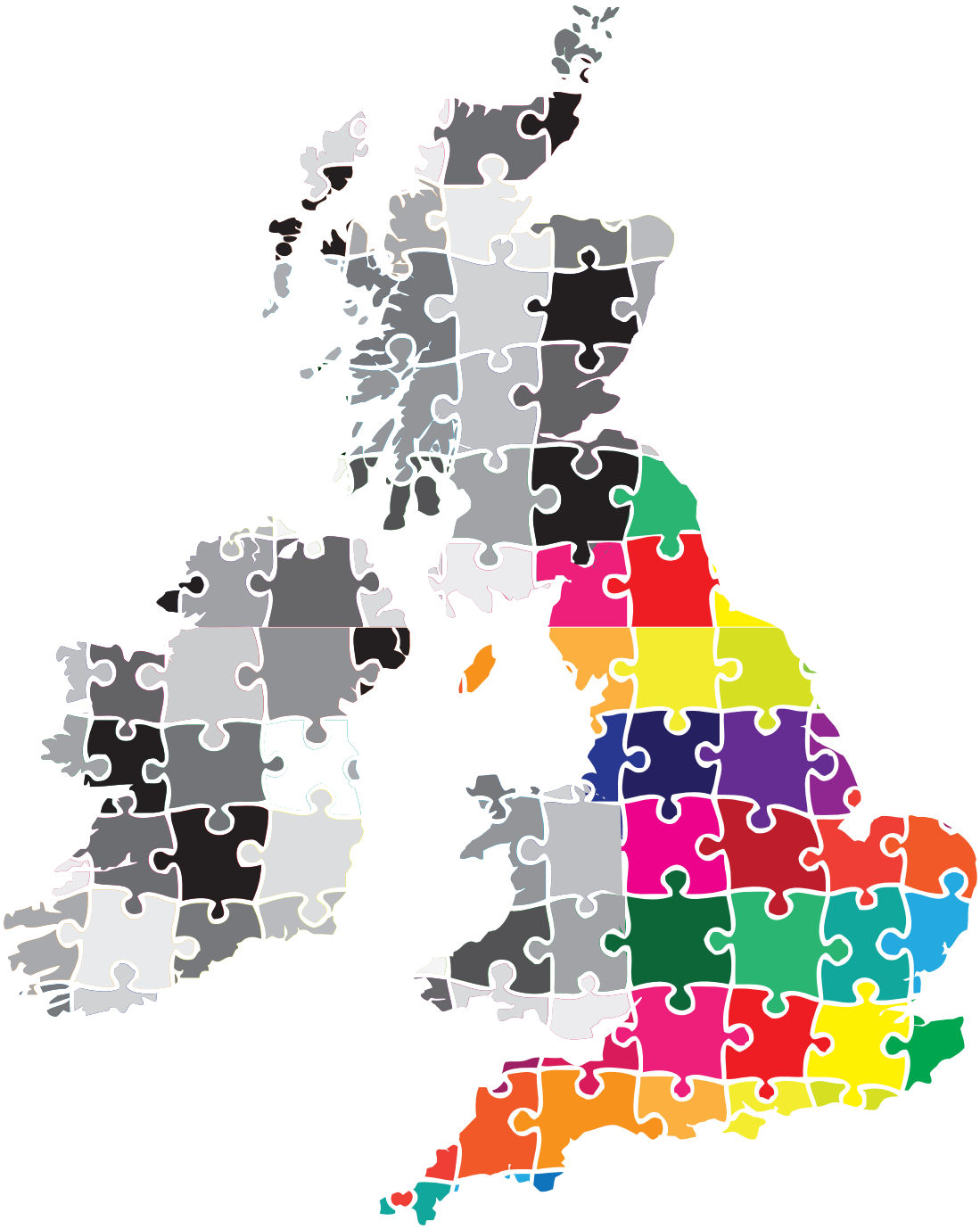
Where to Turn:

A Review of Current Provision in Online and Offline Mental Health Support for LGBT People Experiencing Suicidal Distress



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Foreword

This report grew out of "Mental disorders, suicide, and deliberate self harm in lesbian, gay and bisexual people a systematic review" by the National Institute for Mental Health in England published in 2007. That work reviewed the evidence base that LGB people are at greater risk of mental disorder and suicidal behaviour than heterosexual people. It concludes that: *"LGB people are at significantly higher risk of mental disorder, suicidal ideation, substance misuse, and DSH than heterosexual people."*

In addition the review made a number of suggestions. These include:

1. An awareness of the mental health needs of LGB people become a standard part of training for health and social work professionals
2. Routine inclusion of sexual orientation in data collection
3. Agencies and professionals with particular expertise in lesbian and gay issues should be made known through appropriate publicity
4. Further research to address reasons for the increased risk of mental health problems in this population
5. An urgent need for mental health services to develop LGB sensitive services
6. LGB issues incorporated into diversity training for mental health staff

As a result of this review the National Suicide Prevention Strategy was amended to include LGB people as a specific group with special needs under Goal Two to promote the mental health of the wider population.

PACE is a London based charity to promote mental health and wellbeing for LGBT people. With support from Dr Elizabeth Peel of Aston University and Peter Scott of Ergo consulting, PACE secured a tender from the National Mental Health Development Unit to deliver this project.

This initiative had four aims:

- To review the evidence base, potential and existing provision of online suicide prevention for the LGBT community, and make recommendations for a possible service.
- To explore what was happening in mainstream mental health services and local suicide prevention strategic activity in light of the systematic review. In particular we wished to focus on services' experience of monitoring LGBT identities and barriers to such monitoring in mainstream services. Also we asked about promotion of specialist services, staff training and other steps taken to make services sensitive to LGBT needs.
- To explore the experience and capacity of the LGBT sector in relation to suicide prevention
- To hear from LGBT individuals about their experience of seeking help when suicidal.

Six interconnected projects were undertaken. These were:

1. A brief literature review focusing on the potential and evidence base for online suicide prevention for LGBT people.
2. A comprehensive mapping of online suicide prevention support available for LGBT people.
3. A survey of local strategic leads to gauge the level of strategic activity in relation to suicide prevention with this group.
4. A survey of mainstream mental health providers on how they work with LGBT communities.
5. A survey of LGBT community organisations.
6. A survey of LGBT people who had experienced suicidal distress.

Executive Summary

Methods

This research was commissioned by the National Mental Health Development Unit. Six interconnected projects were undertaken to review online and offline provision for LGBT people experiencing suicidal distress.

1. A literature review of the evidence base for online suicide prevention work was undertaken. This is brief and its limitations are acknowledged.
2. An online mapping of available support was conducted using 24 distinct searches via Google for both world and UK-only pages. The first 5 pages of results were checked, and each link was visited and assessed using a 12 point check list. 1,079 individual pages were recorded and 532 sites were checked more thoroughly. A shortlist of UK sites were contacted directly, their approaches explored and their data reviewed where available. International sites have also been described.
3. 102 strategic leads for suicide prevention were identified through telephone contact with PCTs and mental health trusts in England. These were all sent a paper survey and FREEPOST reply envelope. 28 eligible responses were received.
4. 1,202 relevant mainstream mental health services were identified in both the statutory and voluntary sectors. Each was sent a paper survey and FREEPOST reply envelope, and 177 responses were received.
5. 399 LGBT voluntary and community organisations were identified using www.queery.org and paper surveys were sent with FREEPOST reply envelopes. 65 responses were received.
6. An online user survey was posted for 3 months with a link from the PACE website. Traffic was also driven to the survey through a series of press releases and information posted on other community organisation sites. 98 responses were received. The sample was diverse in terms of gender, race and identity (LGB or T) but with only one respondent over the age of 60.

Main Findings

- There is no LGBT specific online provision of service based in the UK to reduce suicide.
- 23 out of 28 local strategic leads for suicide prevention were aware of the change in the National Suicide Prevention strategy to include LGB people as a group with special needs under Goal 2.
- 13 out of 28 strategic leads said they targeted LGBT people as a priority
- 7 out of 28 were able to cite a specific activity relating to targeting LGBT people as a priority
- Only 31% of mainstream mental health services routinely monitor sexual orientation and 21% record trans identity compared to 93% for gender, 91% for age, 89% for race, 69% for disability and 58% for faith.
- Most commonly cited reasons for not recording sexual orientation or trans identity related to concerns about patient or client benefit
- A minority of organisations are taking active steps to assess LGBT needs;
    - 34% were aware of having consulted with LGBT individuals
    - 29% were aware of having consulted with LGBT organisations
    - 18% were aware of having reviewed published evidence
    - 10% were aware of having done a local LGBT needs assessment
- In the case of 52% of Equalities Impact Assessments conducted, respondents were not aware of any of the above steps taken to assess LGBT need
- 37% of mainstream services were aware of having taken one or more active steps to promote service access by LGBT people

- 33% of mainstream services were aware of having LGBT posters or materials on display in public areas
- 34% of mainstream services were aware of having done specific training on LGBT awareness
- 8% of mainstream services were aware of analysing their service data on access or outcomes for LGBT people (i.e. one quarter of those collecting it)
- 59% of LGBT organisations providing a relevant service were aware of supporting clients who were either currently suicidal or who had made a suicide attempt in the last 6 months
- Of those LGBT organisations described above 19% had no policy on working with suicidal clients, no training on working with suicidal individuals, made no assessment as to suicide risk of their clients or gave no emergency contact numbers for suicidal clients
- 22% of LGBT community organisations describe their relationships with adult mental health services as poor or very poor.
- 40% of LGBT youth services currently supporting someone suicidal describe their relationship with CAMHS as poor or very poor
- 56% of LGBT users who had experienced suicidal distress had approached their GP for support
- 43% of LGBT users who had experienced suicidal distress had approached Samaritans for support
- 30% of LGBT users who had experienced suicidal distress had approached an LGBT community organisation for support
- Samaritans were the most commonly cited helpful service (but also the second most commonly cited unhelpful service)
- Over 50% of LGBT users came out to non-LGBT specific providers
- 23% of LGBT users who had accessed support services reported a negative experience relating directly to being LGBT

Summary discussion

There is much to suggest the applicability of online support to LGBT people experiencing suicidal distress. However, the absence of any currently delivered model in the UK or the English speaking world means that the evidence base for effectiveness is not established. Any initiative should be designed to capture its outcomes and impact as robustly as possible. A new service should strive to deliver interactive responses out of office hours as well as static information. Clearly, safety protocols need to be developed carefully to enable this service to be delivered.

Broadly speaking the recommendations of the Systematic review with regards to mental health services remain largely unimplemented.

At a strategic level although awareness of the change to the National Strategy is high, little is being done to actively target this client group, with only a few notable exceptions such as (but not exclusively) Cornwall, Leeds and Brighton.

In mainstream mental health services the majority of providers do not record sexual orientation data contrary to the recommendations of the NIMHE Systematic Review (although roughly one third are managing to do so). Staff indicated a number of perceived barriers to this monitoring. Broadly these were: lack of external pressure, lack of internal capacity/will, and concerns about the benefit to patients with the latter being the most common reasons given. Absence of monitoring data embeds invisibility of this client group at the heart of the mental health service experience and is reflected in the individual experience of users described below. A coordinated national change plan needs to be developed to firstly make the case for change, then equip for change, and follow through with the appropriate external drivers to enable change.

With notable good practice exceptions the majority of mainstream mental health providers surveyed are not aware of any significant action to assess local need for LGBT people. Less than one third are aware of having done any consultation, less than one fifth have reviewed published evidence and only 1 in 10 have done a specific needs assessment. There is evidence to suggest that the majority of Equalities Impact Assessments have done little or nothing to seriously consider LGBT need. Over half of the organisations which said they had done an EIA were not collecting sexual orientation data, not consulting with LGBT individuals or organisations, not reviewing published evidence, and not conducting their own needs assessments.

Roughly one third of mainstream organisations took some steps to ensure that services were accessible, appropriate and sensitive to LGBT people. Most common actions were specific training for staff and displaying posters in public areas. Only 16% of organisations indicated activity which is more than minimal in relation to LGBT mental health. Only 6% were at what might be considered good practice. Very little work with the LGBT community is well-informed, and invisibility remains the key problem for this issue. Most mainstream services are taking no active steps to address the issues outlined in the systematic review.

Many LGBT voluntary and community organisations are significantly involved in providing support to those with current needs in relation to suicide prevention. Nearly 60% of respondent organisations were aware of supporting LGBT people who were either currently suicidal or who had made a suicide attempt in the last 6 months. The sector showed signs of needing development in this role. Although good practice examples exist (notably Mind Out in Brighton) some are supporting people experiencing suicidal distress without training, appropriate policy or working relationships with statutory providers. Activity to develop better relationships between LGBT youth services and CAMHS seems particularly needed. GALYIC represents an example of good practice both in its assessment and preparedness to work with the issue and its history of engaging with CAMHS.

In the survey LGBT users seeking help when suicidal tended to use multiple support sources perhaps to achieve support both in and out of hours. Multiple modalities of support (in person, phone and email) was a common pattern. Over 40% of the sample had used the Samaritans. Users predominantly wanted access to talking interventions with ease of access and out of office hours access described as the most important structural qualities. Face to face support was preferred although many valued phone and online support. Support from an LGBT specific service was seen as slightly more desirable than from a medical professional.

GPs were the most commonly cited unhelpful service with Samaritans as the next most commonly cited. The Samaritans were also the most commonly cited helpful service. Nearly a quarter of those accessing support services when suicidal described a negative experience relating to their LGBT identities. Only a minority of these were directly anti-LGBT. More common experiences related to the difficulty of coming out, assumptions, invisibility or clumsy and inept responses to disclosure. An experience heard a number of times was that of users having to come out repeatedly and this not being 'heard'. The system does not capture their identities so they are forced to come out repeatedly. Users may experience this as very difficult:

> *I am already working as hard as I can to stay alive moment by moment. I don't have the energy to constantly come out to you, and then have to deal with your homophobia or ignorance or confusion.*
>
> Online Survey Respondent

A number of respondents talked about the struggle to gain help from the NHS – some specifically mentioning the role of charities in providing them with support. Easy to access talking support is hard to find and strongly desired.

Across England the approach to LGBT suicide prevention and mental health is rarely a joined up effort. Meaningful strategic activity needs to address development both in mainstream and LGBT community organisations to achieve an integrated approach where both sectors cooperate to best meet the needs of LGBT clients. In particular LGBT users far too commonly report inappropriate responses to their identities when seeking help.

Brief Literature Review

There is mixed evidence of the benefit of online peer to peer support. In a systematic review of the effects of online peer to peer interactions (Eysenbach, Powell, Eglesakis, Ritzo and Stern 2004) the authors found some evidence of impact on depression, social support, healthcare use, eating disorders, weight loss and diabetes control. However the authors failed to find consistent robust evidence for the benefit of groups. Some groups showed statistically significant improvements, whilst some seemed to show non-significant improvements. However, a number of problems in identifying impact were highlighted. The impact of 'pure' peer to peer interventions was quite hard to isolate, since some had clinical input or were part of complex interventions with many different components (making the distinct impact of the online peer support hard to quantify).

There is much to suggest that the idea of reaching LGBT people online in terms of support in relation to suicide prevention is an appropriate one. Evidence suggests that LGBT young people, in particular, rely on virtual communication and related technologies more than their peers (Hillier 2001); and (Suicide Prevention and Resource Center 2008). It has been suggested that socially marginalised groups such as LGBT people benefit from participation in online groups as a way of overcoming marginalisation, increasing self esteem and normalising their identities (McKenna and Bargh 1998). The online disinhibition effect (Suler 2004), promoted by anonymity, lack of eye contact and invisibility makes the virtual world, one in which people may find it easier to make important self disclosure about identity and suicidal thoughts. Some authors have argued that people communicating online tend to reveal their "inner" or "true" self (McKenna and Seidman 2005), and suicidal individuals often reveal their troubled selves in writing (Joiner, Pettit, Walker et al 2002). The Samaritans find a higher rate of disclosure of feeling suicidal in their email contact (35.6%) compared to their phone contacts (19.1%) (Samaritans 2009). The value of internet support was anecdotally cited in the report Understanding Suicide and Promoting Survival in LGBT Communities, (Johnson, Faulkner et al 2007) where one user commented:

> *"The internet has been an invaluable resource. Um, at night times, one of my hardest times – it certainly used to be when I lived alone and I used to spend all night often on the internet talking to people you know the other side of the world who were up and making friends."*

There is also some evidence to suggest that both depressive young people (Ybarra, Alexander and Mitchell 2005) and self harming young people (Mitchell and Ybarra 2007) use the internet differently compared to 'well' young people, including increased intimate interactions with strangers, intensity, and frequency of internet use.

There are a range of papers specifically addressing the internet and suicide. Most of these are generalised discussions of the issues and focus broadly on two areas: 1) the risk posed to suicidal people by the internet; and 2) the potential for online suicide prevention. Recupero, Harms and Noble (2008), for instance, explore the risks from the internet including: access to how to commit suicide information (methods), pro suicide comments in some suicide forums, internet suicide pacts and 'no prescription needed pharmacies' as sources of potentially lethal substances. They note the availability of online support and suggest conscious placing of support above pro suicide resources in search engines by the 'internet savvy', as well as guides such as the Australian "Using the Internet for Suicide Prevention: A Guide" (Miller and Cugley 2004). The latter helps users and clinicians assess sites. A number of other writers have identified similar concerns about the effect of the internet on suicide notably Mehlum (2000), Biddle et al (2009) and Baume, Cantor and Rolfe (1997).

Conversely, Baker and Fortune (2008) undertook a qualitative study of those using self-harm and suicide web sites and identified three emerging prevalent discourses from email interviews with users of sites. These were: empathetic understanding, community (meeting needs for belonging), and sites as ways of coping. They also noted the description of mental health services as inaccessible, suggesting that the positive side of these forums had been inadequately explored. Gilat and Shahar (2009) suggest an action theory-based model for suicide prevention by online support group moderated by paraprofessionals, but acknowledge the scarcity of empirical evidence of suicide prevention by this means.

There is very little outcome focused work on the effectiveness of online interventions in relation to suicide prevention, and none have been found which are LGBT specific. A two year evaluation of the Samaritans phone and email service was currently being undertaken by Nottingham University and was due to be completed in January 2010. Haas, Koestner, Rosenbery et al (2008) published a description of an interactive web based method of outreach to college students at risk for suicide. The process involved a general invitation to participate to student populations. Participation involved completing online assessments (PHQ9 and items on suicide risk: past attempts, affective states, alcohol and drug use, eating behaviours and current psychiatric treatment) and access to an online assessment. Students were classified as Tier 1, 2 or 3 risk. Tier 1 and 2 students were contacted and encouraged to contact the counsellor to schedule a one-to-one appointment. They were also given the option of anonymous online dialogue with the counsellor. At-risk students' rates of attending for an in-person assessment and entering treatment were three times higher among those who engaged in online discussions. In addition some students engaged in online dialogue, but did not attend in-person. The online relationship appeared to have a therapeutic effect.

A field project report on the Israeli SAHAR project (Barak 2007) identified their initiative as the most comprehensive internet based suicide prevention service existing in the world. The site provides at its heart a thorough information site about suicide covering: topics related to distress, myths, how to help a friend or relative, and a reading list. It maintains a thorough listing of help and support agencies and services. The site offers a range of online communication modes: synchronous (chat based) and asynchronous (email based) support, free and open online support groups via four forums, and is developing group chat facilities. The site has 1,000 personal contacts with distressed individuals a month and is accessed approximately 350 times a day. Anecdotal evidence of positive feedback is provided. Additional empirical impact data is not currently available.

It is worth noting that many of the papers examined have reported work with young people. This reflects the fact that internet use is more prevalent among this age group. Moreover, much of the literature on LGBT suicide is also focused on young people. The consequences for older users also need to be considered. SAHAR, the Israeli online suicide prevention service reports that most of its users are under 30 and that hardly any referrals are from those over 50 (Barak 2007).

The evidence base for a single model of online suicide prevention is not clearly established. Some tentative, theoretical work and model descriptions exist but we have not found support by strong empirical data. There is much to suggest the applicability of online interventions tempered with a range of legitimate concerns.

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Mapping of Online Support

Methodology

The first part of the mapping project focused on the availability and evidence of effectiveness for online support for LGBT people experiencing suicidal distress. Using Google, volunteers entered the following searches in both World Wide Web and UK Pages Only search modes:

1. LGBT suicide prevention uk
2. LGBT suicide help uk
3. LGBT suicide support uk
4. LGBT suicidal uk
5. LGBT kill myself
6. Gay lesbian bisexual transgender suicide prevention uk
7. Gay lesbian bisexual transgender suicide help uk
8. Gay lesbian bisexual transgender suicide support uk
9. Gay lesbian bisexual transgender suicidal uk
10. Gay lesbian bisexual transgender kill myself
11. Suicide prevention uk
12. Suicide help uk
13. Suicide support uk
14. Suicidal uk
15. Kill myself uk
16. LGBT online help support mental health uk
17. LGBT online feeling depressed isolated anxious uk
18. LGBT online mental health promotion uk
19. Online help support mental health uk
20. Online feeling depressed isolated anxious uk
21. Online mental health promotion uk
22. Virtual help support mental health uk
23. Virtual feeling depressed isolated anxious uk
24. Virtual mental health promotion uk

Researchers followed up each link of the results for the first five pages, sites discovered were reviewed against the following yes/no check list:

1. UK based?
2. Does site show any LGBT support intent?
3. Is the site LGBT exclusive?
4. Does the site show any intent to support mental health?
5. Does the site show signs of recent maintenance/updates?
6. Does the site give emergency advise for those feeling suicidal including relevant numbers?
7. Does the site give information about suicidal feelings/thoughts?
8. Does the site give UK based places to get further help?
9. Does the site give people an opportunity to subscribe to a newsletter?
10. Does the site offer support via the site which is Delayed Time Interactive (email or other delayed message feature such as Ask a Question)?
11. Does the site offer Real Time Interactive support?
12. Does the site host a forum or user group?

In addition a brief one-line summary of each visited link page was written.

1,079 individual web pages were initially recorded. These were collated and a process of de-duplication and removal of extremely obvious non-relevant sites produced a full list of 532 sites to check more thoroughly. These were visited and then categorised as follows:

Table 1: Categorisation of sites visited

Code Number	Description	No. of Sites
1	Publication – research, report, guidance – primarily targeting professionals, policy makers, academics etc. Includes some newsletters (professional bodies for instance).	188
2	News item – article in general, non-specialised press (but including minority community groups)	42
3	LGBT support site – search took us to a relevant page on a site targeting LGBT community. Primarily websites for LGBT organisations providing support with a greater or lesser degree of static information or referrals. Generally portal sites.	66
4	Suicide/self harm support site – specific remit around DSH	26
5	LGBT listings – student, local authority, NHS or other listings for real world help for LGBT community	5
6	Other listings - student, local authority, NHS or other listings for real world help primarily mental health but sometimes for another group – e.g. asylum seekers, students etc	66
7	Mental health support site with suicide reference or page	32
8	Anti LGBT site	1
11	Personal blog with reference to issue	20
12	Other site – miscellaneous	34
13	Other issues support site (alzheimers, older people, addiction, homelessness, domestic violence, abuse)	41
14	Training and education – either course guides or outlines or course adverts	11

An initial long shortlist of sites specifically targeting suicide prevention, mental health support and/or the LGBT community produced 126 sites which were scrutinised in greater depth. From these, the purely general sites with only basic information and links relating to suicide prevention were removed. A number of sites which were support sites for those bereaved by suicide (for example but not limited to www.suicidegrief.com; www.suicidebereavement.co.uk and www.widowed-by-suicide.org.uk) were also removed though many had basic crisis referral information – typically emergency numbers or sites. Other sites were de-selected due to inactivity. A final shortlist of the most relevant sites consisted of the following 15:

Online Suicide Prevention Support	UK Based	LGBT Specific
http://stoplgbtsuicide.com	No	Yes
www.lgbtmind.com	Yes	Yes
http://self-injury.net	No	No
www.befrienders.org	No	No
www.livingisforeveryone.com.au	No	No
www.papyrus-uk.org	Yes	No
www.samaritans.org	Yes	No
www.stampoutsuicide.org.uk	Yes	No
www.suicide.org	No	No
www.suicideforum.com	Yes	No
www.xchangesuicideprevention.org.uk	Yes	No
www.metanoia.org	No	No
www.mind.org.uk	Yes	No
www.thetrevorproject.org	No	Yes
www.youth-suicide.com	No	Yes

Of the 15 projects selected for closer investigation 10 are UK based and 4 are LGBT specific.

Only one site that was both UK based and also LGBT specific was found during this search, the site for MindOut in Brighton. This site is essentially a general portal for the MindOut service with some additional site content about suicide as well as links to the National Mind website for further information, fact sheets and advice. The site gives contact information via phone, email or in writing for visitors to access any of the range of services described (one of which is a suicide prevention project). In addition the site has a link to a downloadable PDF version of relevant research on suicide among the LGBT community. The site also has Samaritans contact details and information on local support from both statutory and non-statutory services. Though entirely relevant and useful of its kind the site does not specifically offer an online service.

This leads us to conclude that there is currently **no specific LGBT online provision of service based in the UK to reduce suicide.**

Other UK based sites

XChange is a website for a local suicide prevention initiative targeting Craigavon in Northern Ireland. It has an interactive get-in-touch email feature, links to phone lines and advice and information on a range of different problems (drinking, immigration, money etc). We could find no reference to LGBT on the site.

Papyrus provide information targeting young people who may be feeling suicidal, and their parents, carers and friends. The site primarily promotes access to its Hopeline service but also provides contact links to a number of other organisations such as Samaritans (and including PACE). Feeling 'confused about sexuality' is listed as one of the factors that may affect young people. Essentially this is a static information and listings site with some research and links to other organisations. There is no sign of any online provision.

Stamp Out Suicide is another suicide issue-based site. It provides signposting to those in need of help to Befrienders, Papyrus and The Samaritans. No specific reference is made to LGBT and no services are provided online.

The National MIND website has information and fact sheets on both suicide and LGBT mental health. The site promotes the MIND information line number and has comprehensive LGBT listings covering a wide range of different community organisations. The site also provides emergency guidance.

The two UK based sites with a more interactive online service provision are The Samaritans and the Sucideforum.

The Samaritans

The most significant voluntary sector provider in the field of UK suicide prevention and one of only two online interactive suicide prevention initiatives in the country is The Samaritans. As mentioned above the email service has a higher rate of expression of suicidal feelings (35.6%) compared to all dialogue contacts in general (19.1%).

The site gives a comprehensive overview of the organisation, its mission and its values, introduces Samaritans training courses, Samaritans research and information sheets, and provides some links to a number of organisations providing additional support (including London Lesbian and Gay Switchboard and Terrence Higgins Trust). The primary focus of the site however, is not to inform people about suicide but to encourage people to make contact and talk about what is bothering them. Users can contact the Samaritans by phone, email, text or in person. Essentially the Samaritan model is of easy to access non-time-limited dialogue with a trained and sympathetic volunteer who will provide non-judgemental listening.

The site publishes its online user survey report of September 2007. In this report, out of 462 eligible responses, 24 (or 5.2%) identified themselves as lesbian or gay and 33 (or 7.1%) identified themselves as bisexual. In total therefore 57 or (12.3%) of respondents to the user survey positively identified as LGB. It is worth noting that this is more than any single ethnic minority and indeed more than all non-white respondents combined. LGB people thus constitute the largest minority group in the user sample. However, this only tells part of the story. An additional 77 or (16.7%) chose not to state their sexuality and 32 or (6.9%) did not answer. Thus a further 109 respondents (or 23.6%) did not disclose their sexuality.

Clearly one cannot draw any definitive conclusions from these figures yet it would seem reasonable to speculate that at least a proportion of these are LGB and that, given prejudice to LGB identities, internalised homophobia and the reduced social acceptability of LGB, there may be greater incentives not to disclose an LGB identity compared to heterosexual identity. In addition these respondents may also include those who are not sure, questioning or undecided. Thus, in total, less than two thirds of the survey (296, or 64.1%) positively identified as heterosexual.

Depending on how representative the sample is of Samaritans users the 2007 survey would suggest at face value that a significant proportion of Samaritans users are LGB. Since we do not know what proportion of the UK population is LGBT we cannot say whether this is above average for the population (though it seems likely). Nor can we say what would account for this if it were above average. Possible explanations may include: increased likelihood of using services, increased likelihood of participating in surveys, more likelihood of accessing the internet (as this was an online survey), or increased need/isolation within this group. Among reasons given for using the Samaritans 8.4% of users gave sexuality as a reason for contacting the service. The user survey did not record Trans identities so it is not possible to comment, except to say that 15 people or 3.2% of the sample did not specify a gender, although this may of course, be totally unconnected.

The email service is a growing part of what the Samaritans provide. Based on the Information Resource Pack 2009, the email service made 160,351 responses to email contacts in 2008, accounting for 6.7% of dialogue contacts. In Messages to Jo – The Samaritans' Experience of E-Mail Befriending by Stephanie Howlett and Robert Langdon the service is described as follows:

"The Samaritans' current Strategy for E-mail states that:

> *'E-mail befriending is offered to callers in a manner consistent with all other methods of contact (i.e. telephone, letter and face to face). Callers that choose to contact The Samaritans by e-mail will receive a response that is caring and compassionate and in accordance with Samaritans policies.'*
>
> *The Samaritans have been keen to avoid e-mail work being possibly seen as the preserve of an elite group, detached from the rest of the service. They have thus chosen to locate the work not within a centralised call centre, but within their local branches. The computers are located in the central operations room alongside the telephones, not tucked away somewhere separate. The e-mail work is done by existing, experienced Samaritans volunteers who, at different branches, may take on an additional e-mail shift in addition to their regular telephone work, or may respond to e-mail callers as part of their ordinary shift.*
>
> *Branches apply to go into the e-mail scheme, but will only be accepted if early briefing meetings indicate that the majority of volunteers are supportive. All volunteers in the branch will then be expected to attend an initial training providing a basic awareness of e-mail support and how it is integrated into the work of the branch. E-mail work will thereafter be included in the initial training for any new volunteers joining the branch. There is then a further five hours of training for those who will be directly involved in downloading messages and drafting replies.*
>
> *Responsibility for e-mail work is shared within the branch: volunteers downloading messages and drafting replies, supported by others talking through possible responses and proof-reading replies. The system demands that all replies should be overseen by another volunteer before they are sent. At present about 4,000 volunteers nationally are estimated to be involved in e-mail work in some capacity.*

How the service is operated?

The e-mail service is run in an integrated way by all Samaritans UK on-line branches, and two branches in Hong Kong and Perth, Australia, united under the umbrella organisation, Befrienders International.

All calls are routed through one e-mail addresses, jo@samaritans.org. Calls go onto a global list and the next branch to log on will deal with the call at the top of the list, so that any call can go to any branch. This remains the case if the caller makes a second, third or fourth contact, so that one caller may be dealt with over time by several different branches. To ensure the coherence of replies the history of all the exchanges in one 'episode' is attached to the calls, so that the volunteer taking the call can look back at all the previous messages and responses to help them gauge how to respond.

This framework means that there is no establishment of any ongoing relationship between particular callers and particular volunteers. All the e-mail volunteers use the relatively gender-neutral pseudonym 'Jo', and callers are made aware of this in a standard footnote. In fact, it is part of Samaritans policy positively to discourage any kind of ongoing relationship between individuals as this can foster an unhelpful dependency in both directions. The relationship is always between the caller and the organisation, rather than the caller and an individual befriender.

There are exceptions to this random allocation, however. Branches have a responsibility to judge whether it might be beneficial for a particular caller to be assigned permanently to one branch. This enables the branch to manage the caller care for that person, and consider the type of support offered, imposing restrictions on the service offered if necessary. This helps to avoid the danger of the service being used as a chat line. Even then they try to ensure the calls are not handled by a single volunteer.

The user satisfaction survey described above indicates users as having a generally positive view of the impact of Samaritans on their mood and actions. Overall headline findings were that:

- 73.5% of suicidal people felt that contact with Samaritans helped them take a decision not to end their own life.
- 66.6% of people at risk of self-harm felt that contact with Samaritans helped them take a decision not to injure themselves
- 56.3% of people felt more in control after contact with Samaritans
- 63.4% of people felt less anxious after contact with Samaritans
- 70.3% of people felt it helped them cope with the problem they were facing

Whilst it is acknowledged these are not results exclusively for the email service it is worth noting that 54.1% of online survey respondents had used the email service. (Given that only 6.7% of dialogue contacts with Samaritans were via email this would, perhaps unsurprisingly given that it was an online survey, suggest that the email service users were significantly more likely to have completed the online evaluation form.)

The service aims to respond within 12 hours and makes it clear that people can call the helpline if they need help now. 59.1% of email users were 'a lot' satisfied with the response time (compared to 10.9% not at all satisfied with response time).

The site does not offer instant messaging support though the site does say this is being investigated.

Sexual orientation or gender identity issues do not figure prominently on the Samaritans web site. Searches for LGBT reveal one news story and searches for gay lead to minor references and an information sheet on young people and suicide, which is a literature review with 3 references to homosexuality. The evidence presented is inconclusive either way. Sexuality does not occur on the list of reasons given for calling the site and does not appear to be viewed as a prominent risk factor. We could find no reference to trans people anywhere on the site. This contrasts markedly with the handling of LGBT issues on the Befrienders site (see below) and a number of other international sites.

The Suicide Forum

The forum was set up in 2004 by a man with depression and suicidal ideation. Its original 20 members have now grown to over 5000. The site is run and moderated by volunteer staff operating at different levels – Administrator, Senior Moderator, Moderator, Befriender and Chat Monitors. All staff are users who have become and remained active on the site, shown themselves to be supportive and welcoming and as with everyone else on the forum are people who have personal experience of the issues involved. The site is self funding through donations.

The site is structured with a number of different forum topics and threads – one of these is relationships and sexuality where occasionally users have posted comments or started threads relating to their LGB and/or trans identity (or doubts about these issues). Responses have been generally supportive though have not involved suggesting that people contact LGBT help organisations. We could not easily find information on LGBT helplines or resources (a search did reveal an American number). The Forum operates a policy of respecting difference and disrespectful language will lead to the offending post being deleted and the person responsible given a warning.

The site is pro-life and material likely to cause distress is clearly marked 'triggering'. Pro suicide content is removed.

The site also runs a live chat facility which is monitored as often as possible (coverage seems substantial). The chat is divided into three areas: a general Main Room, Triggering Subjects for those currently experiencing distress and a Quiet Place.

If anyone presents on the site with immediate distress, or at the point of attempting suicide, site staff will try and persuade them into Chat and from there attempt to persuade them to access external/medical help. Essentially staff will encourage people to talk and help people through the moment. If someone has taken an overdose they might be encouraged to give a phone number and, on a couple of occasions the site have called the police.

As an entirely voluntary, unfunded initiative the site does not collect outcome data.

International Sites

A number of non-LGBT specific international sites were reviewed as containing some interesting features including the following.

Suicide.org is essentially an information and portal site. It provides an array of information about suicide, links to suicide support sites and prominently promotes helpline access. At a number of points the site pages act as letters to the suicidal or those experiencing the issues under distress. Its basic message is that pain can pass and that it is important to seek help. The site has a specific page on LGBT issues which focuses on LGBT youth and refers to The Trevor Project (see below). The site has a newsletter but no other online provision.

Befrienders.org has been run by the Samaritans since 2003. It is a network of suicide prevention befriending organisations offering support in multiple languages around the world. There are member centres in Argentina, Armenia, Australia, Barbados, Belgium, Brazil, Canada, China (Hong Kong), Cyprus, Denmark, Egypt, Estonia, France, Hungary, India, Italy, Japan, Kosovo UNMIK, Lithuania, Malaysia, Mauritius, New Zealand, Norway, Poland, Portugal, Russia, Serbia & Montenegro, Singapore, South Africa, South Korea, Sri Lanka, St. Vincent & Grenadines, Sweden, Thailand, Trinidad & Tobago, Ukraine, United Kingdom (& ROI), USA and Zimbabwe. Essentially the site is a portal site to help around the world.

The site also has a marked difference in its approach to LGBT issues compared with Samaritans. Homosexuality is listed as a reason for additional support along with bereavement, self harm and bullying on the front page of the website. The site has a section on LGBT identity, acknowledges LGBT as at enhanced risk (particularly youth) and has a number of pages on sexuality. There are more links to UK based LGBT organisations on this site than on the UK Samaritans site.

Living is for everyone is a national Australian resource for those involved in suicide prevention. It maintains a database of research, factsheets, a practitioner forum, a calendar of events and project practice examples. It does not provide online support for the suicidal. It is the site of the Australian Suicide Prevention Strategy.

Metanoia.org is a US-based online therapy service with a page linked to its main page entitled "If you are suicidal read this first." In effect the page constitutes a brief intervention in the form of a letter addressed to someone suicidal. The letter empathises, explains a model of suicide as pain exceeding ability to cope, and offers two possible choices of reducing pain and increasing ability to cope as alternatives to suicide. The page urges contact with one of the help organisations (including Samaritans' email service and US based help lines), provides links to other suicide information and resource sites, pages on depression, and a page of jokes. `E therapy' (the main service provided) is not recommended for those in crisis. The description is included as a suicide intervention on a non-suicide website. Links to this intervention featured on a number of other websites.

International LGBT Specific Sites

A number of more specific LGBT suicide prevention sites were identified in the US. Prominent among these were Stop LGBT Suicide, Trevor Project and youth-suicide.com.

Stop LGBT Suicide is a campaigning information and portal site whose stated aim is to prevent suicide within the LGBT community. It is US-based and much of its content is US-focused. The site provides emergency contact numbers for the Trevor Project (see below) which has a 24 hour LGBT youth suicide prevention helpline staffed by counsellors. Stop LGBT Suicide also refers to a range of other US help lines and the UK based Papyrus Hope Line. The site has a campaigning agenda with sections on news and research. The site also has many prominent links to commercial enterprises (ranging from the relevant, such as a site to market an approach to mental health first aid for suicide prevention called QPR, to dating, holiday and contact sites). There is no interactive provision. Essentially the site offers brief, comforting and supportive messages combined with signposting to support.

The Trevor Project is an LGBT youth suicide prevention initiative serving the USA. It originated from a 1994 Academy Award winning short film about a boy's struggle to come to terms with his sexuality and suicide attempt following rejection at school. This was broadcast on HBO. The director/producer founded the organisation to address the issue when he became aware of a lack of support for this client group.

The core service is a 24 counsellor staffed help line. In addition the project runs a website with strong social networking site links and internet presence (Facebook, Twitter, YouTube, etc.). The organisation appears media savvy with some extremely high profile supporters (notably Daniel 'Harry Potter' Radcliffe) whose public support for the organisation made a media impact internationally (to the extent that it impacted on part of the internet search as many links to this story were found during the research).

The project designs and runs suicide prevention campaigns targeting LGBT young people. The most recent of these is the 'I'm Glad I Failed' campaign. The project provides a downloadable teaching resource to be used with the film in schools, downloadable banner ads, and some general information and resources. The site's interactive content consists of an online problem-sharing advice page called Dear Trevor. Prominently at the top of the page is the emergency phone line number for those in immediate distress. An adjunct to the Trevor site is trevorspace.org. This is a monitored online LGBT youth networking site which has forums, chat rooms, news updates, blog links and video content. One of the site's main aims is to teach young LGBT people how to become active in the LGBTQ community (as well as reduce isolation and get support). The site links to the Trevor project main page and promotes the helpline prominently.

The final LGBT specific site is:
youth-suicide.com which is the host site for gay/bisexual male suicide problems. Essentially this is a campaigning site advocating for the greater understanding of the suicide issue within the gay community. Primarily the site is a significant collection of research articles from around the world. The site does not provide online support but signposts to a range of help lines including Befrienders (see above) for international support.

Conclusions and recommendations

The only Interactive online support for suicide prevention in the UK that we found is delivered by volunteers either through the Samaritans or the community staff of the Suicide Forum. The Samaritans provides a comprehensive email service in addition to its phone line support and the Forum is able to provide real time online support using its chat feature. Both sites show use by LGB (and T in respect of the Forum) users. The 2007 Samaritans Survey suggests a high proportion of LGB users. Due to time constraints the Samaritans have not yet been able to analyse the LGB data separately. It would be useful to see if impact and satisfaction for this client group was consistent with the rest of the survey.

The UK LGBT community is not currently served by an LGBT focused online mental health promotion/suicide prevention initiative. In addition LGBT people in the UK accessing mainstream sites such as The Samaritans do not at present find identity related isolation or distress due to discrimination figuring prominently as an issue. (MIND, though not exclusively a suicide prevention site does have more LGBT specific content). This is in marked contrast to similar international and US-based sites such as Befrienders.org or Suicide.org which both have specific pages targeting LGBT people and acknowledge identity-related distress as a problem needing support on their main page. As with mainstream mental health services delivered in person, invisibility seems a key issue for this client group. The Samaritans web based initiative shows clear evidence of being accessed by LGB people in significant numbers (perhaps even disproportionately) yet the national site is extremely limited in terms of content for this group. The site actually maintains a very neutral and non defining approach to its users. Both Samaritans and the Forum should be encouraged to give thought to raising the profile of this client group. In addition the potential for a specific online LGBT service is clear.

Such a site could focus on providing the following:

- Clear signposting for help – especially in an emergency. Ample models for this already exist.
- Simple affirmative messages about LGBT identities and encouragement to engage with LGBT community networks
- Links to appropriate LGBT listings and websites
- Clear and concise information on LGBT suicide for professionals
- A campaigning approach to the issue of suicide within LGBT communities
- An interactive online element of combined professional and volunteer delivered support
- A moderated user mental health forum.

The interactive element would need the following qualities:

- Clearly thought out and documented safety protocols particularly addressing emergency contact, accountable managers and limits of confidentiality. User safety is paramount.
- As far as possible to try to be an out-of-hours service, ideally available through the night. At the very least the service should NOT focus on key office hours.
- As far as possible the service should try to be a fast response service.
- Achieving significant cover may best be delivered through volunteers. Significant thought needs to be given to training and support of volunteers particularly as they are likely to be physically dispersed. In the initial development stage the site may be more staff dependent.

In addition:

- Site content should be mindful of unintended adverse consequences of 'triggering', and consistent in a pro-life approach.
- Site placement should be carefully considered in terms of working with search engines to try to ensure the site occurs prominently in relevant searches
- The site should build links with existing provision (both national and international).

By contrast with the sites identified in this search, a British site should clearly have integrated content relating to young people and coming out, and there is no reason why this should require a separate site.

Strategic Survey

Methodology

The strategic survey was a brief snapshot view of strategic activity relevant to this research. Given overall limitations as to time it was not possible to do a large or in depth questionnaire or do in-depth work exploring the views of strategic leads or their barriers in relation to this work. Its limitations are therefore acknowledged from the outset.

Our aim was to assess evidence of activity at the strategic level in relation to suicide prevention targeting the LGBT community. An initial, time consuming process involved contacting health and local authority services across the country via telephone and asking who the local lead on suicide prevention was. In total 102 suggested recipients were identified and sent a strategic survey. The survey asked about local strategic activity relating to suicide prevention, priority groups and activity directed towards priority groups. We also asked about knowledge of local LGBT organisations and the involvement of these organisations in strategic activity. A specific question was asked about the inclusion of LGB people as a group under Goal 2 of the National Suicide Prevention Strategy.

Responses

There were 28 completed eligible responses from 102 forms sent out.

Broadly there was a good geographic spread of forms sent out.

Table 2: Forms Distributed by Area

Region	No. of Forms distributed
London & the South East	26
North West	21
West Midlands	12
Yorkshire & Humber	11
East Midlands	11
South West	9
East of England	8
North East	4
Total	102

The main reason for regional differences was the difficulty in identifying strategic leads on suicide prevention in some parts of the country, most notably the North East.

In all there was a response rate of just under 28%. Proportionally this was the highest response rate across all three organisational surveys. We suggest that this reflects:

- Preparation work done by the NMHDU
- The process of attempting to secure a named respondent leads to a higher likelihood of response.

Respondents

Respondents were asked to give a job title; these were as follows:

Table 3: job titles of strategic respondents

Assistant Director - Adult Services
Associate Director of Public Health
Consultant in Public Health
Curriculum Advisor - Healthy Schools
Deputy Director of Commissioning
DPU
Emotional health and wellbeing lead (Mental Health)
Equality & Diversity Lead
Governance Manager, Mental Health
Head of Health Policy
Head of Joint Service Development for Mental Health
Head of Mental Health Commissioning
Head of The Older People's Psychology Service
Health Improvement Principal
Joint Commissioning MGR / Public Health Lead
Mental Health Commissioning Head of
Mental Health Promotion Co-ordinator
Nurse Consultant
Project Manager, Suicide Prevention Strategy
Public Health Lead
Senior Health Improvement Specialist
Senior Health Promotion Specialist
Senior Practitioner Suicide Prevention
Senior Project Manager for Mental Health
Senior Public Health Improvement Specialist (Mental Health)
Suicide Information Manager
Suicide prevention Manager, East Midland & Team Leader MHCT Derby
Training & Development Manager

Most respondents seem sufficiently senior and relevant.

Respondents were asked to identify their organisation.

Table 4: Responding Services

Bromley Primary Care Trust
Hertfordshire PCT's
Coventry & Warwickshire Partnership Trust
Derbyshire County PCT
NHS Barking & Dagenham
South West Yorks. Partnership NHS Foundation Trust
NHS Hull
Bedfordshire PCT
NHS Derby City (PCT)
Rotherham Metropolitan borough Council

Tees Esk & Wear Valleys, NHS Foundation Trust, but funded through local PCTs
Public Health NHS Leeds
NHS Bristol
NHS Westminster
Strategic Health Authority & Mental Health Trust
BEH MHT – i.e. the Barnet Enfield & Haringey Mental HealthTrust
NHS East Lancs.
North Lancashire Teaching PCT
Devon PCT
NHS Cornwall & Isles of Scilly
NHS Barnsley
NHS Oldham
Kensington & Chelsea PCT
North Yorkshire & York PCT
NHS East Riding of Yorkshire
Ealing PCT
Lancashire Care NHS Foundation Trust

London and the Yorkshire/Leeds areas seem well represented. There is a mix of urban and rural areas but more urban generally.

When considering the responses to all three organisational surveys (the strategic, mainstream and LGBT) it is worth considering what factors may make an organisation more or less willing to respond. We suggest throughout that those active, engaged in the issue, receptive to the issue, or with good practice examples to share are more likely to respond than those who are inactive, or perceive the issue as not relevant. It is not possible to quantify this and the idea should be treated with a degree of caution.

Awareness of change in National strategy

Respondents were asked whether they were aware of the change in the National Suicide Prevention Strategy to include LGB people as a group with specific needs under Goal 2 of the strategy. Responses were:

Table 5: Awareness of Strategy Change

	Yes	No
Aware of Strategy Change	23	5

There was a relatively high level of awareness of the change resulting from the NIMHE systematic review. Although not perfect this change has clearly been communicated effectively to this sample. However, caution is needed in generalising this finding to the whole of the sector, which may have less awareness of this change to National Strategy.

Respondents were asked to select from a list of strategic actions which they had in their area:

Table 6: Broad descriptions of local activity

Activity	Yes	No	Don't Know
A suicide prevention strategy	25	1	1
A suicide prevention strategy group	23	3	1
A suicide prevention action plan	21	3	1
A commissioning process in relation to suicide prevention	16	8	3
Leaflets, materials or resources about suicide	15	8	3
Web based information or support about suicide	6	13	7
A designated budget for suicide prevention	5	16	5
A suicide prevention providers forum	3	18	5

One respondent did not know whether they had a strategy, strategy group or plan. This suggests to us that a misidentification has occurred and that they were not in fact the appropriate person to answer the survey (or they were implausibly bad at fulfilling their role as strategic lead on suicide prevention).

Most respondents had a strategy, a strategy group and a plan. Respondents were asked if they were willing to share their strategies/plans and willing respondents were approached about submitting plans.

In the context of this research it is also worth noting that only a minority were actively aware of local use of the internet for suicide prevention (though there was a high degree of uncertainty about this as well). Whereas over half of respondents were able to identify local provision of leaflets, materials and resources, only 6 (roughly a fifth) were aware of online activity. This would suggest that the potential of the internet in relation to suicide prevention activity is not yet being explored fully at a strategic level.

Respondents were asked to identify target or priority groups. The groups identified were as follows:

Table 7: Numbers identifying targeting of particular groups

Target Group	No. Identify Targeting of These Groups
Self harmers	20
Users of mental health services	20
Young men	18
Alcohol & Drug Users	18
BAME	16
Older People	14
Prisoners	13
LGBT	13
Low Income	8
Particular Professions	8
Travellers	1
Children Leaving Care	1
Asylum seekers/refugees	1
Bereaved	1

Targeting particular groups was an activity indicated by 23 respondents. 2 did not answer this question, 1 answered "don't know" to all categories and 2 indicated that they did no specific targeting of priority groups. It would seem that targeting specific at risk groups is therefore a widespread practice. Particular professions cited included 2 mentions of agricultural workers, 1 mention of London Transport and 1 mention of the building trade.

It is initially encouraging to note that nearly half the entire sample and over half of those engaging in targeting activity, were targeting LGBT people.

We then asked respondents to identify how they target priority groups. A list of actions was given along with the opportunity to specify additional actions they took in relation to target groups. Answers given were as follows:

Table 8: Approaches to targeting priority groups

Target Group	Specialist service	Access targets for mainstream services	Outreach	Targeted Materials
Self harmers	12	1	1	2
Users of mental health services	9	2	2	1
Young men	1	3	3	5
Alcohol & Drug Users	10	2	0	2
BAME	4	4	2	2
Older People	5	2	4	1
Prisoners	5	0	3	1
LGBT	1	2	2	2
Low Income	2	1	1	3
Particular Professions	1	1	0	2

In all, seven respondents identified a specific activity of some sort relating to their targeting of LGBT people. Six distinct areas were identified: two were based in Derby (county and city), and one each in Leeds, Cornwall, Bromley, Lancashire, and Bristol. It is worth noting that this is only half of those that reported targeting LGBT people as a strategic priority. One way of perceiving this discrepancy may be that some areas had identified the priority but not yet developed any particular activity. Indeed one respondent said precisely this and another said they were waiting for this report. A less generous way of interpreting this discrepancy is that there is a clear gap between people saying they target a group and then doing anything about it. The possibility that some of the responses to LGBT need are tokenistic and lacking in substance, though not a desirable idea, should be considered

Known omissions

Certain strategic initiatives are known to the authors through other parts of the research (web searches, contact with LGBT and mainstream delivery organisations), most notably the Brighton & Hove initiative to produce an LGBT Suicide Prevention Strategy. Thus there is strategic activity that has not been identified through this process. This is perhaps inevitable as no process is perfect. However, our basic method of approaching the issue from four distinct starting points (the LGBT sector, mainstream delivery, strategic leads and LGBT service users) has enabled us to capture initiatives in one survey that we had not captured in another.

Involvement of LGBT Organisations

Respondents were asked about their awareness of local LGBT support services. In all, 19 respondents were aware, 5 did not know of any, and 3 were not sure.

In total 34 services were identified. MESMAC, Derby Friend and the Navajo Project were all identified more than once. All other services were mentioned once. 8 respondents said local LGBT services were directly involved in local suicide prevention activity. Activity ranged from membership of the local suicide prevention strategy group (Derby x 2 and Durham), consultation (Warwick) and involvement in research (Leeds). Cornwall also mentioned local LGBT sector involvement.

Local Strategies

At the time of writing, seven local strategies have been forwarded to us. Two make no reference to LGBT issues. One contains a commitment to finding out more about LGBT needs and another to acting on this present report. Two contain aims to deliver awareness training. One strategy from County Durham and Darlington has in its high level strategy and action plan a multi component commitment to the LGBT population including:

- Awareness training
- Needs assessment and ensuring local audit includes LGBT
- Partnership with local community organisations
- Development and commissioning of specific services for high risk groups (which specifically include LGBT)

As a generic strategy this represents the most comprehensive inclusion of LGBT issues found in this project.

Conclusions & Recommendations

We have only been able to identify a small number of strategic leads that are actively engaging with the LGBT issue. Although awareness of the strategy change is high in this sample of resdpondents, only half the sample have adopted LGBT as a target group and of these less than half have done anything about it. Much activity is fairly limited in scope with a handful of more proactive initiatives.

Case Study One

Leeds Lesbian, Gay, Bisexual and Transgender Mental Health Partnership

There is an LGB&T mental health Steering group of staff from across the City (both statutory and voluntary services). It works closely with Mesmac and with the "LGB" groups in the City, and is represented on the Pride organising group. The partnership has produced materials for NHS staff such as their 11 page booklet on the views and experiences from the lesbian, gay and bisexual population which provides both information and tips. The partnership has been involved in supporting a research project to establish the needs of LGB people in relation to their mental health and suicide prevention.

The work has been funded with the support of a grant from the Healthy Leeds Initiative, and DoH Pacesetter programme. Few local needs assessments like this one have been identified. The report "Closing the Gap – Service needs and prohibitions to access: The LGB community, self-harm, suicidal ideation and suicide" by Andrew Richards was launched in March 2010.

The report makes a number of recommendations for local services including training, links with LGB organisations, consultation where feasible, appointment of staff champions and the creation of an LGB Mental Health Development worker.

Survey of Mainstream Mental Health Organisations

Methodology

Our aim was to take a snap shot of how mainstream mental health services:

1. Monitor sexual orientation and trans identity and what barriers exist to monitoring
2. Promote access to their services by LGBT people, and
3. Ensure that LGBT people receive a good service.

We also asked whether services have done Equalities Impact Assessments (EIA).

Initially we had hoped for a contact list of relevant services via the commissioner. This unfortunately was not available. Using a little additional admin time paid for by the commissioner and a group of volunteer researchers from the internet survey we spent a number of weeks searching online to establish a national contact list for mental health organisations. From the Direct.Gov website we compiled a list of all regional local authorities, borough and district councils. Similarly the NHS website was used to compile a list of all PCTs and NHS trusts in England. Admin staff and volunteers then used the internet (Google and local authority and local NHS websites) to identify addresses for as many mental health services as possible. This also included as many voluntary sector mental health providers as we could find (often council websites had a list of helpful contacts). Frequently services were phoned to secure postal addresses. In all 1,202 mainstream mental health services in both the statutory and voluntary sector were sent questionnaires and FREEPOST reply envelopes.

Responses

177 responses were received. This amounts to a response rate of nearly 15%. A wide range of organisations responded. Respondents by sector were as follows:

Table 9: Mainstream service respondents by sector

Services Based in Respondent Organisations	Number	% of Sample
Mental Health NHS Trust	96	54%
A local Voluntary Sector Agency	30	17%
PCT	14	8%
Local Authority Adult Service	13	7%
Local branch of National Voluntary Sector Agency	13	7%
National Voluntary Sector	5	3%

69% of the sample are statutory providers and 27% voluntary sector. 4% of respondents did not answer this question. The largest number of respondents were services based in Mental Health NHS Trusts.

Monitoring of users

Respondents were asked to indicate which types of user demographic data they routinely collect.

Table 10: Demographic Data Collection

Demographic data collection	Number	% of Sample
Gender	164	93%
Age	161	91%
Race/ethnicity	158	89%
Disability	122	69%
Faith	103	58%
Sexual Orientation	55	31%
Transgender or gender variance	37	21%

Clearly sexual orientation and trans identities are significantly less likely to be collected. Responding organisations are nearly twice as likely to record someone's religious faith as sexual orientation. Trans identities are the least likely to be recorded.

We analysed results by sector to see if there was any significant difference between statutory and voluntary sector organisations when it came to monitoring.

Table 11: Demographic Data Collection in Statutory Services

Demographic data collection	Number	% of Statutory Sample
Age	120	100%
Race/ethnicity	119	99%
Gender	118	98%
Disability	94	78%
Faith	86	72%
Sexual Orientation	41	34%
Transgender or gender variance	25	21%

Table 12: Demographic Data Collection in Voluntary Sector Services

Demographic data collection	Number	% of Voluntary Sample
Gender	40	83%
Age	36	75%
Race/ethnicity	33	69%
Disability	26	54%
Faith	15	31%
Sexual Orientation	13	27%
Transgender or gender variance	11	23%

Some differences do seem to exist, with statutory services generally more likely to collect demographic data and having very high rates of collection of data on race, gender and age. Also the statutory services seem to have a significantly different approach to collecting data on faith, and are more than twice as likely to collect data on religion as the voluntary sector. However, rates of monitoring of sexual orientation and trans identity are broadly similar between the two sectors.

Clearly the majority of mental health services do not record sexual orientation data, contrary to the recommendations of the NIMHE Systematic Review. Arguably the impact of this is significant. It means:

- Absence of needs data from local service knowledge about these client groups.
- Impaired ability of services to assess access by these minority groups.
- Consistent with what we found from user responses, it may also directly affect the experience of these services by LGBT people.

Where appropriate we asked respondents to indicate why they thought that sexual orientation or trans identity data was not collected. In all 129 respondents gave 170 reasons why they thought their organisations did not collect this data. It should be noted as this point that we were collecting the opinions of staff – not necessarily an official policy or an organisationally thought out, or stated, position. Our aim was to explore the perceived barriers/reasons from staff in order to understand the basis for resistance to monitoring that staff in different organisations may present with.

Comments have been reviewed and grouped thematically into four themes in **Table 13**:

- don't know
- lack of external pressure
- organisational barriers (size, staff training, databases etc) and
- client considerations.

Table 13: Respondents thoughts as to why organisations did not collect data on LGBT identity categorised by theme

Reason	Number	% Reasons	Theme
Don't know why	15	9%	Don't know
Absence of External Pressure			
Not required to	3	2%	External
Not a legal requirement	1	0.5%	External
Not Government Driven	4	2%	External
Not Part of MH data set	3	2%	External
Funder does not require it	12	7%	External
Not a priority	1	0.5%	External/ Organisational
Total external	24[1]	14%	
Organisational Issues			
Senior management don't drive	1	0.5%	Organisational
Organisation is out of touch/not up to date	2	1%	Organisational
Historically haven't	1	0.5%	Organisational
Keep no client data	4	2%	Organisational
Don't know how to ask/lack of training on asking	3	1.5%	Organisational

1) It is not clear whether "Not a priority" means this is not an external or organisational priority – it has therefore been included in both categories of theme in this table.

Reason	Number	% of Reasons	Theme
Have recently introduced – boxes stay blank	1	0.5%	Organisational
Will do so in the future/planning to	4	2%	Organisational
Don't know how accurate it would be	1	0.5%	Organisational
Small numbers of people involved	5	3%	Organisational
Rural	1	0.5%	Organisational
Database not set up for it	3	1.5%	Organisational
Don't have facility	1	0.5%	Organisational
No box for it	2	1%	Organisational
Org too small	1	0.5%	Organisational
Need not established	1	0.5%	Organisational
Don't think they have thought about it	1	0.5%	Organisational
Little understanding of why equalities data is important	2	1%	Organisational
Supply staff	1	0.5%	Organisational
Lack of awareness	1	0.5%	Organisational
Personal beliefs/prejudices of staff	1	0.5%	Organisational
Total organisational	**38**	**22%**	
Client or Patient Issues			
We support anyone	7	4%	Client/equalities
Guidance on Trans	2	1%	Client/equalities
Equal ops	6	4%	Client/equalities
Don't recognise special needs	1	0.5%	Client/equalities
Equalities	**16**	**9%**	
Not relevant/important/needed	15	9%	Client/relevance
Not clinically important	1	0.5%	Client/relevance
Don't know purpose	2	1%	Client/relevance
Not needed for service	1	0.5%	Client/relevance
Doubt therapeutically helpful	1	0.5%	Client/relevance
Relevance	**20**	**12%**	
Interferes with client assessment	1	0.5%	Client/ Negative impact of asking
Fear of offending	1	0.5%	Client/ Negative impact of asking
People don't like to be asked	1	0.5%	Client/ Negative impact of asking
Awkward when clients in crisis	1	0.5%	Client/ Negative impact of asking
Negative impact	**4**	**2%**	
Intrusive/Privacy/Sensitive	12	7%	Client/Privacy
Allow people to express for themselves	4	2%	Client/Privacy
Keep questioning to a minimum	1	0.5%	Client/Privacy
Balance using personal info for statistical purposes	1	0.5%	Client/Privacy
Privacy	**18**	**11%**	

Reason	Number	% of reasons	Theme
Age – young general	7	4%	Client/ Appropriateness
Age – young under 12	1	0.5%	Client/ Appropriateness
Age – young 13-14	1	0.5%	Client/ Appropriateness
Age – young under 16	2	1%	Client/ Appropriateness
Age – young under 18	5	3%	Client/ Appropriateness
Age – development issues 'not fixed'	3	2%	Client/ Appropriateness
Age and learning disability	1	0.5%	Client/ Appropriateness
Age/appropriateness	**20**	**12%**	
To ensure clients don't experience discrimination	2	1%	Client/ Protection
Nowhere to go with data – make little difference	1	0.5%	Client/ Protection
Not sure how info would be used	1	0.5%	Client/ Protection
Protection	**4**	**2%**	
Not coming up	2	1%	Client/other
Varying viewpoints on advantages	1	0.5%	Client/other
Ask but don't record or not routinely	7	4%	Client/other
Other	**10**	**6%**	
Total client issues	**92**	**54%**	

Over half the reasons given related directly to the experience of the service user. Of these 7 (or 4%) of all reasons for not recording refer to a compromise arrangement which seems to acknowledge that sometimes the issue is relevant and notes are kept but that this is not recorded for monitoring purposes or not routinely addressed. The remainder of client based reasons variously suggest that staff do not see any benefit for their clients, or even see potential harm, in asking about or monitoring LGBT identities. These account for 50% of all reasons given. However, within this are a number of different sub concerns. The largest of these are general relevance (12% of reasons given), age (and to a lesser extent ability) based concerns over appropriateness (12%), privacy (11%) and equalities (9%). These account for 44% of all reasons given for not asking.

The equalities argument is broadly based upon the concept that if everybody is treated well and equally then it is not necessary to ask ('we just respect everybody'). Presumably this would apply to all demographic groups with equal force (i.e. why record race if you are just nice to everyone?). Connected to this idea is an unease with treating anybody differently (which might amount, by implication, to treating them preferentially) which was directly expressed by one respondent. Arguably this approach could work as long as this treatment was a genuine and successful effort on behalf of the providing organisation to make no assumptions about the presence or lack of LGBT identity for anyone using their service. The danger is that treating everyone as the *same*, becomes treating everyone as the *same as the majority*. In addition this view seems to be predicated upon the belief that providing a good service to LGBT people only requires that you aren't actively nasty or discriminating towards them when they access services. In this model a successful LGBT service is one that ignores their identities, disclosed or otherwise, on the basis that identity makes no difference. This view does not admit the possibility that LGBT people may have mental health needs for positive action in relation to their identities. These could include: affirmation, dealing with stigma/shame, consequences or fear of family or cultural rejection due to LGBT status, experience of violence or abuse based upon LGBT identity, and self loathing due

to internalised negativity towards LGBT identity. Essentially there is a commonly held belief that equalities is about treating everyone the same whereas a counter argument is that it is about acknowledging, respecting difference and responding appropriately.
Two respondents also referred to having made a decision that the most appropriate way to be inclusive of trans people was simply to support them in terms of their gender and not treat them as a third gender (in line with good practice guidance). Some trans individuals (and for that matter some LGB ones too) may not want to be categorised or identified by their difference. This desire needs to be considered in any approach to routinely raising the issue with patients.

Perhaps an extension of the 'treat everyone the same' concept is one of the most commonly given reasons for not asking, namely that it is not relevant. Again this view suggests that those giving this answer can see no way in which the needs of their client may be influenced by their identity. In short they cannot imagine doing anything differently. Conceivably, clinically, this may at times be true and absolutely the right thing to do (though see above for possible identity related needs connected to mental health). However, in terms of customer care it may not be true, particularly in light of the experiences described by users of the negative impact of assumptions, invisibility and denial of identity that they have experienced. Additionally if staff don't know how to respond to LGBT clients, aren't aware of local LGBT services or support that they can refer to or haven't developed methods of meeting LGBT needs, then their belief in no benefit from asking merely becomes a self fulfilling prophecy.

An extension of this concern is the belief that it is important NOT to routinely monitor LGBT identities until staff are able to respond appropriately. This view forms the conclusion on patient monitoring in Stonewall's report by Ruth Hunt and Katherine Cowan, in *Monitoring Sexual Orientation In The Health Sector*, published in 2006. The argument is not to do this before the NHS is capable of responding adequately to LGBT needs. Clearly there is a significant risk of encouraging LGBT clients to come out only for them to receive inappropriate, harmful or inept reactions. Until such time as adequate responses are achieved an approach of empowering individuals to come out and ensure that they are met with appropriate response if they do, is preferred in the Stonewall report, with a longer term aim of reaching routine monitoring within 5 years (which would be by 2011). A few respondents seem to acknowledge this issue as a barrier to asking, with 3 or perhaps 4[2] members of staff expressing concern about the safety of the disclosing patient. Although a very small number, it is disturbing nevertheless that any staff in mental health services should say it is not safe for LGBT people to come out there. An additional concern raised by the Stonewall report is the appropriateness of simple 'box' categories for addressing complex fluid entities like identity and sexual behaviour. Our own experience in the user survey seems to support this view for some individuals.

11% of reasons given for not monitoring concerned privacy or intrusiveness. A typical comment from these answers is:

> *"The sexuality of clients is their own concern. To question around sexuality can appear unnecessarily intrusive"*

Within this grouping people expressed a struggle between gathering useful statistical data and asking many questions, particularly personal ones, without a sound clinical, patient focused benefit for doing so. Perhaps once again this relates to the theme described above that clinicians do not perceive any benefit for their clients of staff becoming aware of sexual minority status (although we imagine that in fact they routinely do become aware of whether people are married, have children and draw conclusions – appropriately or otherwise – from this information).

In addition to the 18 responses concerning privacy a smaller, perhaps connected group, saw asking as having the potential for negative impacts, essentially stating that 'people don't like being

2) One answer is ambiguous.

asked' or that the question could damage client relationships in assessment. It is probably true that some people in society may react with hostility or negativity towards any attempt to record sexual difference. Taboos on sexual activity, identity, discussion about sexual matters and any approach to gender beyond the 'you are born it and you better act it properly' run deep. Strong religious and cultural prohibitions towards talking about sex, sexuality and same sex activity exist. Many people first experience the question 'are you gay?' as the prelude to an attack or an insult; it is unsurprising therefore that they may continue to be insulted by anything resembling that question. Questioning a person's gender has a similar hostile value in many parts of society.

In addition LGBT people themselves may not feel trusting or willing to disclose to service providers (and a number will agree with some respondents in believing that their identity has absolutely no relevance – often they will be right). We do not doubt that this is sensitive, should be handled carefully and that respect for privacy and an understanding of client reluctance or unease should inform any routine approach. At the same time we are concerned that this silence can partly collude with discrimination. Not talking about LGBT issues on the basis that it may offend those with hostility towards these identities seems unjust. Subtly re-enforcing shame, stigma, invisibility and marginalisation of this client group is the risk created by a silence based upon fear of giving offence. The tension between these two points can be seen as creating some different attempts at addressing this issue. Broadly these are:

1. Developing approaches to monitoring which allow for or even encourage clients to opt out of answering questions where they feel uncomfortable.
2. Taking actions to actively promote self disclosure (clear public messages, reassurance of acceptance, clear statements of confidentiality and raising the issue without direct questioning). One form of this may involve saying something to the effect of: 'We don't ask people about their sexual orientation or whether they identify as transgendered because we know it is a private issue and it is something that some people feel uncomfortable with. However, if this is an issue for you and you would like to talk to us about anything to do with sexual difference then we would like to assure you that we will do our best to respond appropriately and helpfully. If you would like your sexual orientation or gender identity monitored for equality purposes we would be happy to do so. When you come out to us it helps us to better understand what is going on for LGBT people and plan better services in the future'. Clients could then be given a choice about whether they simply want to be recorded or whether they actually want to talk about their identity in relation to their presenting problem; hence avoiding another problem of over or under reacting to disclosure.

Ultimately health providers in this country are constantly struggling to find the most appropriate ways of having difficult, sensitive conversations at the right time with their clients. The health service itself has had to find ways to talk about death, sex, drug use, contraception, infertility, a bewildering range of embarrassing or intimate medical conditions, phobias, anxiety, suicide, child abuse and domestic violence. Arguably, the personal, sensitive and private are the routine business of health care. It is also worth remembering that nearly one third of respondents are managing to monitor sexual orientation and one fifth are monitoring trans identities. Actively promoting their experience and effective solutions to these concerns may go a long way to reassuring services that this is possible if done appropriately.

The final large group of reasons given for not asking concerns age (and one respondent mentioned age and learning disability jointly). 20 responses or 12% off all reasons given were that the clients were too young. Interestingly the age range at which clients were thought too young varies from under 12 to under 18. A number of respondents raised development issues, saying broadly, that identity may not yet be fixed or decided. Possibly a concern is that services working with young people do not want to pressure young people into a definition or identity which may then make it harder for individuals to change their minds or develop differently later on. Whilst this

is basically reasonable, needless to say, this concern largely ignores the fact that young people are systematically and routinely pressured into orientation and gender identities from a very young age (and this is 'fine' as long as it is the 'right' identities they are being pressured into). Similarly, therapeutically, services may not want to force disclosures from young people who are not ready or willing to make that step. These concerns raise several important questions. Firstly at what age (if ever) is it appropriate to routinely start raising these issues with young people? Many LGBT young people seem to 'know' their identity at an early age. Conversely the concept of a homosexual phase of development that passes has been a commonplace for decades. Secondly, how could this issue best be raised in a way which is enabling of young people, does not provoke anger or hostility in parents and is not harmful to young people? We do not in any way wish to trivialise or ignore these concerns.

There does not seem to be evidence of a widely accepted approach to LGBT issues within CAMHS. We are aware of the Organisational Cultural Competence Self Assessment Tool (OCCA Tool) for Child and Adolescent Mental Health Services (CAMHS) developed by the National CAMHS Support Service with additional development by GALYIC, Gay and Lesbian Youth in Calderdale and North West Region CAMHS staff. This tool is very clear that monitoring should include sexual orientation/gender identity and that assessment should seek to identify any potential bullying and discrimination issues including internal stigmatisation of identity. However, we are unable to comment on how broadly it has been disseminated or adopted. At present the tool, along with a range of useful guidance and information on LGBT youth (including links and referrals), is available on the Child and Maternity Partnership (CHaMP) website. We have also found reference to a DCSF Guidance on Monitoring Sexual Orientation in Young People's Services, 2007 (in the tool kit mentioned above). We have endeavoured to find out more about this but have been unsuccessful (it is not on the DCSF website and the DCSF staff we have spoken to do not know of its existence). A review and/or update of existing guidance and a concerted campaign to make CAMHS services aware of the guidance would be of benefit. The latter is particularly important. In order to find the tool kit described above a service would need to be both willing and actively looking for it. From the homepage one would need to click> Social Inclusion> LGBT Young People> Information & Resources for Health Workers> Link to the Toolkit. Although we have no problem as to the rationale of this as a filing system we fear that unless promoted it will remain an underused resource. In any event the tool kit though thorough, describing much good practice and of undoubted benefit does not address the primary barrier described here, namely, at what age is it appropriate to start raising the issue with young people? Guidance on this, though no doubt controversial, may go some way to making CAMHS staff feel more secure in doing so. This guidance needs to be actively promoted in order to reach its audience.

In addition to patient focused concerns about monitoring, two other groups of barriers emerge. Respondents identify a range of practical/organisational concerns. The first of these concerns lack of capacity (staff, database, size of organisation, don't know how to) which account for 6% of all comments. Training and adaptation resources will plainly be required. Economies may be achieved by facilitating local exchanges of knowledge between the LGBT community and statutory sector. Relatively small, time limited, pump priming resources to encourage adaptation may help overcome some of these concerns. The second organisational theme concerns lack of willingness (out of touch, prejudice, lack of understanding, senior management not driving) which account for 5% of comments. Finally, doubts about validity (need not established, numbers too small, don't know how accurate it would be) account for a further 5% of all responses. 5 responses concerned small numbers (a further comment referred to a rural service which we have taken to be a reference to smaller local LGBT populations). It is undoubtedly true that many areas do not have the LGBT population of certain London boroughs, Manchester or Brighton. In addition what population does exist in rural areas may well be less visible and more broadly spread. A number of points occur to us on this issue:

- The greater the invisibility the more effort that needs to go into ensuring that local need has been accurately assessed. Presumptions of non-existence based upon a refusal to count do not constitute a valid method of assessing local need.

- Small or thinly spread populations may require a more strategic or larger area approach to meeting these needs. If numbers have been robustly shown to be sufficiently small to make action at the local level uneconomic then economies of scale can be achieved by combining resources with neighbouring areas, encouraging urban initiatives to reach out to rural areas, reviewing needs on a regional basis and identifying and nurturing any voluntary community provision that does exist.
- The absence of local LGBT voluntary provision makes the appropriateness of statutory and mainstream, services even more important.
- Online and telephone based interventions may be more vital to those in rural areas but cannot entirely replace the need for appropriate in-person services.

The last strand of barriers to monitoring concerns absence of external pressure. In total 14% of reasons given were based upon the absence of any external driver requiring organisations to monitor LGBT. 3 responses mention that this is not part of the mental health minimum data set and 12 responses (7%) said that their funder does not require them to monitor. For many organisations the data burden is a considerable pressure and apt to increase. It is unsurprising that some organisations limit this burden by collecting solely what they have to. It is our opinion that ultimately the only way that sexual orientation will ever be monitored at the levels of race, gender or age is by making it a requirement of funding to do so. This step would undoubtedly have its dangers:

1. It may encounter complaint and resistance.
2. Coerced activity may be less well thought out, staff less well prepared and the matter handled insensitively. This is likely to generate ill will and complaint and further stiffen resistance.
3. Resistant providers may initiate discussions with patients about LGBT identity badly and concerns about negative experiences may prove to be justified.
4. Services may not be ready to offer LGBT friendly responses.
5. Identity based equalities initiatives may find themselves increasingly on the defensive in the next few years as resources tighten and priorities re emphasise poverty as opposed to identity as the primary focus of equality activity.

Given the above it is by no means certain that we are currently ready to make this change. However, change will only happen piecemeal and slowly without a top down commitment and an appropriate change management strategy. We urge this to happen and advise the following steps as essential:

1. **Make the case for change.** The most commonly articulated barriers to monitoring sexual orientation and gender identity are related to patient welfare and response. Underlying a significant proportion of these seems to be a lack of belief in the benefit to patients of monitoring this aspect of identity. Until this is made clear it is hard to see why services would want to introduce this. The key points of this case seem to us to consist of the following.

a) A clear, consistent and growing body of evidence indicates that LGBT people are more likely to experience some common mental health problems including attempted suicide. Not asking may obscure local need.
b) Some LGBT people may have mental health needs directly relating to their experience of discrimination and rejection. Appropriate responses may therefore include affirmation of this identity.
c) A range of appropriate LGBT voluntary sector support may be available locally to service users.
d) Many LGBT people are willing to come out to their medical providers.
e) Failure to record an individual's identity may mean repeated wrong assumptions and repeatedly forcing self disclosure which is then repeatedly not heard.
f) Ignoring, rendering invisible, or making wrong assumptions about somebody's sexual orientation or gender identity are common negative experiences reported by this client group. These can act as significant barriers to service use.

g) Whilst sexual practices are undoubtedly a private matter in point of fact sexuality is often made very public (asking about spouses, children, wearing wedding rings, talking about engagements or marriages are everyday social experiences).
h) Sharing the experience of agencies that are finding it possible to monitor LGBT identity will help to reassure providers that their worst case scenarios often do not come true.

2) Equip for change. It is possible to routinely raise this issue in a way that enables users to choose whether they disclose, minimises the likelihood of giving offence and which does not constitute prying. Staff need to know how to do this and most importantly need to know appropriate responses to disclosure. Policies need to be appropriate to protect people who disclose, and adequate systems need to be in place to collect and store data safely and review it frequently. There should be clear guidance for CAMHS on when and how it is appropriate to routinely raise this issue. This should include guidance on confidentiality. Most importantly a child is never at risk because of an orientation. No practitioner would ever consider the need to notify parents of a child's interest in, or expressed, heterosexuality.

LGBT Appropriate Services

In order to provide an appropriate service to LGBT people we believe that there are four things that need to happen. These are:

- Estimate the local LGBT population and attempt to assess the level of need among LGBT people
- Attempt to promote access to services proportionate to need
- Attempt to ensure that service delivery is safe, appropriate and effective for LGBT people
- Measure progress against the above through monitoring of service access, retention and success with LGBT clients.

Having considered the issue of monitoring we now consider need, access and delivery.

Assessing Need

In the absence of systematic monitoring it is arguably even more important that useful and positive steps are taken by services to assess LGBT need. Therefore, in addition to monitoring, we asked services what other steps they had taken to assess the need of LGBT people locally.

Table 14: Steps taken to assess LGBT need

Action	Yes	No	Don't Know
Consulted with LGBT individuals	61 (34%)	48 (27%)	59 (33%)
Consultation with LGBT Community Groups or Services	52 (29%)	57 (32%)	58 (33%)
Reviewed published or other research evidence on LGBT needs	32 (18%)	57 (32%)	58 (33%)
Local LGBT Needs Assessment	17 (10%)	78 (44%)	69 (39%)

Roughly speaking one third were aware of having done some consultation with either LGBT clients or organisations and smaller numbers were aware of having taken more steps. In total 17 organisations or 10% of the sample had actually done an LGBT needs assessment.

It is interesting to note the effect of having done an Equalities Impact Assessment on this question. In all, 81 (46%) had done an EIA (69 of these were by statutory services and the rate of having done an EIA was 58% among this group).

Answers to this question from those that had done an EIA were as follows:

Table 15: Steps taken to assess LGBT need by organisations that reported having done an EIA

Action	Yes	No	Don't Know
Consulted with LGBT individuals	33 (41%)	18 (22%)	27 (33%)
Consultation with LGBT Community Groups or Services	32 (40%)	20 (25%)	26 (32%)
Reviewed published or other research evidence on LGBT needs	18 (22%)	28 (35%)	58 (38%)
Local LGBT Needs Assessment	12 (15%)	31 (38%)	34 (42%)

It is pleasing to note that having done an EIA does seem to make organisations more likely to have taken active steps to assess LGBT need. In particular they are 50% more likely to have done an LGBT needs assessment with 71% of these needs assessments being done by organisations that have done EIAs. Similarly EIA organisations are slightly more likely to have done some consultation or reviewed some research.

The Improvement and Development Agency defines an EIA as follows:

> An equality impact assessment (EqIA) is a tool for identifying the potential impact of a council's policies, services and functions on its residents and staff. It can help staff provide and deliver excellent services to residents by making sure that *these reflect the needs of the community.*
> [our emphasis added].

When one considers the goal of an EIA it is perhaps disappointing to note that some organisations doing an EIA have not taken more steps to assess LGBT needs. In particular it is worrying to observe that only 39 of the 81 organisations that had conducted an EIA (48%) were aware of having taken any of these steps to assess LGBT need. This begs the question how the remaining 52% were able to complete an EIA for their service without any evidence of having taken any steps at all to gauge

need within the LGBT community i.e. over half of EIAs conducted by these services did not consult with LGBT individuals or organisations, review published or other research evidence or conduct an LGBT needs assessment. This leads us to question the value of a significant proportion of EIAs with regards to reflecting the needs of this client group. Clearly one cannot reflect a need that one has done nothing to ascertain.

Promoting Access

Mainstream organisations were asked what steps they took to promote access by LGBT people. Respondents gave the following answers:

Table 16: Steps Taken to Promote Access by LGBT People

Action	Yes	No	Don't know
Publicised equal opportunities statement	108 (61%)	26 (15%)	36 (20%)
Sent service information to LGBT community organisations	49 (28%)	59 (33%)	62 (35%)
Established referrals with LGBT organisations	26 (15%)	75 (42%)	66 (37%)
Advertised or promoted services on LGBT websites	23 (13%)	83 (47%)	62 (35%)
Produced service leaflets or materials targeted at the LGBT community	21 (12%)	94 (53%)	51 (29%)
Advertised in the local or national LGBT press	17 (10%)	89 (50%)	61 (34%)

Although a large number of services took the step of publicising their equal opportunities statement (and a large number of the statements specifically include LGBT – see below) more active efforts to reach LGBT people were more confined. In all 65 or 37% had taken one of the more active steps to promote access by LGBT people. A significant minority have gone as far as establishing referrals or ensuring that they promote services on LGBT websites or in the LGBT press.

Whilst it is good that services are taking steps to promote access by LGBT people and we would encourage all mental health services to take active steps to build relationships with all communities around them, some may consider it valid to ask is it really necessary to promote access specifically to LGBT people? Ultimately we believe that the answer to this question comes back to assessing local need and monitoring existing access. Fundamentally, activities to increase access by any group should be most driven by a discrepancy between need and current service use. The problem with planning for LGBT needs is the absence of data on both sides of this equation. However, although a small self selecting sample, the user survey combined with the NIMHE systematic review and a growing body of other consistent evidence does give grounds for a credible assumption of unmet local need to be investigated and potential barriers to access to be overcome. Given this and the relative ease and low cost of some of these activities (Google LGBT groups in your area, ask if you can be included on any relevant websites/listings and send groups/organisations a leaflet or even better get in touch and start a dialogue) it is hard to see how a largely self inflicted absence of information can be used to justify such widespread inactivity.

Delivering Appropriate Services

Assessing need, monitoring and promoting access are all ancillary to the fundamental business of delivering appropriate support to people. Thus we asked which of the following steps organisations took to ensure that their services were LGBT friendly.

Table 17: Steps Taken to Ensure LGBT People Receive an Appropriate Service

Action	Yes	No	Don't know
Specifically include LGBT in your equal opportunities policy	104 (59%)	26 (15%)	35 (20%)
Displayed LGBT posters or leaflets in public areas	59 (33%)	62 (35%)	44 (25%)
General equalities training for staff	148 (84%)	10 (6%)	9 (5%)
Specific staff training on LGBT awareness	61 (34%)	74 (42%)	29 (16%)
Specific services targeting LGBT community (either in house or satellite)	24 (14%)	99 (56%)	38 (21%)

The majority of services were aware that they specifically include LGBT in their equal opportunities policy (but not much more than half) and the significant majority did some general equalities training. Roughly one third were aware of having taken the fairly basic steps of staff training on LGBT issues and ensuring that there was some visible (poster/leaflet) LGBT materials in public areas. Roughly half as many again had developed specific service delivery targeting LGBT people.

Measuring Success

The final part of a best practice approach to service delivery for LGBT people needs to be measuring success. We asked services what steps they to took to attempt to gauge their impact on LGBT communities.

Table 18: Indicators of success

Action	Yes	No	Don't know
Analyse service data on access or outcomes for LGBT people	14 (8%)	93 (53%)	59 (33%)
Specifically analyse feedback of LGBT people	13 (7%)	93 (53%)	59 (33%)

Clearly very few of the sample were aware of any measures taken to attempt to quantify their success in relation to LGBT communities. Whereas 55 organisations routinely collect data on sexual orientation only 14 were aware of any LGBT-focused analysis of data (2 of whom stated that this was 'just starting').

Practice Summary

If good practice consists of routine monitoring, action to assess local needs, leading to specific action to address these needs or promote access with review or evaluation of impact then we have been able to identify 10 (6%) respondents who have taken some action in all of these areas. Three of these are voluntary sector providers and seven of them are statutory. A further 18 organisations (10%) of the sample have taken action in 3 out of 4 of these areas. In total therefore 28 organisations (16%) are engaging in activity which is more than minimal in relation to LGBT mental health.

What staff wanted to see locally

Finally respondents were given the opportunity to tell us what they would like to see locally to support LGBT people. 94 individuals mentioned 109 things they would like to see.

Broadly these broke down as follows:

Table 19: What mainstream staff wanted to see locally to support LGBT people

	Number	% of Total Sample
LGBT services	48	25%
Links with LGBT community	14	8%
Staff training	9	5%
Informing LGBT people of services	8	5%
More info on local LGBT services	7	4%
Data/needs assessment	6	3%
Other	17	10%
TOTAL	109	

48 respondents wanted to see more LGBT services available locally. Half of these identified a specific service they would like to see, these were:

Table 20: Specific Services Mainstream Respondents Wanted to See Locally

Service	No.
LGBT Youth Service	7
Support Groups	5[3]
LGBT Counselling	4
Other	8

Other services specified were: buddy system, outreach, social activities, accessible volunteering, employment support, drop in, phone line and a centre.

10 respondents talked about wanting to see something (but did not specify what) in their immediate locality. Half of these specifically identified themselves as in rural areas and a number of comments were made about LGBT people having to travel to cities to access help.

Finally 14 respondents talked generally about the need to develop LGBT services and the LGBT sector. Two respondents talked specifically about the absence of local commissioning with regard to LGBT mental health. One respondent contrasted this directly with sexual health: *"I would like to see PCTs taking more responsibilities in commissioning LGBT specific services through mental health rather than sexual health".* Others talked more generally about better funded local services, increasing capacity in the LGBT sector and developing LGBT specific services.

7 respondents wanted more information on local LGBT service provision and 14 respondents wanted to have better links with the LGBT community. A number of respondents when describing stronger links with the community referred specifically to LGBT voluntary and community sector organisations within this. Typical of these comments were:

> *"Strong campaigning LGBT community group holding us to account!"*
>
> *"We would welcome partnership working with local LGBT orgs"*
>
> *"LGBT groups better funded therefore more able to work in partnership with statutory sector including commissioning of services."*
>
> *"Local community groups and organisations that can provide advice and information on the key issues"*
>
> *"More organisations who actually support organisations like ours to be up to speed with support to LGBT community."*

In all 69 respondents (39%) of the total sample wanted some kind of local LGBT community development or engagement to take place. This constituted the largest grouping of desired local activity.

This suggests at least a perceived gap in LGBT provision. It would also indicate a substantial willingness to see and/or engage with local LGBT provision. A number of respondents articulated frustration and not being able to find or maintain dialogue with an appropriate service or contact organisation.

Following LGBT community development/engagement a number of respondents identified key changes they wanted to make to their own organisations, and these included training (9 respondents), better efforts to tell LGBT people about services (8 respondents) and better data/ needs assessments (6 respondents).

Finally 17 respondents mentioned a range of other things that they would like to see. 7 respondents described activities or aspirations in very general terms (increase visibility, reduce stigma, more equalities awareness, accessible, friendly services). 4 mentioned other specific resources or activities (posters, more staff time, staff group and work in schools). 3 mentioned mainstream competence in a general way and 3 referred generally to absence of local activity saying that they respectively wanted to see: something, anything and more.

3) It is worth noting that one of the respondents indicating that they would like to see a support group locally specifically identified this as for trans clients. Similarly one of the counselling responses was also specifically for trans clients.

Conclusions & Recommendations

1. Most mainstream mental health services are not aware of or simply not taking any significant active steps to specifically address the mental health needs of LGBT people. More needs to happen at the highest strategic level to facilitate engagement with the issue. Trusts need to experience both national strategic drivers on LGBT mental health and suicide prevention and 'case for change' material both from above and from local community networks.
2. A minority (roughly a third) are engaged in a very basic level of monitoring, and/or simple steps to ensure appropriate access and engagement with the LGBT community (displaying a poster, staff training).
3. A small number (between 6-16%) have taken some more active steps (developing a local needs assessment, developing specific services, reviewing local data, partnership working).
4. 6% of the sample describe what might be considered good practice in terms of multiple actions addressing each stage of a good practice service planning, delivery and evaluation cycle. These experiences need to be promoted further.
5. Very little LGBT work is properly informed; invisibility remains the defining characteristic of the issue:
    a. Most services do not monitor sexual orientation.
    b. Most services monitoring sexual orientation do not routinely analyse this data
    c. Most services do not take any active steps to assess local LGBT need
    d. Over half of Equalities Impact Assessments conducted by this sample have been done without monitoring LGBT identity, reviewing evidence on LGBT need or consulting with LGBT individuals or community organisations.
6. All local needs assessments must demonstrate a genuine attempt to gain at least some level of awareness of LGBT people. The LGBT community sector should be supported to ask local providers and planners to demonstrate the steps they have taken to reduce the invisibility of this client group. A national managed change approach to monitoring sexual orientation should be developed. Initial steps should include making the case for change and equipping for change on a broad level rather than relying on isolated single initiatives to produce patchy areas of good practice.
7. Staff in mainstream services perceive significant barriers to monitoring LGBT identity or raising the issue with clients. The most frequent barriers raised relate to client welfare. This should be directly and explicitly addressed in the case for change outlined above.
8. CAMHS services need nationally recognised and significantly promoted guidance on when and how it is appropriate to routinely raise issues of sexual orientation and gender identity with their clients. This needs to be sensitive and appropriate.
9. When asked what they would like to see available locally the most common answers from nearly 40% of the sample involved some kind of community development or engagement with the LGBT community. The relationship between the LGBT sector and mainstream should be systematically strengthened. Pump priming grants such as those in Leeds or direct funding of relevant services such as in Brighton can significantly enhance local provision.

Case Study

Cornwall & Isles of Scilly Primary Care Trust

Following identification of a group of suicides among the gay population in Cornwall, LGBT people were included as being at significantly higher risk of suicide in the Suicide Strategy for Cornwall which has listed actions to improve the situation

The Trust made available ASIST (Applied Suicide Intervention Skills Training) to approx 200 front line service staff from a diverse range of health and community organisations. This included Healthy Gay Cornwall. Healthy Gay Cornwall also contribute to the local Suicide Prevention Plan.

Survey of LGBT Organisations

Methodology

The aim of the survey of LGBT organisations was to understand:

- The extent to which LGBT voluntary organisations are working with the issue of suicide prevention and mental health.
- The involvement of LGBT organisations in local strategic planning on suicide prevention.
- The relationship between the LGBT sector and statutory and mainstream mental health organisations.

During our mapping phase we searched for LGBT organisations in England using Google and www.queery.org (the online Switchboard directory). We tried to exclude purely social groups such as sports clubs and groups focused solely on recreational activities, though groups that had both a social and support function were included.

We posted surveys with freepost replies to 399 LGBT organisations and received 65 completed responses (a response rate of just over 16%). Respondents were asked to describe their services, their activity and awareness of suicide as an issue, local relationships with statutory services and involvement in local suicide prevention strategies

Respondents to the survey

65 organisations responded to the survey. These were:

Table 21: Responding LGBT organisations

- GGLC
- Leeds Gay Community (completely voluntary and self-funded) forty members 2008-2009
- Oxford Friend
- Armistead Project
- Yorkshire Mesmac Group of services
- Space Youth Project
- Gemma
- Regard
- Outburst
- North Staffordshire lesbian, gay and bisexual switchboard
- Drug and Alcohol Service for London (DASL)
- Camden LGBT Forum
- Lesbian Community Project
- Men 4Men Sexual Health Outreach Project NHS Luton Community Services
- Oxford Brookes Student Union
- London Friend
- Enfield LGBT Network
- George House Trust
- Nottingham and Notts Lesbian and Gay Switchboard
- Pink Umbrella
- Tareside Oldham and Glossop Mind
- OUTCOME
- Healthy Gay Life
- The Albert Kennedy Trust
- Lesbian and Gay Foundation
- Coventry and Warwickshire friend
- "Friend" (Bradford) established 1973
- University of Bath LGBT and friends
- Lesbian Community Project
- Brighton and Hove LGBT Switchboard

- Out-side-in
- Project Oscar (at NHS Central Lancashire)
- LAGIP
- Self help services
- Quaker Lesbian and Gay fellowship
- Terrence Higgins Trust (west)
- Pride in Canterbury
- Healthy Gay Cornwall
- Press for Change
- FtM London
- OUTLINE
- Gems (Gay Essex Men's Social Group)
- Allsorts Youth Project
- Organisation: 42nd Street; LGBT project: inside out
- Foundation 66
- MindOut
- Brunel University - see below
- YOUR lgbt*
- Stonewall Info Service
- MESMAC North East
- GLADD (Gay & Lesbian Association of Doctors & Dentists)
- Queernotions
- South London Gays
- THT Telford
- OUTRAGE!
- Haven (Social Group)
- DLGH (Dorset Lesbian & Gay Helpline)
- The Arun Gay Society
- BLAG Youth Group Connexions
- BiPhoria
- UK Lesbian & Gay Immigration Group
- Positive Action
- GALYIC
- Pace

Respondents range from small rural groups to large urban or national organisations such as Stonewall and Manchester Lesbian and Gay Foundation. Respondents are engaged in a wide variety of support activities.

Table 22: Activities of Respondents

Activity	No. of Respondents
Website information	51
Phone line support or information	40
Social/support groups (and age)	38
Volunteering	34
Support for trans people	32
Counselling	31
Awareness training	31
Online support (forums, email or chat)	28
Lobbying and campaigning	28

Advocacy	25
Befriending	24
HIV Prevention work	24
Support for victims of crime	22
Youth Groups	16
Domestic Violence Support	15
Arts projects	15
Couples counselling	14
Support groups for older people	13
Housing Support	13
Drug and alcohol support	12
Employment Support	12
Other	15

We reviewed the activities and aims of every organisation and made an assessment as to the degree and nature of relevant contact the organisation had with LGBT individuals. At this point we chose to exclude four respondents on the basis that their organisations' activities were either exclusively lobbying/campaigning or in fact exclusively social. One of the latter respondents indicated that they did not consider themselves relevant to the issue. Thus we identified 61 respondents engaged in some kind of relevant support activity with LGBT people.

A range of different target support groups were identified; organisations serving younger and older people replied in almost equal measure, in addition groups serving women, people with HIV, immigrants and trans people are included in the survey. No groups working solely with specific racial groups responded.

Working with Suicide and Self Harm

Over half of the 61 organisations identified as providing relevant LGBT support reported that they were aware of supporting people with issues relating to suicide.

Table 23: Numbers of organisations currently aware of working with suicidal clients

Indicator of Present Needs	Number of Organisations
Currently aware of supporting people who are suicidal	31
Aware of supporting clients who have made a suicide attempt in the last six months	29

In total 36 out of 61 (nearly 60%) of respondent organisations were aware of supporting LGBT people who were either currently suicidal or who had made a suicide attempt in the last 6 months. 15 respondents (just under a quarter) saw themselves as providing services specifically aimed at preventing suicide or supporting those who are suicidal. The LGBT sector is clearly significantly involved in providing support to those with current needs in relation to suicide prevention.

This raises two concerns immediately. LGBT voluntary and community sector organisations are not evenly spread or resourced. In particular they tend to be urban as opposed to rural with a small number of medium or larger sized organisations based in cities and a large number of small organisations. LGBT people living in areas without access to an LGBT voluntary sector may therefore be more reliant on statutory or mainstream services for local support.

4) Other activities described included: taxi/driving support, drop-ins, prison visits, religious support and awareness raising, informal 1-2-1 support, advice and cultural events.

LGBT organisations were asked whether they have data available in terms of clients presenting with current suicidal ideation or a history of self harm or attempted suicide. Only 3 agencies submitted data:

Agency 1

This is a larger LGBT service with three youth groups, a youth counselling service and doing work in local schools. Its initial assessment asked about rates of attempted suicide and DSH among users. Of 141 assessments in the last year:

- 28% have attempted suicide before point of contact
- 17% regularly think about harming themselves at point of contact
- 19% are deliberately hurting themselves at point of contact

In total 34% of those assessed by this service have attempted suicide, harmed themselves or thought about harming themselves in the 6 months prior to accessing support.

Agency 2

This is an LGBT youth service with a range of services including groups, drop ins, online work, 1-2-1 support and advocacy. In assessments of its users:

- 74% self-harmed (70% of these said there was a link between their self-harming and their sexual orientation);
- 72% had suicidal thoughts (58% of these said their suicidal thoughts were related to their sexual orientation);
- 56% had actually attempted suicide (61% of these said it was related to their sexual orientation).

Agency 3

A larger LGBT centre with a counselling service had seen 68 clients in 2009 of whom 21(31%) had attempted suicide at least once.

Preparedness of LGBT Organisations to Work With Suicide as an Issue

We also attempted to gauge the extent of development that LGBT organisations have undergone in order to support those with needs in relation to suicide prevention. We looked at internal qualities (primarily policy and training) and external qualities (referrals and links with non-LGBT services).

The following table shows how many of 61 agencies providing relevant support services have developed particular areas of preparation.

Table 24: Preparedness to work with suicidal clients

Activity	Number
Emergency contact numbers for suicidal clients	25
Assess clients for suicide risk when they access services	21
Have working with suicide included in other organisational policies	19
Training for staff and volunteers on suicide risk and prevention	16
Have a specific policy on working with people at risk of suicide	11

Just over a third of agencies assess for suicide risk, about half have some form of policy covering suicide (either specific or within other policies). Just over a quarter have provided training for staff on suicide risk and prevention. Less than a half are making emergency contact numbers available to their clients.

An obvious area of concern is to what extent LGBT organisations may be exposed to clients with this need without the appropriate levels of awareness and procedures to ensure that users remain safe. We decided to look specifically at those organisations currently working with suicidal clients. Within this group we only have 36 organisations. Clearly this is a very small sample and conclusions should be treated with caution. The following table shows how many of these 36 organisations supporting those with current needs in relation to suicide, have developed particular areas of quality.

Table 25: Preparedness to work with suicidal clients among those supporting someone currently suicidal.

Activity	Number
Assess clients for suicide risk when they access services	16
Emergency contact numbers for suicidal clients	16
Have working with suicide included in other organisational policies	15
Training for staff and volunteers on suicide risk and prevention	15
Have a specific policy on working with people at risk of suicide	10

Each element of preparation for working with suicidal clients was reported by less than half of those currently supporting those with recent need (though arguably 25 out of 36 had some kind of policy relating to suicide). However, it remains the case that less than half have received training, assess for suicide risk or provide emergency contact numbers. 7 out of 36 organisations had none of the things listed above in place. Thus just over one fifth of LGBT organisations in the sample in current contact with the issue had no obvious formal preparedness to do so. As mentioned this sample is admittedly small and due caution should be attached to the weight it is given. However, it indicates to us a potential development issue for the sector. Thought should be given as to how to best to skill up and equip the LGBT sector to respond to suicidal clients in the safest way. We imagine there may be a key role in this for mainstream mental health services or local mental health promotion initiatives. Input at a strategic level should be used to facilitate this exchange.

The other aspect of preparedness that we considered was the linkage between the LGBT voluntary sector and mainstream mental health organisations. Respondents were asked to assess the quality of contact and involvement they had with a range of mainstream services. They were asked to rate this on a 5 point scale of very good to very poor. Overall answers were as follows:

Table 26: Respondents' perceptions of contact and involvement with mainstream services

	Very Good	Good	Average	Poor	Very Poor
Adult mental health services	5	15	19	9	5
CAMHS	2	4	12	12	17
Local mainstream voluntary sector youth projects	8	18	10	4	11
Local mainstream voluntary sector adult mental health projects	5	16	12	11	7

A very mixed picture emerges. It is heartening to see that 20 organisations described good or very good contact and involvement with adult mental health services and 21 described good or very good contact and involvement with local voluntary sector adult mental health projects. In both instances however, a slightly smaller number describe poor or very poor contact.

A somewhat puzzling picture emerges in relation to youth provision. On the one hand the voluntary youth sector is the most likely to be described as having a good or very good level of contact. Conversely CAMHS was the least likely to be described in a positive way. Just under half the sample described a poor or very poor level of contact and involvement with CAMHS. Part of this may reflect the client group of the organisation. For example, one would not necessarily expect those running groups for older LGBT people to have any contact with CAMHS. When we looked at the CAMHS relationship of those who specified providing youth services an improved picture emerges. Once again however, by this point the sample is quite small and due caution needs to be taken.

Table 27: Perceptions of contact and involvement with camhs by those providing specific youth services

	Very Good	Good	Average	Poor	Very Poor
CAMHS	2	1	6	4	2

There were 16 providers of youth groups amongst the respondents. One service did not answer this question. Unsurprisingly among the 15 agencies running youth services there is a slightly better proportion of good to poor levels of contact than across the sample as a whole. It is pleasing to see that both of the very good relationships with CAMHS are being described by agencies involved in youth provision (Outburst and the 42nd Street LGBT Youth Project in Manchester). However, it remains the case that double the number of youth projects described their contact with CAMHS as poor or very poor compared to good or very good. In this context it is worth bearing in mind that of the 15 youth service providers, 12 of them (80%) were aware of currently supporting someone who was suicidal. Caution about the size of the sample needs to be maintained but:

1. 12 out of 15 of those providing youth services are currently supporting someone who is suicidal
2. 6 out of these 15 describe their contact or involvement with CAMHS as poor or very poor.

We believe that there are *prima facie* grounds for concern about the relative rarity of constructive involvement between CAMHS and LGBT youth provision. It is not known to what extent this may indicate an issue between CAMHS and LGBT youth provision or youth provision generally. We are not in a position to compare the LGBT experience with that of other non specific youth services. The extent to which LGBT youth services are experiencing this issue, their level of preparedness to do so and their engagement with CAMHS would seem to be a possible priority for further investigation.

We also asked services about their strategic engagement, in particular the degree to which they have been consulted about suicide prevention needs, involvement with a local strategy, or membership of a suicide prevention strategy group or forum. Levels of strategic engagement were generally low:

Table 28: Reported levels of strategic engagement in suicide prevention

Activity	Number
Consulted about the suicide prevention needs of LGBT young people	9
Involved in the development or implementation of a national or local suicide prevention strategy	4
Membership of suicide prevention strategy group or forum	3

Broadly speaking there is little evidence that the LGBT voluntary sector is adequately consulted or engaged in strategic suicide prevention work. Only 3 organisations (in Brighton, Cornwall and Calderdale) reported being members of local suicide prevention strategy groups (though the strategic survey also identified groups in Derby). Consultation is slightly more frequent, having been reported in Birmingham, Manchester and by one national organisation as well as the three areas described above. It is worth noting that the consultations in Brighton and Cornwall were mentioned by more than one respondent.

Asked to identify good practice a number of examples were given. These include the GALYIC screening tool for working with young people, the Brighton strategic initiative, MindOut, Out of the Blue support group and assist training and work in Cornwall including free ASSIST training for organisations. A number of these initiatives are described in greater detail below

Other Comments

Respondents were given the opportunity in two open ended questions to describe what they would like to see happen in terms of suicide prevention work with LGBT people and any other general comments. A number of insightful, practical and useful observations were made. We reviewed these and attempted to group them thematically. Broadly comments covered three main areas: strategic issues (data, partnerships, engagement with strategy and an awareness of underlying causes); LGBT organisational/internal needs (staff training, more info for staff and volunteers on the issue and more info on referral) and changes to local service provision. Within the latter category three sub-themes emerge: access (speed, ease and type of service), increased targeted provision for LGBT people and improvement in mainstream services.

Table 29: Other comments by theme

Comment	Number Raised	Theme
Improve local recording, data, monitoring or research into local need[5]	4	Strategic
Inclusion in local strategy	1	Strategic
Better, more coordinated or visible local strategies and partnerships/relationships with statutory services	3	Strategic
Change LGBT people to a group 1 priority in the National Strategy	1	Strategic
Work to address causes of suicidality – bullying, discrimination etc.	1	Strategic
More training for staff and volunteers	3	Internal
More information on the issue	3	Internal
More information on referral	1	Internal
More targeted work with LGBT people	4	Service Provision – LGBT
More LGBT support services	1	Service Provision – LGBT
Crisis line LGBT counsellors, 24 hr or out of hours LGBT support	3	Service Provision – LGBT
Support for other issues affecting LGBT people: bullying, domestic violence, substance misuse	3	Service Provision – LGBT
Easier to access support services	1	Service Provision – Access
Quick access to counselling	1	Service Provision – Access

5) One respondent specifically talked about the need for this work in the face of having been told that it was not an issue by the local Suicide Prevention Strategy group.

Comment	Number Raised	Theme
Easier quicker access to gender identity clinic	1	Service Provision – Access/T
Awareness raising in mainstream	3	Service Provision – Mainstream
Training for staff	1	Service Provision – Mainstream
Better trans informed mainstream services	1	Service Provision – Mainstream

Some respondents gave quite detailed replies. Particular issues within these were discussed at length. One of these concerned the need for routine raising of sexual orientation and gender identity with people referred to Crisis Intervention Teams following attempted suicide or self harm presentations at A&E. The respondent described the difficulty in achieving this and a reluctance to accept this as relevant to the issue by the Crisis Teams. This resistance is consistent with the reluctance reported by some mainstream services to raise LGBT issues routinely with clients and record LGBT identities.

One general observation from these comments is that the LGBT sector seems to be capable of thinking broadly on this issue in terms of strategic needs, the needs of their users, their own development needs and the need to change local service provision. We are in support of all of these recommendations which also appear to accord with the experience reported by users. Given that the sector does seem to have relevant, sensible things to say about the issue of suicide prevention it seems a shame that their involvement is so scarce.

Conclusions and Recommendations

1. A large proportion of the LGBT voluntary sector agencies that responded are currently supporting someone who is suicidal. Agencies submitting data on their experience of the issue suggest that for those that collect this information the experience is a common one. The LGBT voluntary sector clearly has a significant role to play in addressing this issue. There is some evidence to suggest that youth services in particular are routinely working with substantial numbers of users presenting with needs relating to suicidal distress.
2. Although some organisations have clearly taken steps to ensure that they work safely with those experiencing suicidal distress and good practice can be identified in terms of training, assessment and policy there is some evidence to suggest that some sections of the sector need development on this issue. Though from a small sample it is concerning to note that just over 1 in 5 LGBT voluntary sector organisations who are aware of currently supporting someone who is suicidal are doing so without any policy, training on the issue, or making emergency contact numbers available to their clients. This issue should be noted by mainstream mental health promotion services and mental health services who could assist in upskilling the sector and for 2nd tier Capacity and Infrastructure services. It is worth noting that over 1 in 10 of the entire sample identified internal that organisational development was needed (information and training on the issue for themselves).
3. The relationship between the LGBT sector and mainstream services is patchy. In some areas good or very good contact and involvement is reported in others it is poor or very poor. There is some evidence to suggest that the link between CAMHS services and youth provision supporting suicidal LGBT people needs to be improved. Enhancing the relationship between the sectors should be facilitated by local strategic leads in both equalities and suicide prevention.

4. Strategic engagement with the sector is extremely limited to a few examples of good practice. This is a serious omission and needs to be addressed. Local strategic leads should be encouraged to engage with the LGBT community and explore links with local relevant providers. This should involve a mutually beneficial exchange of skills, capacity building and support to the sector and improved referrals between the sectors. Organisations with limited resources should be supported to be able to engage effectively.
5. The LGBT voluntary sector is itself patchy. Development work may need to take place in rural areas where little exists. At the least in areas where an LGBT sector does not exist or does not have a strong presence then mainstream services need to do more to ensure that their services are appropriate. Conversely. the LGBT voluntary sector can act as agents that drive local change.
6. Greater understanding needs to be developed at a local level of the needs of this client group. Local needs assessments, consultations and data collection should inform this.
7. Greater understanding needs to be developed as to the factors causing suicidal distress among LGBT people, in particular the link with the experience of bullying and discrimination should be explored.
8. Very impressive and comprehensive initiatives do exist where they have been funded.

Case Study GALYIC

Gay and Lesbian Youth in Calderdale

This specialist LGBT youth service has developed a comprehensive Needs Assessment Tool (NAT). The assessment is completed as soon as possible after the young person contacts the service. The tool uses a number of standard validated tools such as AUDIT (Alcohol Use Disorders and Identification Test) and the RSE (Rosenberg Self Esteem questionnaire). Amongst other things addressing each of the Every Child Matters priorities the extensive survey asks about self harm, suicidal thoughts and feelings and attempted suicide. The assessment also asks about the perceived link between these problems and LGBT identity. This means that the suicide prevention needs of all young people accessing the service are routinely explored. The tool is used both as the basis for an individual plan for each young person but also as a means of collecting needs data more generally (for example to support funding bids).

In addition GALYIC have developed an Impact Assessment Tool (IMP) to ascertain intervention effectiveness. Both tools are available online for use by other services.

The group have developed strong links with CAMHS as well as other local services. GALYIC were also involved in developing the OCCA tool with National CAMHS Services.

Case Study MIND Out

LGBT Suicide Prevention Development Project

This is the most comprehensive, integrated and targeted LGBT suicide prevention work in the country identified through this project. The initiative was funded by the South East Development Centre (now part of CSIP). This allowed the project to employ a part time Suicide Prevention and Development Worker.

The project has involved a local partnership of mental health and LGBT organisations, development of a research project through the Brighton and Sussex Community Knowledge Exchange) leading to the publication "Understanding Suicide and Promoting Survival in LGBT Communities" , raising awareness, and simultaneously developing capacity and skills within the LGBT sector through ASIST training and awareness training to mainstream organisations. In addition a peer support project Out Of the Blue has been developed (and is one of the helpful services cited in the user survey below).

The partnership has also contributed to the development of a local LGBT Suicide Prevention Strategy which is the only one of its kind we have identified.

Survey of Users

> *When you assume that I'm straight you make it clear to me that your services aren't relevant to me or to my life, which pushes me closer to letting go of life. I am already working as hard as I can to stay alive moment by moment. I don't have the energy to constantly come out to you, and then have to deal with your homophobia or ignorance or confusion.*
>
> Online Survey Respondent

Methodology

The aim in this survey was to ask LGBT people, who had experienced suicidal thoughts/feelings or made a suicide attempt, about their experience of services, their thoughts on what helped or didn't help and what they would like to see available in terms of suicide prevention support. We posted a web based survey via SNAP market research website and using SNAP software. The survey was live for 3 months and was accessible via a link from the Main Page of the PACE website.

We drove traffic to the survey through an awareness campaign; we press released the survey link to a broad spread of LGBT and non-LGBT paper and online based media. A number of articles, links and postings were generated as a result. Incidentally the success of this campaign is partly indicated by the frequency in which the campaign featured in the online web search running concurrently.

Responses to the survey

We received 98 completed eligible responses.

Demographics

95 respondents were willing to give their ages – these break down as follows:

Table 30: Respondents by Age

Age range	No. respondents	% respondents
13-19	22	23%
20-29	25	26%
30-39	19	20%
40-49	22	23%
50-59	6	6%
60-69	1	1%
70+	0	0
Total	95	

Clearly the sample is skewed towards the younger age range. Whilst it appears that we have a good spread of ages beneath the age of 50, with as many people in their forties as in their teens and a broadly similar response rate between these two ages, responses drop off sharply over the age of 50 with only 7 responses from this age range and no respondents over the age of 69. We suspect that this may reflect internet and computer use in these age ranges though would wish to guard against making assumptions. Clearly older LGBT people may have different needs and experiences which might need to be followed up in further research.

It is worth noting that high numbers of teenage respondents and respondents in their 20s (together making up in total just under half the sample in these) would suggest that the issue is not a historical one (i.e. we are not just hearing about historical deficiencies of service or historical need from a time before recent liberalising legislation or attitudes).

92 respondents gave us an ethnic identity – these break down as follows.

Table 31: Ethnicity of respondents

Identity	No.	%
White British	74	80%
Other European (Serbian, Eastern European, Hispanic)	5	5%
Mixed	4	4%
Irish	3	3%
Caribbean	2	2%
Black	1	1%
Egyptian	1	1%
Indian	1	1%
Jewish	1	1%
Total	92	100%

The overwhelming majority of respondents are white British, if we include Irish and other European we can see that 88% of the sample were from a white background. This is directly comparable with the ONS estimates on population for 2007 revised in 2009 which estimated the total white population as 88.5%[6] . However, the overall smallness of the sample would make this unsafe as a basis to generalise on the experience of ethnic minority LGBT individuals and this may form the basis of further research.

92 expressed various gender identities – these break down as follows.

Table 32: Gender of respondents

Identity	No.	%
Female	45	49%
Male	42	46%
Intersex	2	2%
Gender queer	2	2%
Androgyne	1	1%
Total	92	100%

This represents an even split between those identifying as male and female with 5% of the sample choosing an intermediate gender identity.

6) Population Estimates by Ethnic Group: 2001 to 2007 Commentary **September 2009. ONS**

25 people expressed various trans identities – these break down as follows

Table 33: Trans identification among respondents

Identity	No.	% of those using a trans identification	% of total sample
Transgender	19	76%	19%
Transsexual	4	16%	4%
FtM	1	4%	1%
Don't know	1	4%	1%
Total	25	100%	25%

This represents a significant response rate (25%) of respondents using trans identifications of some form.

We received 102 expressions of sexual orientation (some people submitted more than one or composite expressions) – these break down as follows

Table 34: Sexual orientation of respondents

Identity	No.	% of Orientations
Gay	46	45%
Lesbian	30	29%
Bisexual	19	19%
Pansexual	5	5%
Heterosexual	2	2%
Total	102	100%

There seems to have been a good spread of orientation identities being articulated. It is worth noting that our approach of providing a list of identities in terms of orientation, gender and trans identification, and asking people to select as many or few as they chose allowed people to express many different combinations. 31 (32%) of respondents chose more than two identities perhaps suggesting a flexible approach to identity and sexuality. When it came to simple two part identities (e.g. gay/male, lesbian/female, bisexual/male etc) the largest group was gay male 25% of the sample. However, this did not reflect a gender imbalance; rather more women identifying as female/bisexual (6%) or as gay/female (3%) as well as lesbian (14%). In all 23% of the sample were women who chose a straightforward two part identity.

Demographic Summary

The sample, though admittedly not large seems diverse in terms of gender, sexual orientation and trans identification. We have a very even spread of ages from teens to forties after which our spread drops noticeably. Older LGBT people are a significant gap in the data. It is broadly in line with national population demographics but therefore not large enough to tell us about the experience of ethnic minority LGBT people.

Experience of Issues Raised

The sample presented with a clear history of suicidality, suicide attempts and treatment for common mental health problems. The experiences of the group are given below:

Table 35: History of respondents

History of:	No.	% of Sample
Seriously considered suicide	82	84%
Treated by a doctor for depression	69	70%
Made a plan of how they would commit suicide	68	69%
Attempted Suicide	54	55%
Treated by a doctor for anxiety	50	51%

Support Services

Across the sample respondents cited a very wide range of service use. Many different patterns of service use emerge ranging from absolutely no support used or cited, to informal support networks only (friends, including online friends) to multiple services and multiple mediums of support used.

Table 36: Sources of help or information when feeling suicidal

Service	No. of Users	% of sample who have used this type of support or service
GP	55	56%
Local Friends	50	51%
Counselling	49	50%
Samaritans – any service	42	43%
Of which:		
Phone	33	34%
Email support	15	15%
Statutory mental health services	38	39%
Online Friends	33	34%
Family	28	29%
Online forum/support group	17	17%
Emergency services - 999	16	16%
Lesbian and Gay Switchboard	15	15%
LGBT Support Group	14	14%
Mental health website	12	12%
Other phone line	11	11%
Other support group	10	10%
Other online or email support	7	7%
Private psychiatrist	3	3%
Occupational support	2	2%
Self help books	1	1%
Alcoholics Anonymous	1	1%

It is re-assuring to see that GPs are the most commonly used source of support by LGBT people when feeling suicidal. Arguably though, the proportion seeking help from their GP is still lower than one might hope. This is partially mitigated by the consideration that of those who report using statutory mental health services 10 respondents do so without indicating that they have also received help from their GP[7]. In addition 2 respondents using counselling seem to have obtained this through statutory support (CAMHS and doctor's surgery) without indicating that they have accessed GP or statutory services. In total therefore 67 users (68% of the sample) report having used NHS services (GP and/or statutory mental health services and/or statutory provided counselling) for help when feeling suicidal. Notwithstanding that the NHS is the largest provider of support to this group, given that respondents present with arguably serious suicidal ideation and histories of suicide attempts, the fact that 31 users or just under a third of the sample have not received any help from the NHS is of concern. It raises the question whether a significant proportion of suicidal LGBT people are endeavouring to cope with their feelings with insufficient clinical input into their cases? It is not possible without comparison to a similar heterosexual sample[8] to comment on the role that sexual orientation or gender identity may play in the proportion of respondents choosing not to use NHS services..

From this initial table the following trends are also noteworthy.

- The importance of social support (friends and family both in the real world and online)
- The popularity of counselling as a support modality
- The large proportion of respondents who report using just one voluntary sector provider: The Samaritans. This represents a significant achievement on the part of The Samaritans in terms of reaching its client group. Experiences of The Samaritans appear mixed and will be discussed later but the organisation have clearly managed to promote themselves widely and effectively as a provider in the realm of crisis support.
- 30 people (nearly 31%) of the sample report having used an LGBT specific service, commonly Switchboard, youth groups, PACE, MindOut and London Friend.

The table above only tells part of the story in relation to service use. Across the sample respondents cited a very wide range of service use. Many different patterns of service use emerge ranging from absolutely no support used or cited, to informal support networks only (friends, including online friends) to multiple services and multiple mediums (phone, online, in person etc) of support used.

Table 37: Multiple and limited service use

No. of Sources of Support	No. of People	% of sample
No help	5	5%
Social support only – family, friends including online friends or networks	9	9%
Information only – text based website or self help book	2	2%
1 support source[9] used (other than social or text based)	19	19%
2 support sources used	12	12%
3 support sources used	11	11%
4 support sources used	14	14%
5 support sources used	10	10%
6 support sources used	5	5%
7 support sources used	3	3%
8 or more support sources used	6	6%

7) This might suggest respondents accessing statutory mental health services directly without GP referral perhaps indicating established relationships with statutory services not requiring GP mediation.

8) Such a comparison group was beyond the remit of this study.

A worrying minority of respondents do not report having received any formal support (either statutory or voluntary) at all. 14% seem to be trying to cope by themselves or with family and social support as their only source of help, an additional 2% are only accessing text/information support. Thus in total 16% of the sample are attempting to deal with their problems without formal interactive input from either the NHS or voluntary sector. An obvious initial question would be how this compares to help seeking in the non-LGBT population of those feeling suicidal. As mentioned we are not in a position to comment upon whether the proportion of LGBTpeople who attempt to cope with their suicidal thoughts and feelings without accessing formal help is greater or lesser than those without minority sexual orientation or trans identities. However, given some of the experiences of service use described below; that some LGBT people may hold back from or choose not to use services due to perceived inaccessibility is a plausible hypothesis and could be investigated further. This view finds some support from some of the statements made about unhelpful services, for example one respondent although not citing any particular example of unhelpful service provision did describe how the perception of homophobia influenced their service use choices:

> *I try to avoid the NHS as it has bad press when dealing with the gay population.*

The majority pattern of service use (62%) is of multiple support services used. Most frequently this represents multiple mediums: in person individual, groups, online, phone, email etc. 50% of the sample report having used 3 or more sources of formal support. This pattern of answers could indicate:

1. Sequential use – people 'shopping around' moving from service to service until they find out what suits them best. This might be considered consistent with dissatisfaction or incomplete satisfaction from an original service or services. This view could be supported by higher experiences of unsatisfactory service use cited by those choosing multiple support services[10] . However, if one looks at rates of citation of unhelpful services we find that 35 of 49 (71%) of respondents who used 3 or more services cited an example of an unhelpful service compared to 23 of 31 (74%) of respondents of only one or two support services who cited an example of an unhelpful service i.e. there is no statistically significant difference. Overall numbers are small therefore this should be treated with caution and this may have multiple explanations.
2. Concurrent use – people constructing multiple component sources of support of different modalities. One theory is that this might reflect the two primary qualities that respondents described as important discussed in greater detail below. Overwhelmingly these were speedy response and out of hours access. This may lead people to access services based upon these qualities: typically this might involve a person seeking support from formal sources during office hours and crisis phone or online support during the night/ evening or whilst waiting to access in-person provision.

Clearly people have a range of mediums in which they can seek help – in person, over the phone and online. When service use is considered from these points of view the following can be seen:

9)For the purposes of the rest of this table we have analysed only formal support services used – statutory or voluntary in a range of modalities. So for all categories this is the number of sources of support used other than friends and family.

10)Though this could also of course merely reflect the increased probability of having an unhelpful service experience the more services you use.

Table 38: Use of support mediums

Medium	No. of people using medium	% of sample using medium
In person	72	73%
Over the phone	48	49%
Online	34	35%

When considering these results it is worth remembering that these are responses largely from an online survey[11] . Thus, responses are likely to be nearly all from people with access to the internet and sufficient skills to use it. It is perhaps surprising therefore that there isn't more of an obvious bias towards online service use. We suspect that a non-online based survey would be likely to find even lower levels of online service use. Although we have no basis upon which to speculate on this pattern of use certain questions do immediately spring to mind. The comparative lower rate of online service use may reflect a number of possibilities:

- Fewer online support services/under use of online potential to address these issues
- Preferences for interpersonal or immediately reactive forms of communication
- Absence of awareness of online support provision.

Although this analysis does show a significant proportion of our sample choosing to access online support when we analyse the data in terms of exclusivity of medium use further information becomes apparent.

Table 39: Exclusive or combined use of support mediums

Medium	No.	% of sample support use
Combined in person and remote support (online or phone)	53	58%
In person formal only	20	22%
Telephone formal only	8	9%
In person social only	4	4%
Combined social	3	3%
Online social only	2	2%
Online formal only	1	1%
Total	91	

What is initially striking about these responses is the absence of any large or significant group whose sole source of support is online. Only one person's sole support use came from exclusively online formal support provision. Given that virtually all respondents are online and that over a third of them are using online provision this is significant. Particularly, the fact that those not using face to face services seem more likely to choose phone services than internet services is of interest. This should be borne in mind when assessing the merit of some of the suggestions from the literature review. Namely that online disinhibition phenomenon, or the experience of increased likelihood of disclosing suicidal intent in writing[12] , may lead one to expect more exclusively online support around this issue. Reasons why this might be so are considered below, however, this does suggest

11) Two individual responses were in fact submitted by post as respondents became aware of the survey through non online means, wished to contribute but could not do so through a computer. They contacted PACE and hard copies were sent out.

to us that:

1. Currently online use (and telephone use but to a lesser extent) is an adjunct to interpersonal support.
2. Therefore any attempt to meet LGBT needs with regards to suicide prevention cannot ignore the provision of appropriate local in person services or aim to solely meet this need through online provision.

Outness with Services

As part of understanding the LGBT experience of service use to we asked whether people were asked about LGB or T identities as part of their service use and whether people disclosed.

Only 14 respondents could remember being asked about being LGB or T by services, discounting those that have not used any services this means that 17% of those using services report being asked about being LGB or T by these services. This is significantly less than the proportion of services that responded that they monitored sexual orientation or trans identities.

What is worthy of note at this point is that regardless of being asked just over 50% of the sample said they had told their non-LGBT specific services about their LGB or T identities. It does suggest at first instance that LGBT people are more willing to come out than their services are to ask.

Helpful Services

Participants were invited to describe a service that they felt had been helpful or useful when they were feeling suicidal and prompted to say what they had found most useful. A number of specific services were mentioned and a number of modalities and mediums. 72 respondents answered this question. 14 of these did not involve a formal service, website or phone line. These answers were either: friends & family (including online friends), comforting activities (music, food, the pub) or 'nothing has helped'. 58 respondents chose to cite a helpful service.

The following table provides a breakdown of the services cited:

Table 40: Cited helpful services

Service	No. of Citations[13]
Samaritans (phone or email)	10
GP	8
Counsellor	5
L&G Switchboard	4
Queer Youth Network	
(online site/forum)	3
MIND	2
MindOut	2
Advocacy	2

12) See for example the Samaritans on their email service.
13) Some respondents cited more than one service

Service	No. of Citations
LGBT Group	2
Psychiatry	2
Medication	2
Statutory Mental Health	2
Recovery House	2
www.suicideforum.com	1
PACE	1
Mental health group	1
Private Psychiatrist	1
Psychologist	1
Mental health website	1
NHS Direct	1
Bodies Under Siege	1
Mindyourhead.nhs.uk	1
Gingerbeer	1
NSPCC	1
Gay Alcoholics Anonymous	1

Many respondents saw service interventions as lifesaving, highly beneficial and extremely positive experiences. Some respondents chose to write reasonably long and detailed accounts of practitioners and services for whom they clearly feel very grateful. Good service experiences seem to have a beneficial and lasting impact upon some individuals:

> *I also saw a psychologist in my GP surgery in Brent - Mr [name], who was exceptionally kind to me. Knowing how low I felt, he saw me every week while I was waiting for my CMHT assessment (12 weeks), even though he was not supposed to see patients for more than two appointments. He helped keep me going, gave me materials to read, and helped me think about reasons for wanting to live and things I could do to make me feel better in the short term. When the CMHT assessed me and said that there was no appropriate local service for me, [he] researched all London services for Borderline personality patients and recommended which he thought would suit me best. (I then moved into its catchment area which was another borough.) He also wrote detailed letters to my GP and the therapy place (Dartmouth Park Unit) explaining my situation and his work with me. All of these invaluable services have kept me alive until today and for the long-term future.*

Qualitative expressions denoting size and impact occurred in a number of quotations, the kinds of terms used included: *"huge"*, *"exceptional"*, *"lifesaving"*, *"extremely useful"*, *"generous"*, *"pure"*, *"unusually intelligent"*, *"invaluable"* and *"i will never forget"* indicating the depth and strength of positive feeling users expressed towards providers. These experiences set the standard and challenge for service providers in the field. They also stand as a testament to its success – at its best.

The Samaritans

Clearly, that the most commonly reported helpful service cited was one voluntary sector provider is very impressive. It reflects the success of the Samaritans' model and its use by this client group. Within the context of an online survey it is interesting that the phone service is the one receiving the most praise. 3 respondents mentioned the email service as helpful, and 1 of these was also using the phone (in total 8 respondents cited the phone service as helpful). Those describing the email service tended to be less glowing in their praise. Email service citations tended to be quite measured, for example note how these expressions have both been qualified [emphasis added in bold]:

> *"The samaritans email service was helpful in dealing with the depression* ***over an medium term***
>
> *Or:*
>
> *"samitains [sic] email service was useful if suicide was* ***more than a few days away***

Many of the phone service quotations tended to sound more enthusiastic and be more unqualified, creating a generally more positive impression:

> *The Samaritans were very helpful and generous in offering pure listening - in particular they listened to me endlessly repeating myself about how I had no life and how I wanted to commit suicide*
>
> *Samaritans have been very helpful. I've called them at various times in my life.*
>
> *Samaritans - on each occasion the call responder sounded to me genuinely concerned, interested and caring.*

As the last three opinions indicate some people are using the Samaritans as an ongoing crisis support service. Some of the successful qualities of the Samaritans experience will be considered below as we consider what it was about services that people found most helpful. It is worth raising here that even though this was the 'positive' or helpful section two negative comments about the Samaritans were included. One respondent described another service as useful in contrast to the Samaritans and one respondent seemed not to get what they wanted from the Samaritans model:

"The Samaritans were OK - they don't really provide advice though, they just listen, so I kind of felt like I could have just talked to a tree and got the same response, what I was really looking for was practical suggestions."

Arguably another service than the Samaritans should be providing the kind of intervention that this individual seemed to require. Perhaps this kind of support would be more appropriate from a more expert or clinical source. In short this may not be so much a flaw in the model as mismatch against expectations. This 'just listening' quality is for many what they value most about The Samaritans experience (see below).

One user of the email service particularly referred to the service's ability to include sexual orientation in how they handled the issues under consideration:

> *I told them about my sexualtiy, which then was labled as bisexual for convenience. The service only differed in the advice they gave me. Not in a negative way, it was just more supportive and inclusive of my sexuality, taking it into consideration.*

We suggest that this experience represents a desirable achievement on behalf of any mainstream organisation – to include and acknowledge difference in a way that is helpful and that the good practice of the Samaritans in this instance should be commended.

GPs

The next largest number of commendations went to GPs. Given the significance of the GP within the structure of the NHS we have looked at these in more detail. Some of these were very brief and it is not possible to draw much from the reference. One of these comments simply saw GPs as a portal to access medication. When looking in more detail at the good experience of GPs in relation to suicide from more detailed descriptions a few observations can be made:

> *GPs are generally helpful in that they are reluctant to prescribe medication and instead advocate talking therapies (not that these are particularly accessible). They are also able to provide evidence of your condition which is important for things like work and study.*

> *I have found that my Doctor is the best person to talk to about depression.*

> *My GP was extremely useful because my main problem was my rejection from my mother, and because she was a single parent, she was all I had. My GP knew us both and made me realise that some people are gay and it's no ones fault. She sent me to see a psychotherapist which was very useful.*

> *GP support - didn't feel i needed any specific support just because i am a lesbian, I was treated with the patience and professionalism one would expect.*

> *My GP practice. I went to ask for sleeping pills (genuinely to aid sleep) and the doctor asked specific probing questions and very quickly identified depression. She was very, very good.*

> *My GP was/is exceptionally supportive. He happily encouraged me to make an appointment at any time even if it was only to have someone to talk to and would even take phonecalls if I was in a crisis point. He was also not afraid to be blunt if he felt it appropriate. There was also a very high level of trust already established prior to seeing him about suicidal feelings With reference to Q7 & Q8, although my GP is a non-LGBT specific service he is a gay identified individual who was aware of my sexuality as I was of his.*

These are a small number of comments and should not therefore have too much weight attached to them. We would however, simply observe that 3 out of 6 of them refer directly to sexuality but in different ways. One emphasises a professional 'it didn't make a difference' quality that they seemed to value. Another highlights understanding and affirmation of sexuality in a non blaming way, and the third the helpfulness of a gay identified GP. In any event, some aspect of the handling of identity by GPs was seen as important to these people.

All answers in some way or another are about dialogue and talking – unsurprisingly feeling able to talk to your GP is a key element in a helpful intervention. Two answers are specifically about a relationship with the GP characterised by trust and being known.

LGBT Specific

In total there were 14 respondents who chose to describe LGBT specific services. LGBT services constitute nearly a quarter of all commendations received. This should be considered in terms of the relative size of the LGBT sector. As many participants may have been recruited through LGBT portals, websites or services it is possible that there is a bias in the sample towards those who have used LGBT services. However, it is worth noting here, that specific LGBT services are only quoted once in the unhelpful group below (this is to favourably compare one LGBT service's hours of operation with another LGBT service's hours of operation). It would seem that a very small sector is significantly valued by a proportion of LGBT people with suicidal ideation. A matter for local planners should be what local LGBT voluntary sector provision exists. It also raises the question of how well equipped is this sector to be supporting this need. This will be considered further in the detailed responses of the LGBT sector.

Qualities of a Helpful or Useful Service

People were asked to describe a useful/helpful service and say what they found helpful. All of the qualities mentioned as positive were listed and then grouped thematically. Initial grouping of qualities were as follows:

Table 41: Initial grouping of qualities

Quality	No. times
Not rushed – given time, patience etc	11
Peer contact – people like me, been through same	8
Showing concern/care	7
Affirm/understanding identity	6
Talking things through	6
Non-judgemental	5
A kind ear	4
Supportive	4
Info/practical	4
Known	3
LGBT workers	2
Guilt over hurting partner/others	2
Professionalism	2
Trust	2
Free	1

Quality	No. times
Talking Freely	1
Getting things off chest	1
Advocate of talking therapies	1
Listened to	1
Having someone to talk to	1
Comforting	1
Respect	1
Safe	1
Practitioner effort	1
Helpful	1
Made feel special	1
Removal of external pressures	1
Something to do	1
Calm	1
Personal affirmation	1
Confidential	1
Positive	1
GP looking	1
Unconditional	1
Easy to access	1

One thematic analysis of these comments focuses on an idea we have called the *desirable dialogue.* Clearly, from the outset, references to talking and listening are apparent. In all 15 such references (10 to various ways of being able to talk and 5 to listening) were identified. Many of the other answers then seem to relate to other desirable aspects of a dialogue. Broadly speaking these encompassed: the desirable context and broke down into two themes: access, of which the most frequently occurring quality was not feeling rushed or limited with regards to time. This occurred on 11 occasions in all (other access issues were: free, out of hours and easy). The next desirable context for the helpful dialogue is personal safety in which we saw: trust, confidential, safe and non-judgemental (in total 9 references to safety qualities were made). In addition 2 references were made to professionalism; this could capture a sense of safety but also introduces the next theme of the desirable listener.

This desirable listener has a range of good emotional responses showing care, concern, calm, comforting, supporting and kindness. This kind of emotional responsiveness was apparent in 19 answers. As an extension of calm the desirable listener is also described as clear headed. (Another quality which emerges is 'known', though to a lesser extent occurring in 3 cases.) One emerging theme of the desirable listener/responder for some, is desirable likeness. In all 8 answers referred to peer contact as an element of their helpful interaction (this could also be seen as a desire to be understood) and a further two respondents identify LGBT workers as helpful.

Finally it would seem that one of the desirable outcomes of the dialogue is affirmation. 6 people referred specifically to affirmation of their LGBT identity and two others referred to personal affirmation or being made to feel special. This affirmation theme could also link to part of the safety context of non-judgemental in that absence of rejection could be seen as a part of affirming.

With all due caution attached to over generalising a 'one size fits' approach to helpful interactions if one had to summarise the emergent desirable dialogue it would be easy to access, unrestricted,

nurturing, with a calm, kind person with whom one identifies and lead to personal affirmation as one of its outcomes. Or to look at it another way, one analysis of these answers suggests people like to talk, they like to have control over how quickly, often and long they can talk for. They have fears about how what they have to say will be responded to, they appreciate kind responses and they like it when they feel better about themselves at the end of it. Two thoughts occur to us in this context. Firstly, to what extent is this the opposite of many initial attempts to secure help from institutions? These can be hard to access, time pressured and limited, depersonalised and delivered by busy, distracted, staff with whom one has no connection and over whom one has little control. This may go some way to explaining why one voluntary sector provider whose model consists of unrestricted dialogue with kind volunteers available round the clock has almost as many helpful citations from this sample as the entirety of the NHS. Secondly, though very tentatively, it may be worth considering the desirable dialogue as an attempt to interact with an available, nurturing, stable self. Again within the context of suicidal, self destructive feelings this might reflect an absence or opposite of a current lived experience.

Two vital cautions need to be sounded about this idea of the desirable dialogue – for some respondents this was not what they wanted. Some seemed to enjoy something more practical or even directive: "psychiatric rather than psychological", medication, removal of stressors, something to do, information. Thus a sub theme emerges of frustration with the listening model. Secondly, this study only asks people what they value – it makes no claims whatsoever about what works. The clinical impact of the interventions described has not been investigated and should of course be paramount in all service planning.

Finally, none of these results strike us as particularly unpredictable or surprising.

Structural Qualities

In a separate question respondents were asked to rate the qualities that they would value as most important in a service for those feeling suicidal. In particular this question focused on structural qualities (who delivers, when and how) rather than emotional ones. The answers given were:

Table 42: Importance of structural qualities for a suicide support service

	Very Important	Important	Neither Important nor unimportant	Unimportant	Very Unimportant
Speedy response	71	18	1	0	3
Out of hours access	67	15	10	0	3
Face to face help	47	29	12	4	3
Phone help	44	27	15	6	2
Online help	40	23	15	10	6
LGBT Specific Service	40	24	20	4	6
Help from a medical professional	37	23	20	5	7

Clearly speed is the quality seen as important by most people, followed closely by out of hours access. In terms of modalities it is worth noting that online help is perceived as unimportant by the largest number of people. It is also worth noting that the quality seen as important by the fewest number of people was access to a medical professional. We suspect that the medical profession may think differently. This view of medical help is concerning on a number of levels. It may suggest that suicide is not being seen by a proportion of those who have experienced suicidal distress as a medical issue (it is hard to imagine cancer or HIV receiving a similar response). It must also raise questions as to the perception of the utility of the NHS in relation to suicidal distress. Given the experiences reported by some of the user group in relation to NHS services (see below) this is perhaps not surprising.

Unhelpful or Not Useful Services

Respondents were invited to describe a service that they felt had not been useful or helpful. 63 answers were given to this section. Of these: 1 was a general comment/observation (about a type of response rather than a specific service), 1 was 'N/A', 1 said 'everything', 3 said family and 1 said work. In the context of the focus of this report it is worth recording that one of the general complaints was "a service that doesn't say they are gay friendly." In all 19 respondents said that how their LGBT identities had been handled by services was unhelpful or not useful. Thus 23% (19 out of 82) of those who reported using a service have had a negative experience relating to their LGBT identities whilst trying to access help about their suicidal feelings.

In all 56 respondents identified a service they felt had not been helpful or useful. These were:

Table 43: Cited unhelpful services

Service	No. of Times Cited
GP	12
Statutory Mental Health	11
Samaritans	10
Psychiatrist	3
Counselling	3
GP Counselling	2
In patient	2
CAMHS	2
HIV Clinic	1
Saneline	1
Religious Counselling	1
MOD Welfare	1
Phonelines	1
Mental Health Website	1
Contact Youth Counselling	1
Depression Alliance	1

From the outset it is alarming to note that 33 references by 27 individuals quoted an NHS service as unhelpful or not useful. This should be considered in the context that of the sample 67 users reported accessing NHS provision for support around suicide. It would appear that 40% of those attempting to access the NHS for support when feeling suicidal have found some part of their experience unhelpful or not useful. The GP was the most commonly quoted unhelpful service.

GPs

A number of the references to unhelpful GPs do not describe why the GP is unhelpful, but merely state that they have been found to be. Typical of these kinds of responses are:

> *"GP"*
>
> or
>
> *"I have never had a good experience with doctors or the NHS when it has come to asking for help with mental health issues"*

However, a number of more specific issues emerge. Only two specific references to LGBT identities were cited in the reasons why GPs were unhelpful. One of these was from 1963 – which, as the respondent described it was "a long time ago" in which the respondent was advised to take up golf after coming out to their GP. The second LGBT specific incident was a case of the GP making an assumption of heterosexuality:

> *Went to GP for antidepressants GP: Do you live alone? Me: No, I live with my partner GP: And is he supportive? Me: She's a girl, and she's very supportive GP: I'm so sorry, I shouldn't have assumed anything ... conversation continued and I got the antidepressants Moral to the story: Please please don't assume that I'm straight.*

It is worth noting with this particular example that the respondent quoted this as one of three examples of assumed heterosexuality by different services. The GP is the only one who seems to 'recover' the situation well, suggesting that this mistake is at least somewhat qualified by the GPs response to being corrected (the other 2 examples resulted in not receiving a service).

More commonly quoted negative aspects of GP responses were related to reactions to disclosures of suicidal feelings. One strand of these might be classified as dismissive, unsympathetic or under-reactions. These include:

> *"One GP told me to consider myself lucky that I was not dying of cancer when I felt suicidal"*
>
> *"the GPs and the hospitals who just kept saying that I was anxcious [sic] and not suicidal"*
>
> *"My GP also called me stupid for being suicidal"*
>
> *"My GP, told me it was 'teenage hormones' despite me no longer being a teenager"*
>
> *"My GP told me to get a job"*

Clearly we do not know the full circumstances around these 'diagnoses' yet it is initially concerning to encounter what at face value appears to be a failure by some GPs to take suicide seriously.

Another strand of displeasure with GPs manifests in prescribing or referring to inappropriate or ineffective treatment, such as the following:

"GP referred me on three occasions for counselling and it was a waste of time"

"I told my GP about all of it and I was put in a mental health hospital for a week. It was an extremely unpleasant experience. I don't really feel it was the most appropriate thing for me."

These strands seem to correspond to a theme that one respondent expressed as:

"Overreaction and underreaction. I want someone to respond to the problems that are causing me to feel suicidal without causing more, rather than to the feeling itself. I would wish for the problems to be taken very seriously but not to be treated as if I'm radioactive"

Fear of overreaction is a theme within the responses which will be considered below.

Finally with GPs and the services they prescribed there were a range of comments relating to access and time, for example:

"I found that my docters (sic) just couldn't wait to get rid of me"

"My GP Surgery. One of the problems I faced at the times I felt worst was a serious sleeping problem. My sleeping patterns were chaotic such that I had days of real sleep deprivation and days of excessive sleeping.This made contacting my GP surgery to make appointments very difficult as they insisted on a rigid 'call at 08.30am' and did not allow forward booking. That has changed now, but at the time it was a severe problem to me and no matter how much I explained the practical problem it seemed to just pass by the reception staff and my GP was not only unsympathetic but when - out of exasperation - I wrote a letter of complaint, he replied in a manner that was positively unfeeling and 'informed' me of my right to move to a different GP Practice. As a result of that I have never opted to see him again and have managed to see other GPs at that health centre."

"I have not had much luck with GPs … they are generally very busy and seem not to have much time/or much to offer me"

"therapy provided via a GP practice was not helpful to me as the sessions were time limited"

"My GP referred me to the local mental health services for CBT or similar treatment on the NHS. A year later I am still waiting"

"Most services have been unhelpful at times and make you fight to get some help when you can't even fight yourself to stay alive … Statutory services make you feel like you have to actually show them by self harm or overdose to prove how suicidal you feel."

Other statutory mental health services

In all 17 people quoted examples of unhelpful provision from within statutory mental health – either very generally or specifically such as by reference to 'my psychiatrist'. 6 respondents (or just over one third) spoke about the way their LGB or T identities were responded to within these services. Specifically these were:

> *"Statutory mental health services, they seemed to make a huge deal of my sexuality and asked me questions about my relationships. I was constantly asked if I had a boyfriend even though I had stated I was a lesbian. When I mentioned that i had to keep explaining that I was a lesbian to my CPN she laughed."*
>
> *"One nurse even suggested that I was doing well that I had battled my thoughts about being gay."*
>
> *"Derbyshire CAMHS. They focused on my depression when I persistently told them it stemmed from being transgendered (therefore I needed to be referred to a gender specialist) they wanted to "control" and monitor the depression using medication."*
>
> *"I attempted committing suicide and was referred to a psychiatrist; I just remember feeling misunderstood and hating going to see her. She was based in a hospital for seriously ill mental health patients and I found it frightening (old Victorian building in the middle of large grounds). She was much, much older than me and even though I'd told them why I'd taken the OD and slit my wrist ('cos of a breakup from my girlfriend), I don't remember her mentioning this - I felt invisible."*
>
> *"psychiatrists just kept giving me different labels, were overtly bi-phobic (told me it was a symptom of a borderline personality disorder) and only interested in my medication. with all of them i felt that my sexuality was being judged, if i told them at all, and mostly i just didn't."*
>
> *"The NHS psychiatrist in the Monklands hospital tried to blame my suicide attempt on being transgendered despite me explaining that the suicide attempt was the result of being raped by my partner. He was extremely disrespectful to me and consistantly pried for information about my genitals and transitional status which was completely inappropriate."*

Of other unhelpful experiences in statutory mental health services a number were broadly negative, such as:

> "crisis team"
> *"Tolworth Hospital – they just drugged me, stuck me in a room and left me to it. There was no attempt to deal with what was bothering me"*

"Maudsley Hospital – Total Lack of Interest"

3 responses were unhappy with diagnosis and mis-diagnosis, these were:

"I saw an expert at the Chelsea hospital who after an hour gave me medication to control skitofrenics? which I took. Two weeks later saw another doc at same place who decided that I wasnt depressed at all????????A complete waste of time and money indeed."

"I saw 12 psychiatrists within these hospitals over a period of 3 years. Not one of them was able to diagnose my condition. They wasted 3 years of my life. Through the lack of proper care, my continuing ill health and lack of money in 2005 I had to sell my home, which I cherished and about which I am still devastated. The accuracy of the 13th psychiatrist, his wisdom and his care highlight the desperate ineptitude of the previous 12. Once I was seeing him he diagnosed me with mild bi-polar disorder, I recovered in a few months and was back to work as a solicitor within 6 months. I remain on medication and well."

"I had psychoanalytic therapy at the Tavistock centre for 6 months, but the therapist did not notice that I had Borderline Personality disorder (despite my showing very obvious symptoms) and therefore continued with her analysis approach. During this period, I began cutting myself and also tried to commit suicide. I have since found out that psychoanalysis has been proven to be the worst type of therapy for BPD patients, as it heightens feelings of insecurity and being alone, which make patients feel much worse."

A further 4 patients described as frightening, stressful and/or negative the experience of In Patient care.

Finally, as with GPs 3 respondents referred to access issues in particular struggling to get services.

The Samaritans

After the NHS the most commonly quoted unhelpful service was The Samaritans. As many individuals cited The Samaritans as an unhelpful service as a helpful one. Of these 4 out of 10 citations were directly related to how the Samaritans handled the issues of LGB or T identity:

"Samaritans based in Worcester. This was my first ever contact with a helpline and it almost put me off forever. I spoke to a very posh older lady who clearly had no idea or understanding of LGBT issues and gave me the number of a local charity who could support me with "those sort of things" (ie. gay issues?!)"

"In one call to the samaritans i raised concerns about an employer who was being inappropriate. I thought this was about my sexual orientation which i felt pressured to declare on an application form and also because people talk…. the person whom I spoke to reminded me that sexual orientation wasn't generally the issue in the workplace . But she did so in a patronising way. I wrote to complain about their service to the email and they said I need to call them and be more specific but I'm not up for that right now. The patronising tone just angered me later on."

"Samaritans, strangely enough have been sometimes the hardest to gain support from. Not always because some volunteers have been amazing, but it's hard because it's pot luck who you get to talk to. Some people I have spoken to have struggled to cope with the subject at hand, and I have felt worse after speaking to them. They need more training in coping with talking to gay individuals."

"Rang Samaritans when acutely suicidal Samaritan: Do you live alone? Me: No, I live with my partner Samaritan: Is he in? Me: She's a she, and she's away at the moment Samaritan: [very long silence, as if she couldn't take it in]... Is there anything else I can do for you? (we hadn't done anything about the fact that I was at very high risk of committing suicide yet!) ... I hung up"

These comments would suggest that The Samaritans should consider how its volunteers are trained to respond to LGBT callers. This is something that the organisation could be helped with externally either by support from statutory funds to achieve this or through partnership with the LGBT sector.

Other unhelpful aspects of The Samaritans service were: not knowing what to say, being 'overly sympathetic', or 'just made me feel worse'. Two respondents talked about the delay in receiving a reply from the email service.

Counsellors

Five unhelpful or not useful experiences described counselling related to being LGBT[14]. These were:

"Counselling, she told me how I was feeling and would refer to my girlfriend as my friend"

"Private psychoanalyst I went to for treatment She referred to my partner throughout the session as my 'friend', despite me calling her my partner. Towards the end of the session, she burst out: Are you telling me that the 'friend' who brought you here is your sexual partner? ... I didn't go back"

"Counselling at school which was run by a trained counsellor. I started to express concerns about my gender identity at this point and the counseller was very misinformed about trans issues; presented a stereotypical view of it e.g. men in drag so I came away not knowing what was wrong with me just desperate to get rid of the feelings; which lead me back towards suicide."

"The counsellor did not seem to recognise that I needed her to ask specific questions as I couldn't approach subjects myself…. They never asked about my sexuality/gender identity"

"Religious counselling as it pathologised my sexual identity"

Other problems cited with counselling were that it was negative (looked at problems all the time not solutions), unsympathetic, and unsupportive. Two respondents talked about lack of confidentiality and the impact of disclosure:

"After I talked to the counsellor she contacted my parents (I specifically asked her not to because they didn't believer me) and nothing else was heard after that. Really it made me feel even more ashamed of myself and pretend I was perfectly happy all the time"

"the first thing counsellors tell you when you walk in the door is that they will contact your gp if you are feeling suicidal. as if they want to rule it out before any counselling can begin. i don't want a gp involved. so i didn't tell any of them. i am not sure, but i might have talked about it if i had been reassured that it was ok to feel suicidal and that it would be ok to talk about it without me thinking i would end up sectioned."

14) NB – some talking therapy services have been considered in statutory mental health above when it is made clear that these were part of those services. The other counselling services are where this is not clear, is a private practitioner or voluntary provider.

Other Unhelpful Experiences

Of the other unhelpful experiences most go into little detail. One respondent did say of mental health websites:

> *Some mental health websites and forums can worsen moods. Understandably, listening to others' hopelessness and anxiety is not the most useful thing to do. But sometimes it can feel there is no other information out there*

This note of caution should be considered in the context of a potential negative impact of online provision.

Qualities of an unhelpful service

People were asked to describe an unhelpful or not useful experience and say what they found unhelpful or not useful about it. These are the qualities of an unhelpful or not useful service experience, as we have grouped them into 5 marked categories:

Table 44: Qualities of an unhelpful service

Quality	No. of References	Theme
Time pressures	5	Access
Not easy to access	4	Access
Delay	4	Access
Hard to complain	3	Access
Not free	2	Access
Refused service	2	Access
Confidentiality	2	Access
No service to offer/available	2	Access
Frightening environment	2	Access
Bureaucracy (numbers/paperwork)	1	Access
American	1	Access
TOTAL ACCESS REFERENCES	**28**	
Left feeling worse	8	Treatment/modality issues
(Mis)diagnosis issues	5	Treatment/modality issues
Exposure to negative	2	Treatment/modality issues
Lack of training	2	Treatment/modality issues
No attempt to deal with what's wrong	2	Treatment/modality issues
Reaction to medication	2	Treatment/modality issues
Not preventing self harm	2	Treatment/modality issues
Not effective	1	Treatment/modality issues
Didn't know what to say	1	Treatment/modality issues
Waste of time	1	Treatment/modality issues
Failing to act	1	Treatment/modality issues

No positive solutions	1	Treatment/modality issues
Treat surface problem – not deep	1	Treatment/modality issues
Just drugged me	1	Treatment/modality issues
Not appropriate treatment	1	Treatment/modality issues
Unsuccessful	1	Treatment/modality issues
Beyond useless	1	Treatment/modality issues
TOTAL TREATMENT REFERENCES	**33**	
Posh/older provider	2	Personal characteristic of provider
TOTAL PERSONAL CHARACTERISTIC RESPONSES	**2**	
Unhelpful	4	Provider response
Unsympathetic	3	Provider response
Patronising	3	Provider response
Suicidal intent not taken seriously	3	Provider response
Ascribing unacceptable cause	2	Provider response
Judged	2	Provider response
Discordant response	2	Provider response
Lack of concern	1	Provider response
Unfeeling	1	Provider response
Not being taken seriously	1	Provider response
Lack of empathy	1	Provider response
Lack of respect	1	Provider response
Unsupportive	1	Provider response
Unpleasant	1	Provider response
Not approachable	1	Provider response
Lack of interest	1	Provider response
Told me how I was feeling	1	Provider response
Therapist upset	1	Provider response
Categorised	1	Provider response
Overreaction	1	Provider response
Under reaction	1	Provider response
Appalling	1	Provider response
Inaccurate	1	Provider response
Rude	1	Provider response
Nasty	1	Provider response
Consider yourself lucky	1	Provider response
Upsetting	1	Provider response
Misunderstood	1	Provider response
Awful	1	Provider response
Pushed into things	1	Provider response
Insulting	1	Provider response
Frustrating	1	Provider response
Told manipulative	1	Provider response
TOTAL PROVIDER RESPONSE REFERENCES	**45**	

Inappropriate or not wanted response to LGBT	8	LGBT
Anti LGBT	3	LGBT
Assumed straight	3	LGBT
Ignorance or unease with LGBT	2	LGBT
Lack of reference to LGBT	2	LGBT
Partner = friend	2	LGBT
Keep coming out	2	LGBT
Access to gender specialists	2	LGBT
LGBT not heard	2	LGBT
Identity treated as a problem	2	LGBT
Religious	1	LGBT
Bad press	1	LGBT
Invisible	1	LGBT
Not being asked	1	LGBT
Not safe to tell	1	LGBT
TOTAL LGBT REFERENCES	**33**	

By and large unhelpful qualities seemed to fit into 4 categories. These are what we have called access issues which are all of those related to the structural: the systems, procedures and mechanics of receiving support. We grouped delay, time limitation, safety, confidentiality, bureaucracy, buildings, cost or refusal/unavailability of service into this theme. We also decided to include difficulty in making a complaint in this theme.

The next theme related directly to treatment either in terms of modality, impact or diagnosis. This tended to range from a group of responses which were about generic ineffectiveness (waste of time, useless, didn't work) through to quite specific treatment issues such as medication and misdiagnosis.

The third and smallest theme was about a mismatch with some personal characteristic of the individual service provider. Only two references to this theme were made and concerned age and class.

The largest theme concerned what we have called provider response. This included all the comments which we perceived as being primarily to do with how a service provider has behaved/responded during treatment or help seeking. Within this theme we noticed a distinct sub category characterised by the use of a linguistic negative. Typically these are the responses which include "un-", "not" or "lack of". In all 18 out of 45 provider response references were expressed as an absence of a desirable quality. The remainder of provider responses were expressed in terms of a presence of an undesirable quality (most obviously rude, insulting, patronising, nasty etc). We accept that in some cases the difference between these two points may be small (e.g. unpleasant and rude[15]).

Distinct from these four themes which are generic and not explicitly related to LGBT identities we have isolated responses which are specifically about the LGBT experience. In fact all of these comments would fit within two of the four areas outlined above. We have isolated them solely for the purposes of this study. Most LGBT references are unsurprisingly about provider response with a few (bad press, access to transgender specialist and lack of reference) which would fit within our access grouping above. It is curious to us that in spite of the fact that peer support and LGBT

15) In fact this is probably not a good example. In spite of the fact that unpleasant is linguistically constructed as a negative (i.e. un+pleasant) in most day to day use we suspect it has something of a positive character; unpleasantness is a tangible thing in its own right. Most absence responses were more evidently about a missing quality – warmth, concern, interest etc.

workers are cited as part of the helpful experiences described, having to see heterosexual workers is not explicitly mentioned (whereas the age and class of workers is). It could be implicit or it could be that the majority of respondents accept that pragmatically there is little or no choice (albeit acknowledging the tensions it creates).

General discussion

Predictably many of the negative qualities are a converse or opposite of the qualities of the desirable dialogue outlined above. Instead of a dialogue which is easy to access, unrestricted, nurturing, with a calm, kind person with whom one identifies and leading to personal affirmation as one of its outcomes, respondents describe an interaction which is hard to get, limited in duration and frequency, with an indifferent or worse, actively hostile person, who one cannot trust, who does not hear, notice or respond to LGBT identity and leaves one feeling worse (sometimes for good measure it also takes place in scary environments). Unsurprisingly people don't like this very much.

This is not all that is to be said about the general unhelpful experience. A range of clinical concerns about misdiagnosis and medication are also identified. There is another sub theme about dwelling on and being exposed to negative things and an absence of practical, positive recommendations. Thus once again there appears to be a smaller group who do not want 'to talk about their problems' and we should guard against only envisaging dialogue as the valid response. For some people their journey was about a painful slog to get the right medication which changed their lives.

Across both sets of answers it is perhaps possible to perceive a certain amount of pain occurring from a mismatch of expectations to interventions: people wanting to have therapeutic dialogue with providers who are trying to give them medication; or wanting practical and directive interventions from those who are 'just there to listen'. Clarifying expectations, clarity about modalities and an awareness of the possibility of this tension might be beneficial to all those delivering and accessing support from suicide prevention services.

As already noted above we are not in a position to comment on the clinical efficacy of what people may want, or not want, and this caution should be held in mind. In any event providers of health and social care services in the 21st century, particularly in light of the increasing move to personalisation will need to give thought to both clinical effectiveness *and* customer satisfaction[16]. We would not wish discussion of any possible mismatch of intervention and expectation to obscure the unacceptability of rudeness, hostility, indifference, impatience and interpersonal ineptitude towards anybody seeking help. We acknowledge that this needs to be considered within the actual context of those delivering services which are stretched or pressured, with clients who can themselves be challenging, critical, angry or upset. Not all critics are fair critics.

Problems Relating to LGBT Identities

19 individuals described 33 unhelpful or not useful experiences relating to their LGBT identities. It is immediately apparent that the majority of these responses were not overt expressions of antipathy towards these identities. Only 3 individuals seemed to us to describe experiences where they heard some kind of negativity targeted directly at being LGBT. One of these made specific reference to religion, another to being encouraged to suppress their gay feelings and one to being told that their sexuality was a symptom of their condition. Though appalling, unacceptable and in need of challenge and redress, these are not the majority of experiences and should be addressed through appropriate, easy to use complaints procedures and management action. Another experience already quoted above talks about avoiding the NHS as it has a bad press.

To use a shopping analogy: a rude, unhelpful, uninterested, or hard to attract shop assistant is not theoretically an absolute barrier to the business of forming a legally recognised, contractually binding, transfer of ownership between parties (i.e. selling something). But, they may make the process far more unpleasant and may well stop customers from coming back. If they do both shop and shopper lose out. Similarly solely focusing on clinical outcomes and ignoring patient satisfaction and experience runs the risk of failing both practitioner and patient.

Many of the negative experiences relate to coming out. 6 of the negative experiences were related to assumption, not being asked and lack of reference to LGBT issues from the outset. The absence of routine inclusion of any process to allow disclosure or ascertain and remember the identity of the user, creates a silence in which assumptions can be made or users can feel ignored. In any event it creates the 'tell or don't tell' dilemma which many users resolve by not telling. One consequence of an absence of recording relating to these identities is that patients may not have to just come out once (49 out of 82 people accessing interactive services (60%) said they had come out unasked to a service) but they have to keep coming out or keep correcting assumptions about their identities. In all 10 of the experiences described relate directly to coming out.

The most common negative experiences described related to a range of awkward, clumsy or inappropriate responses to LGBT identity but not relating to treatment. In all 14 of the experiences described were of this nature: typically they include ignorance or unease with LGBT issues, describing sexual partners as a 'friend', not affirming the identity when that was wanted and not hearing or responding when people have tried to come out. Taken with the answers described in the paragraph above there seems to be an awkward point in service use around disclosure pertinent to the experience of unhelpful services. One theme of a number of answers is from those whose distress was related to their identity not receiving the support and affirmation they required. Clearly many of these experiences indicate a training need. One thought that occurs to us is that the LGBT component of staff training should not simply focus on addressing homophobia but have as a basic aim that all providers know how to enable a user to come out to them (perhaps that this should be routinely included in performance monitoring) and that all providers know how to respond to someone appropriately when they do. Broadly this is: acknowledge, affirm, include and don't pathologise.

Finally a number of unhelpful experiences related directly to how treatment responded to or involved the identity of the person seeking help. It is worth noting here that 3 of the 4 responses in this category relate to trans identities. Two of these were from young people specifically relating to how their help seeking directly in relation to their trans identities was not successful. One in particular describes the barriers to accessing appropriate gender support. Other answers were relating to pathologising of identities – where respondents felt their identities were being blamed for the problem.

Anything Else You Would Like To Tell Us

We ended the survey with a general open ended question asking people to tell us anything else about accessing help when feeling suicidal. Many of the responses highlighted or re-iterated key themes already identified. Re-emerging strongly from these answers were the following key issues:

- Time and access difficulties. These issues were raised nine times in any other comments. Typical statements included:

> *"you really need to be able to access help easily and quickly"*
> *"I think 24-hour 7-days-a-week support is essential."*
> *"Finding a service or agency i could access speedily"*
> *"The service needs to be free and new referrals need to be seen quickly."*

- Access to LGBT specific services or somebody who understands these issues was raised nine times in any other comments.
- Access to being able to talk in the manner of the desirable dialogue described above was raised 11 times
- Access to peer groups and those with experience of these issues was raised twice.

In addition some respondents raised ideas for services. Given the overall focus of this work it is interesting to note that one theme emerging from this was the desire for some kind of real time interactive text based service, in all this was raised four times, for example:

"I could not find an online chat. That would have helped because I would not have to talk but still could get rid of some pressure."

"Telephone support is very important, as is online support. Young people are more familiar and comfortable communicating online now, and I would say that online support is more important for them than face-to-face help. Of course, a speedy response is also very important."

"Changes need to be made so that there is more text services avalible as most young people have mobile phones, but would not want others over hearing the conversation. A text service would allow an individual to get help but not be so known to others."

"Calling a hotline has always felt very awkward because I don't know what to say, and sometimes there are other people around and there's no way of avoiding being overheard. I think it would be very helpful to have an online equivalent of a hotline - real-time confidential support through some kind of chat or IM format, without requiring registration."

Conclusions and recommendations

1. A worrying number of LGBT people in the sample access no formal interactive support when feeling suicidal; relying on informal support or getting no help at all. It would be useful to establish whether this is any different from non-sexual minority populations.
2. The Samaritans have an impressive rate of reported use within this sample with nearly half the sample having accessed this one voluntary sector provider. The Samaritans have successfully promoted themselves as a source of crisis support to the LGBT community.
3. Nearly one third of the sample have used the LGBT sector for support when feeling suicidal. This is significant given the relative size of the sector.
4. In person support is the most common medium used with online support as the least common medium used. Although there are signs of significant online use to access support there is no evidence for significant reliance on the internet as a sole source of support. Given the suggestions of the literature review for the appropriateness of online support it could be argued that the internet is a currently an underdeveloped resource in the field of suicide prevention. Simultaneously service planners need to ensure appropriate in person services exist for local people.
5. Most LGBT people using support services when suicidal use more than one of them with the majority pattern being telephone and online services being used as an adjunct to in person support. There is some suggestion that this is to access out of hours support.
6. The service most commonly cited as useful or helpful was The Samaritans. This represents an impressive achievement. However, as many respondents reported negative experiences of The Samaritans as positive ones. Some of these related to the service model and some directly to how Samaritan volunteers have responded to LGBT issues. The Samaritans should be supported and encouraged to review its training in relation to supporting LGBT people.
7. One quarter of all helpful services described were within the LGBT sector, only 1 LGBT organisation was specifically described as unhelpful or not useful (this was an access delivery hours issue).

8. Broadly speaking the qualities of a helpful service were:
    a. Easy and fast to access; not time limited or rushed
    b. A desirable dialogue has taken place; many responses refer to being able to talk and being listened to kindly
    c. Affirmation as an individual and specifically as an LGBT person figured significantly in what made a positive service experience
    d. A sub theme found listening services frustrating and wanted practical advice, medication or support with practical problems.
9. Broadly speaking the qualities of an unhelpful service were often a mirror image opposite of the qualities of a helpful service:
    a. Restricted, limited and hard to access support
    b. Responses perceived as negative or uncaring
    c. Denial, exclusion of or inappropriate responses to LGBT identities
    d. In addition some evidence emerges of tensions caused by a mismatch of modality to expectations.
    e. Some respondents described clinical mistakes.
10. Nearly a quarter of those accessing support services when suicidal described a negative experience relating to their LGBT identities. Only a minority of these were directly anti-LGBT. More common experiences related to the difficulty of coming out, assumptions, invisibility or clumsy and inept responses to disclosure. Absence of any routine process to raise and address these identity issues exacerbates this problem. Some respondents describe the experience of coming out multiple times and this not being heard. The need for appropriate staff training is clear. This training should not simply focus on addressing homophobia or transphobia (e.g. challenging negative attitudes and beliefs) but have as a basic aim that all providers know how to enable a user to come out to them (perhaps that this should be routinely included in monitoring) and that all providers know how to respond to someone appropriately when they do. Broadly this is: acknowledge, affirm, include and don't pathologise.
11. Across the research is a worrying representation from the respondents of the NHS. In all 31 people of a sample of 98, so nearly one third, have not used the NHS for support when feeling suicidal. Some refer to negative perceptions about the NHS as the basis for this. 40% of respondents who had used an NHS service described a negative experience relating to the NHS, this compares with 24% of those using the Samaritans describing a negative experience and just one of the negative experiences relating to the LGBT sector (0.3%). A number of respondents make unfavourable comparisons between the NHS and voluntary sector, for example: "I wish it wasn't so hard to get help within the NHS system and I'm very glad there are charities there to help or I don't know what would've become of me". This is particularly concerning as for a number of respondents the most helpful solution to their problems turned out not to be empathic listening but good diagnosis and medication. However, an interaction with the NHS which is difficult to achieve and inept at interpersonal relationships or responding to LGBT users may threaten to act as a barrier for some people receiving this effective help. Evidence for this problem may be seen in the fact that access to a medical professional was seen as a less important structural quality than ease of access, out of hours support, the medium of support or accessing an LGBT service. A number of good practice and positive examples were also identified. Commonly these relate to good diagnosis and treatment and good interpersonal responses.
12. I n terms of service development or delivery a number of respondents raise the possibility of a real time interactive online service to support people around suicidal distress. In an ideal world this would be a 24/7 service. However, if it is not, it should focus on out of office hours and late night support. Clearly a large number of considerations concerning safety would need to be addressed. All interactions should be clear about what the service does and does not do; it should not seek to replace in person support but be an adjunct to it. There is some preference for an LGBT specific service though one respondent emphasised that it was coverage and access that mattered more. They suggested a Samaritans service which was better at supporting and referring LGBT people to LGBT support would be a model of working.

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