, Mental Health Day Centre Manager, Gay Man

• Lesbian, Gay and Bisexual MH User Groups

As indicated in Section 5, general MH service user groups have rapidly expanded in the last ten years (Campbell, 1996) but there is a feeling that LGB issues are not really understood or even considered. We have also seen that service users are as likely to hold prejudiced, discriminatory and homophobic attitudes as anyone else. User groups specifically for lesbians, gay men and bisexuals were therefore very much in demand, and were valued for the support, friendship and opportunities for socialising which they provided. However common complaints included:

* lack of local provision
* held infrequently
* not well enough advertised
* lack of networking between groups.

"I tell you what I would like to see. I know there are lesbian and gay mental health groups in London. But they're too far away to get to ... I'd like to see more lesbian and gay groups at places that are more accessible for people with mental health problems ... It helps to talk to people who have been through a similar experience. It's a bit like coming out all over again really. Keeping in contact so you don't feel isolated. Because often the problem with people with mental health problems is that they are isolated people ... These are often people at risk from committing suicide, because they feel so desolate and lonely. These are the sort of issues that need to be addressed."

Anne-Marie, Lesbian Orientated

"The lesbian and gay MH user group - it's once a fortnight. So that's why I'm saying it would be best if we could have it like once a week or something, somewhere to go - it gets you out of the house and meeting new people as well. There should be more locally." TJ, Lesbian

It was also suggested that provision of such groups was necessary within mainstream services as well as outside them.

• Groups with Awareness of MH Problems for Young LGBs

There was also a demand for more groups for young lesbians, gay men and bisexuals which addressed mental health issues. Some youth groups were found to be excellent in this respect, but participants also drew attention to the failure of others to be inclusive or supportive of young people with mental health problems. Yet it

was precisely this sort of group which young lesbians, gay men and bisexuals felt would meet their needs - providing opportunities to meet lesbian, gay and bisexual peers for example, and finding support around acknowledging and accepting their sexual orientation and thinking about coming out.

> *"Well I definitely see it's important to have youth groups, definitely. I mean where else are young people who don't want to go out to clubs - and clubs are useless anyway, you don't get to meet anyone. But where else are young people going to meet each other if they don't go to youth groups. There's nowhere else. I mean I met all my friends practically from going to youth groups. And you know, I've met so many good people, and it's been an absolute lease of life, being able to go and just relax with people and feel safe that you're only around gay people, therefore if you ever see them out of that group, they're gay as well, and they understand and even if they're out, that they won't out you to people. I've always felt safe in that way there.*
>
> *But you couldn't feel that going to a straight youth club and telling anyone you're gay or anything. It just wouldn't work. There's too much homophobia for that, I think, to ever work. So there is a need for groups specifically for young lesbians and gay men ... and preferably with counselling services as well, counselling to sort of back them up ... I think it's important to have that as a background to a youth group."* Justine, Lesbian

• Self-Help and Facilitated Groups with a Particular Focus

A need for these type of groups was identified, and a number of specific lesbian, gay, bisexual and general groups were suggested:

* MH service user group for gay men to explore sexuality
* male survivors of child sexual abuse
* minority ethnic MH service user group
* gay and lesbian survivors of child sexual abuse
* lesbians, disability and mental health.

• Befriending and Buddy Schemes

These schemes were seen as necessary for those people not yet able to participate in the type of groups discussed above.

> *"I don't know of one LG MH service. I don't know of one. And I reckon there should be one. I would use it, yeah I would. I've got a friend who understands about being in hospital but like, there's no-one I can confide in. I actually asked [local council] if I could have a lesbian befriender, which would be good for me, but nothing has happened ... I just don't think they give a shit ... I reckon it would definitely help me. Because I won't go to places, groups or pubs or clubs or anything like that ... because of the state of my arms you know [as a result of self-harm]. Like, I need a befriender, someone to help me get out of myself, because I got lack of confidence."* Kerry, Lesbian
>
> *"And so the area of discharge policy is a problem. You know people are being sent home who don't have anyone to look after them ... in a way that does affect gay people more than other people, because gay people are more likely to live on their own, and more likely to be a considerable distance from their*

family. My family are in [place] so it's not possible for my mother to come in and check that I'm eating or whatever. Or to check whether I'm taking my medication.

And so there is a need I think for some of the, well for some of the LGB user groups to develop a sort of buddying service for gay and lesbian people who have mental health problems. I mean in theory my CPN checks that I'm taking my medication. But in fact you know, I see her every week or every fortnight, and she has too many cases to check everybody. And in the same way the consultants have too big a caseload to see everybody every fortnight or anything near that ... So I think this is a problem for gay and lesbian people ... I don't know how you combat that, I think maybe having a substitute extended family of lesbians and gay men would be a good thing. And exchanging information about medication and things like that." Ron, Gay Man

- **Prevention**

Many of the above specialist services could be seen to also have a role in preventing people from getting caught up in the mental health system, particularly where their distress stems from issues arising out of homophobia and heterosexism. The Lesbian Youth Support and Information Service is an unfunded voluntary organisation which provides the type of preventative services much needed all over the country, and illustrates how positive help and support can often help young LGBs avoid more serious mental health difficulties.

"Lesbian Information Service [LIS] is the umbrella organisation of LYSIS [Lesbian Youth Support and Information Service], and we have various things that we do. Like we do training, research, publications, advocacy and support. And we get something like 2000 enquiries a year and of those, sort of half will be from agencies: health, education, youth service etc. And the other half will be from lesbians. The vast majority of them - 80%, are young lesbian, with 20% older lesbians. They are nearly all isolated lesbians. They're from all over Britain. We sometimes get them from abroad as well.

We get both telephone calls and letters ... Invariably they're just coming out. And they're in some sort of crisis trying to come to terms with it, tell parents or whatever. So we give them support, we talk to them on the telephone, or if they send a letter ...we send them a free copy of a booklet called 'I Think I Might Be Lesbian, Now What Do I Do? ... We send that, we send them any local information, if we know of any local groups. We send them information about the pen pal scheme that we have ... and we try and match them up with an age and area, it's like a peer support scheme. And we've got about 210 on the moment...

... We do advocacy, in other words if a young lesbian's in contact with the mental health system, or a doctor, social worker or teacher or whatever, and they're having problems, then with their permission we will contact the relevant person and speak to them, send them information, whatever ... The counselling, the support, is on-going. And when they're ready, we're happy to help them come out to their parents. We encourage them to come out, but checking out of course what the situation is first. Because we don't want them to be thrown out.

And then if there's going to be problems, we'll make enquiries ... We'll put them in contact with Stonewall Lesbian and Gay Young Housing Association in London. Or make enquiries wherever they are in the country. Like the Albert Kennedy Trust. Things like that. But generally it's sort of first of all helping them to come out, talk through about their feelings, get them to accept, to challenge the myths that they've got about being lesbian, give them supportive information.

And it's really wonderful ... it's good to go from somebody phoning up being depressed and suicidal, and having attempted suicide or what-have-you, to in a few months time, literally a few months time, with support, information, peer support, they become a changed person. An absolute changed person."

Jan Bridget, Lesbian Information Service, Lesbian

Due to lack of any funding the Lesbian Information Service has now closed down.

Summary

◊ There should be a *choice* of mainstream and specialist services.

◊ Mainstream services need vast improvements. These were identified as:
- * ensuring physical safety
- * actively tackling homophobia
- * offering choice in terms of worker
- * raising the visibility of lesbians, gay men and bisexuals - including supporting workers to be 'out'
- * indicating acknowledgement and acceptance of sexual minorities, inherent within which is an assurance that non-heterosexual identification and behaviour is not pathologised
- * promoting mental health and creating a healing environment for all
- * increasing staff knowledge and awareness
- * training.

◊ Training was identified as a major key to improvements.
Findings included:

- * training needs identified across sectors and disciplines, for both students and workers
- * training needed to address the ignorance, discrimination and homophobia which currently exists within MH services
- * content should include information about LGB lifestyles, communities and the diversity within, as well as explanations about homophobia and heterosexism, how they operate and how they can be challenged.
- * LGB issues should be an integral part of student training courses
- * LGB service users, workers and organisations should be involved in the development and delivery of training
- * the implementation of training will entail overcoming many obstacles.

◊ Specialist services have key role to play in specific areas:
- * crisis services, particularly crisis housing as well as longer term housing
- * counselling and therapy
- * LGB MH service user groups
- * groups with awareness of MH problems for young LGBs
- * self-help and facilitated groups with a particular focus
- * befriending services
- * prevention.

Section 7

Conclusions and Recommendations

Findings from this research show that lesbian, gay and bisexual mental health service users are discriminated against and oppressed, not only by the attitudes and behaviour of society at large, but also from within mental health services. Judgement is made on the basis of their sexual identity and their identity as service users. Not only that, they are also discriminated against from within lesbian, gay and bisexual communities, again on the basis of their use of mental health services.

Conclusion 1
The majority of respondents in this study experienced or identified homophobia, heterosexism and biphobia as having an impact on mental health.

From the experiences and observations of the majority of those taking part in the research, we have seen that the homophobic, heterosexist and biphobic attitudes of this society can and do impact on the mental health of lesbians, gay men and bisexuals. Some participants felt they had suffered or observed some of the effects of internalised homophobia : shame, low self-esteem, self-hatred, drug and or alcohol dependency. Difficulties in coming out compounded feelings of loneliness and isolation, guilt and fear, and led in some instances to feelings of depression, self-harm and attempted suicide. To achieve a sense of well-being as we develop into adulthood, we have to integrate sexuality into our identities. For lesbians, gay men and bisexuals however, what has to be integrated is an aspect of identity which is stigmatised. This can lead to feelings of loss - both about one self as a person, and in relation to others who may be rejecting of that identity. Heterosexism, homophobia and biphobia can also lead to lesbians, gay men and bisexuals being subjected to physical, sexual and or verbal abuse. *(For further details see Section 2)*

Conclusion 2
Equal opportunity of access - for those wishing to use mental health services - is currently not available.

Findings show that lesbian, gay and bisexual mental health service users can face the same prejudice and discrimination within mental health services as they do in wider society. This means that some people choose, where possible, to avoid mainstream mental health services; others use services but do not disclose their sexual orientation. Service users who do not 'come out' can experience feelings of loneliness and isolation. Not only that, experiences of inappropriate care can arise from workers being unaware of sexual orientation, and the importance of living in heterosexist culture as a context to emotional distress. Barriers to access or coming out in services included:

* fears about safety
* fears about being pathologised/ negatively judged / stigmatised
* worries about confidentiality
* invisibility
* lack of acknowledgement of orientations other than heterosexual
* issues of multi-oppression.

(For further details see Section 3)

Conclusion 3

The extent to which good practice with lesbian, gay and bisexual service users is found in mental health services varies within and between services. Quality depends on the awareness and commitment of individual staff members.

Findings show that:

* the prejudices, ignorance, liberalism or informed practice of individual workers can affect the diagnosis, treatment and care of LGB service users
* some workers still pathologise, ignore or deny non-heterosexual orientations.

(For further details see Section 4.1)

Conclusion 4

As well as dissatisfaction with bad practice arising out of homophobia, biphobia and heterosexism, there is a sense of dissatisfaction with services generally.

Dissatisfaction with diagnosis and treatment mirrored that expressed elsewhere by service users generally, regardless of sexual orientation. Areas identified included:

* lack of information on diagnosis and medication
* too much dependence on medication - more 'talking treatments' needed
* the sense that MH care is punishing and disabling, rather than healing and empowering
* lack of respect for individuals - service users treated as labels.

(For further details see Section 4.2)

Conclusion 5

The safety of lesbians, gay men and bisexuals who use MH services is an issue needing urgent attention. Women in particular feared or experienced intimidation, sexual harassment and sexual assault.

Findings revealed that:

* Whilst safety was a crucial issue for the majority of participants, the inter-relationships of gender and sexual orientation meant that the threat or actual experience of physical or sexual harm could arise for different reasons.
* Women were almost unanimously in favour of single-sex wards, and were also far keener on other types of single-sex space: women-only rooms, groups and meetings for example. More women than men raised the question of same-sex workers.
* Lack of support and intervention from workers towards participants fearing or experiencing unsafe environments.
* In general men tended not to want single-sex accommodation and space. Amongst service users findings revealed two reasons for this:

For women, single-sex accommodation would ensure a degree of safety which they are not currently experiencing. However, gay and bisexual men experience mixed environments differently, thus some thought needs to be given to how they could best be accommodated.

(For further details see Sections 5.1, 5.2, and 6.1)

Conclusion 6

Even where respondents did not observe or experience physical or sexual assault, evidence nevertheless showed that homophobic, heterosexist and biphobic attitudes from both service users and staff create environments which can be abusive, invalidating, marginalising and emotionally damaging for LGB service users.

The range of ways in which biphobia, homophobia and heterosexism operate are illustrated by the findings on attitudes. Attitudes held by both mental health workers and other service users play a very large part in the ways in which services are experienced by lesbian, gay and bisexual service users. Findings revealed that negative attitudes and behaviour were more common than positive and included:

* verbal abuse and ridicule
* ignorance and lack of awareness
* stereotyping
* voyeurism/inappropriate questioning
* being silenced
* judgmental attitudes
* relationships trivialised
* sexual orientation
  1. denied/discouraged/devalued
  2. ignored
  3. pathologised

(For further details see Sections 5.1, 5.2 and 6.1)

Conclusion 7

Attitudes held by some mental health workers towards anyone viewed as having mental health problems, could affect access, treatment, the quality or relevance of the service received and the hopes and aspirations of service users.

Such attitudes were shown to:

* stereotype
* stigmatise
* patronise
* unfairly discriminate

(For further details see Sections 5.3 and 6.1)

Conclusion 8

The lack of awareness and understanding shown by individuals and organisations in lesbian, gay and bisexual communities, towards LGBs who have used or are using mental health services, creates environments in which LGB service users feel unsupported, marginalised or excluded..

Participants observed or experienced:

* prejudice
* fear
* ridicule
* exclusion or marginalisation
* racism
* lack of awareness and /or avoidance of disability issues.

(For further details see Section 5.4)

Conclusion 9
The majority of participants want choice, that is, the opportunity to choose from a variety of equitable mainstream services and from a range of specialist LGB services.

To fulfil the demand for a choice of equitable mainstream services and specialist LGB services, changes to present services need to be made. Details are presented in the conclusions which follow (10-12).

(For further details see Section 6)

Conclusion 10
Vast improvements to mainstream services are needed.

These were identified as:

* ensuring physical safety
* actively tackling homophobia
* offering choice in terms of worker
* raising the visibility of lesbians, gay men and bisexuals - including supporting workers to be 'out'
* indicating acknowledgement and acceptance of sexual minorities, inherent within which is an assurance that non-heterosexual identification and behaviour is not pathologised
* promoting mental health and creating a healing environment for all
* increasing staff knowledge and awareness
* training.

(For further details see Section 6.1)

Conclusion 11
Training was identified as a major strategy in helping to implement improvements.

Findings included:
* training needs identified across sectors and disciplines, for both students and workers
* training needed to address the ignorance, discrimination and homophobia which currently exists within MH services
* content should include information about LGB lifestyles, communities and the diversity within, as well as explanations about homophobia and heterosexism, how they operate and how they can be challenged.
* LGB issues should be an integral part of student training courses
* LGB service users, workers and organisations should be involved in the development and delivery of training
* the implementation of training will entail overcoming many obstacles.

(For further details see Section 6.1)

Conclusion 12
Specialist LGB services were considered by many to have a key role in providing specific types of services.

These were identified as:
* training, information provision, advocacy and 'watchdog'
* crisis services, particularly crisis housing as well as longer term housing
* counselling and therapy
* LGB MH service user groups
* groups with awareness of MH problems for young LGBs
* self-help and facilitated groups with a particular focus
* befriending services
* prevention.

(For further details see Section 6.2)

Recommendations for Good Practice with Lesbian, Gay and Bisexual Service Users

Safety

1. The guaranteed physical safety of mental health service environments needs to be a given from which all other recommendations can grow, thus the safety needs of lesbians, gay men and bisexual people should be addressed with the greatest urgency.
2. There needs to be automatic provision of women-only wards, meeting rooms, groups and other spaces for those women who wish it.
3. Further discussion with gay and bisexual men needs to take place in order to decide how their safety needs can best be met.
4. Requests for workers of the same gender as service users should be met.
5. Physical or sexual abuse of service users by staff should not only be acted upon as grounds for dismissal, but also reported to the police on the grounds of assault.

Actively tackling homophobia

6. Clear statements that homophobia, heterosexism and biphobia constitute unacceptable behaviour need to be visible within service areas.
7. Staff must be encouraged to deal effectively with such behaviour as it occurs.
8. Accessible complaints procedures need to be in place; these must take complaints seriously, follow them through and report back to the service user concerned.
9. Homophobic behaviour by staff should be a disciplinary matter.
10. Equal Opportunities Policies must include sexual orientation.

Raising the visibility of lesbians, gay men and bisexuals

11. Positive images of LGBs should be on display in all parts of the service. These should reflect the diversity within LGB communities.
12. LGB literature and information needs to be visible.
13. Any advertising of services should make reference to lesbian, gay and bisexual service users.
14. The language used in assessments, on forms and in interviews must be inclusive of LGB lifestyles and relationships.
15. Commitment is needed from managers to support workers in coming out.

Guaranteeing confidentiality

16. Issues of confidentiality to be understood and addressed. Serious breaches of confidentiality should be a disciplinary matter.
17. For example: staff discussing the sexual orientation of LGB service users with, or within earshot of, other service users, staff, visitors - or any other persons - who should not have access to this information, should be disciplined.
18. There should be collaboration with service users about what they want / do not want recorded in medical records and case notes re sexual orientation.
19. There should be collaboration with service users as to who they want to receive information about their care, treatment or any information they may have confided to a worker.
20. All of the above points about confidentiality should also apply to HIV status.

Recognition and acceptance of non-heterosexual identities /behaviour

21. Lesbian, gay and bisexual orientations should not be pathologised, ignored or denied.
22. MH workers should not make assumptions about 'causes' - for example making links between sexual abuse in childhood and sexual orientation.
23. LGB service users should be supported in exploring their sexual orientation if they so wish.
24. Relationships and friendships of LGB service users to be respected and their significance understood.
25. Information about treatment and care to be given out to 'significant others' as requested by service user.
26. Support for any campaign which addresses the discrimination against LGB partners inherent in the Mental Health Act.
27. MH workers should be informed about local and national groups, organisations, meetings which may be of interest or use to LGB service users; this information should be passed on as appropriate.

Training / Raising Awareness

All workers should be knowledgeable, non-judgmental and proficient to work with lesbian, gay and bisexual clients, thus:

28. Training needs to be given to all workers, across all sectors and at all levels.

29. Student training on LGB issues, homophobia, heterosexism and biphobia should be included as an integral part of coursework.
30. LGB service users, workers and organisations should be involved in the development and delivery of training.

Funding of specialist LGB services

31. Resources to be made available to allow the development of specialist LGB services in those areas identified by the research:
    * training, information provision, advocacy and 'watchdog'
    * crisis services, particularly crisis housing as well as longer term housing
    * counselling and therapy
    * LGB MH service user groups
    * groups with awareness of MH problems for young LGBs
    * self-help and facilitated groups with a particular focus
    * befriending services
    * prevention.

Further research

32. Research is needed to explore in greater detail the different and separate needs of gay men, bisexual men, bisexual women and lesbians.
33. Research is needed to explore the needs of Black and ethnic minority service users, and disabled, younger and older LGB service users.

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Appendix

The areas covered in interviews, focus groups and telephone questionnaires are presented here.

Demographic Areas Covered

All

* gender
* sexual orientation
* age
* physically disabled
* ethnic background

Service users

* disabled by MH problems
* MH services used/forced to use, in last 5 years
* MH services used/forced to use, more than 5 years ago

MH workers

* MH services worked in, in last 5 years
* MH services worked in, more than 5 years ago.

Areas Covered with Service Users in Semi-Structured Interviews and Focus Groups

Contact with services

How did you come into contact with MH services?
What was going on for you at this time in your life?
To what extent did sexual orientation play a role?
What are or have been some of the main mental health issues for you?

Experience of services

In terms of sexual orientation, what have been your experiences of services?
Of those mental health services used, which did you find were accessible to you as a lesbian, gay man or bisexual?
Where accessible, how do you think that is achieved
Where not accessible, what would you say is wrong?
What about attitudes of staff? MH professionals? Other service users?
What about rights in terms of nearest relative issues?
How were partners/friends treated?
What about treatment issues? Diagnosis?
Do you feel, or have you ever felt, that your sexual orientation has been pathologised in any way by mental health professionals?
If you have felt a need to talk about your sexual orientation with mental health professionals, were you able to do so? If so, what kind of response did you get?
Have you ever felt that you received particular clinical treatment(s) because of your sexual orientation?

Improving services
In what ways would you like to see services improved for LGBs
Views on mainstream services? Specialist LGB services?

Attitudes of LGBs
How comfortable do you feel 'coming out' to other LGBs as a user or ex-user of MH services?
Do you feel supported within LGB communities?
What attitudes have you experienced?

Experience of working in MH services
I have focused on your experiences of MH services as a user of those services, but you may also have experiences of working or training in this field. If that is the case, would you like to say anything about your experiences as a lesbian (gay man/bisexual person) from that perspective?

Other issues
Are there any other issues relevant to your experience as a lesbian (gay man /bisexual) using MH services, which you would like to cover?

Areas Covered in Telephone Interviews with Service Users

Contact with, and experiences of, MH services : In last 5 years
Which mental health services have you used, or been forced to use, in the last five years, including current use?
What brought you into contact with services?
Do you feel satisfied with the service(s) you received / are receiving?
Can you tell me why that was / is?

Contact with, and experiences of, MH services : More than 5 years ago
Which mental health services have you used, or been forced to use, in the past? (i.e. more than five years ago?)
What brought you into contact with services?
Did you feel satisfied with the service(s) you received?
Can you tell me why that was?

Sexual orientation
Do you feel your sexual orientation has played any part in the quality of service(s) received?

Diagnosis
Have you ever received a diagnosis from a mental health professional
If yes: would you be prepared to tell me what that diagnosis is / was and how you feel about it?

Areas Covered with MH Workers in Semi-Structured Interviews and Focus Groups:

Access
From observations of your own field, how accessible are services to lesbians, gay men and bisexuals?
Where they are accessible, how do you think that is achieved?
Where not accessible, what would you say is wrong?

How service users experience services
From what you have observed in your professional capacity, how do you think lesbian, gay and bisexual clients experience your field of expertise?
What is the level of professional awareness re lesbian, gay and bisexual issues what about staff attitudes
Do you think lesbian, gay and bisexual clients may receive particular (clinical) treatment because of their sexual orientation
Are partners of lesbian, gay and bisexual clients treated the same as partners of heterosexual clients
What about the attitudes of other service users?

Mental health issues
In your experience are there mental health issues commonly presented by lesbian, gay and bisexual clients ?
Do you have any sense that particular groups come with particular issues
From your observations are issues of difference and diversity amongst LGBs addressed professionally?

Improvements to services
In your view, how could services best be developed to ensure that the needs of lesbian, gay and bisexual clients are met in a sensitive and appropriate way?
Views on mainstream services?
Views on specialist services?

Training
Are lesbian, gay and bisexual issues addressed in training and education programmes within your professional field?
Is there a need for (further) training / education ? How can that best be satisfied?
What, if any, are the obstacles to training re lesbian, gay and bisexual issues?
Have you yourself done any training and if so, how was it received?
Did you encounter any particular problems?

Out at work
As a professional working in your particular field, how comfortable is it to be 'out' as a lesbian (gay man / bisexual). Obviously 'coming out' is an ongoing process - is it something you have a personal policy on in terms of work ?

What has your experience been as a lesbian/gay man/bisexual working in your field?
Are you out to colleagues?
In your professional field in general?
In contact with clients?
How has your sexual orientation been received?

Attitudes of LGBs

From your own personal and/or professional experience, do you think there is support and understanding for lesbian, gay and bisexual people with mental health problems from within LGB communities? 'Community' is a hard word to define, but what I am driving at is the level of awareness to be found among other lesbians, gay men and bisexuals who have not experienced mental health problems themselves.
As part of that 'community' I am also interested in how you perceive coverage of mental health problems by the 'gay media' - press, radio, TV?
How do you think we can best tackle lack of support and or coverage?

Experience of using services

In this interview we have focused on your perceptions as a professional, but obviously you may have had experiences yourself as a lesbian, gay or bisexual user of mental health services. If this is the case, is there anything you want to say from that particular perspective?

Any other issues

Are there any other issues which you would like to raise, in your capacity as a lesbian /gay /bisexual mental health professional?

PACE (the Project for Advice, Counselling and Education) offers counselling, groupwork, HIV prevention workshops and mental health advocacy to lesbians and gay men in the London area. Our philosophy is to provide free or low-cost services which do not pathologise on the grounds of sexual orientation or mental health status. We also provide training on lesbian and gay issues and on HIV to the voluntary and statutory sectors.

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