mental health

Additional Findings Report

May 2008

Count Me In Too

LGBT Lives in Brighton & Hove

Report written by

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in consultation with:

Count Me In Too Mental Health Analysis Group

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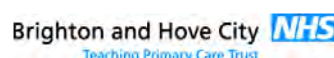

Synopsis of key findings

Understandings of mental health have historically pathologised LGBT people, associating gender and sexual identities with psychological dysfunctions. Since the 1970s, understandings have shifted and suggest that, rather than being the result of individual pathology, the experience of mental health distress can be, but is not always, a result of discriminatory practices. This research found that the majority of LGBT people who live, work or socialise in Brighton & Hove report having experienced some form of mental health difficulty in the past 5 years (a discussion of how the term 'mental health difficulties' is used in this research can be found in the 'key terms' section of the Introduction). This research found that 23% of LGBT people have had suicidal thoughts with 7% attempting suicide in the past 5 years. Yet, not all LGBT people experience mental health difficulties and some groups are more susceptible than others to these experiences. Bisexual, queer and those who identified as 'other' in terms of sexualities, trans people, BME people, those with a low income and those who feel isolated are more likely than other LGBT people to report having experienced difficulties with their mental health in the past five years. Those living with HIV are less likely than other LGBT people to report good or very good mental and emotional health over the past twelve months.

Risks of suicide and suicidal vulnerabilities vary within the LGBT collective. Bisexual, queer and those who identified as 'other' in terms of sexuality, trans people, young people, those who feel isolated, those on a low income and those who are disabled and/or long term health impaired are more likely to report having experienced suicidal thoughts and often also to have attempted suicide.

This research found that those who have experienced domestic violence are more likely to report having experienced difficulties with their mental health in the past five years. Those who are identified as 'other' in terms of sexuality, who are trans, BME identified people and traveller and other ethnic groups deaf LGBT people, those on a low income and those who are disabled or long term health impaired are more likely to feel isolated. These link closely to issues of multiple marginalisation and point to the place of prejudice and discrimination in creating and exacerbating mental health difficulties.

There was also evidence to suggest that LGBT people who identify as experiencing mental health difficulties are also likely to experience multiple layers of prejudice and discrimination. These may relate to, result from or result in mental health difficulties. Those with mental health difficulties are also more likely to have problems getting accommodation, are more likely to be dissatisfied with their place of residence and are more likely to experience homelessness. Those with mental health difficulties may also experience increased levels of hate crime, and experience of hate crime correlates with increased suicidal risks and isolation. Some of this research

supports the assertions that mental health difficulties can result from experiences of hate crime. Yet it should not be forgotten that mental health difficulties can result in individuals being targeted and increase vulnerabilities to abuse, violence and discrimination.

Services designed to cater for mental health difficulties may not be accessible to LGBT people. Most of the respondents who report experiencing some form of mental health difficulty said that they felt the need for support around their mental health difficulties in the last five years. Those who have serious thoughts of suicide are more likely to have used NHS services over the past five years, but are somewhat more likely than those who have not had serious thoughts of suicide to rate NHS mental health services as poor or very poor. Throughout the focus groups, Mind Out was mentioned as a service that LGBT people relied on. There is a clear need for services to reach those who do not use mental health services, including those who may feel that they 'don't need them' because they find them unsafe.

Other services can also be problematic. Those who identify as experiencing significant emotional distress; depression; anxiety; stress; fears and phobias; problem eating/eating distress; panic attacks; self harm are more likely to say that they feel excluded or uncomfortable using mainstream services than other LGBT people. Similarly, those who have thought about and attempted suicide in the last five years and those who identify as having experienced significant emotional distress, depression, stress, anger management, fears and phobias, problem eating/eating distress and panic attacks are less likely than other LGBT people to find council and other public services friendly. Moreover, those who have thought about and attempted suicide and those who have had serious thoughts of suicide but have not attempted it are more likely to say they feel uncomfortable and/or excluded using mainstream public services compared to other LGBT people.

This research suggests that health initiatives across smoking, alcohol, drugs, and physical activity should work with mental health services in order to provide a range of services for LGBT people who have mental health difficulties, and also to ensure that, regardless of the point of initial contact, LGBT people can find the correct range of services that meets their needs. These should be designed to improve the emotional and physical wellbeing of LGBT people.

Executive Summary

Prejudice, discrimination and mental health difficulties

Context: LGBT identities have historically been pathologised within understandings of psychological dysfunction and abnormality. Mental health difficulties can be understood as developing from intolerance, injustice and the experiences of growing up in a 'heterosexual society'.

- Coming out can be a isolating processes, and it is not always easy or even possible to find senses of belonging and acceptance, nor friendship networks.
- 26% of people with mental health difficulties thought it difficult or very difficult to live in Brighton & Hove as someone with mental health difficulties, compared to only 5% of the overall sample who were asked about living in Brighton & Hove as an LGBT person.
- LGBT people with mental health difficulties experience multiple marginalisation that can exacerbate mental health difficulties and lead to isolation.

Prevalence of mental health difficulties

- 79% (n. 643) of respondents reported mental health difficulties including emotional distress, depression, anxiety, anger management, fears / phobias, problem eating, panic attacks, self harm, addictions / dependencies, suicidal thoughts, stress, confidence / self-esteem, stress, insomnia in the last 5 years.
- 55% (n. 302) of these reported experiencing three or more mental health difficulties in the past five years.
- 38.5% of the participants who experienced mental health difficulties (n=211) reported having experienced depression, anxiety and stress together.

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Suicidal distress

- Of those who identified with any of the mental health difficulties listed, 30% have also had serious thoughts of suicide in the past five years.
- 26% (n. 55) of these people have attempted suicide (7% of the overall sample). 37% of people who have attempted suicide (3% of the overall sample) did so in the past year (n. 23).
- 4% (n. 31) of those who have thought about suicide in the past five years have not attempted suicide in the past 12 months, whereas 3% (n. 23) of those who have thought about suicide in the past five years have also attempted suicide in the past 12 months.
- Bisexual, queer and those who identified as 'other' in terms of sexuality are more likely to have serious thought of suicide and attempted suicide in the past 5 years and in the past 12 months.
- Those who identified as trans were twice as likely to have serious thoughts of suicide, more than three times as likely to have attempted suicide in the past five years and over five times as likely to have attempted suicide in the past twelve months than non-trans people.
- Those who identified as having no gender or an 'other' gender were more likely to have serious thoughts of suicide in the past five years and attempted suicide in the past five years.
- Young people are more likely to have serious thoughts of suicide and to have attempted suicide in the past five years compared to other age groups.
- Those aged between 36 and 45 are more likely than other age groups to have thought about and attempted suicide in the last 12 months.
- Respondents who said that they felt isolated or felt isolated sometimes were also more than twice as likely (47%) to say that they had serious thoughts of suicide as those who did not feel isolated (20%).
- Those on a low income are twice as likely (49%) as those on a higher income (17%) to have serious thoughts of suicide.
- Those who identified as disabled were over twice as likely (54%) as those who did not identify as disabled (25%) to have had serious thoughts of suicide.
- Those who reported experience of depression are almost 7 times more likely to have had serious thoughts of suicide in the last 5 years.
- Those who engaged in self-harm are 5.5 times more likely to have had serious thoughts of suicide and are over 7 times more likely to have attempted suicide in the last 5 years.
- Having experienced isolation makes one twice as likely to have had serious thoughts of suicide. Those who feel isolated are over three times more likely to have attempted suicide in the past 12 month (7%) than those who do not feel isolated in Brighton & Hove.

Differences amongst LGBT people

- Bisexual, queer and those who identified as 'other' in terms of sexualities, trans people, BME people, those with a low income, and those who feel isolated are more likely than other LGBT people to report having experienced difficulties with their mental health in the past five years.
- Those living with HIV are less likely than other LGBT people to report good or very good mental and emotional health over the past twelve months.
- Sexual identity made a significant difference to the likelihood of reporting experience of difficulties with each of the categories of mental health difficulty (except stress) over the past five years. Those who identified as bisexual, queer or of an 'other' sexual identity often (but not always) tended to be more likely to say they have experienced each of the categories of mental health difficulty than lesbians or gay men. Lesbians were more likely to say they had experienced significant emotional distress than gay men.
- Trans people were significantly more likely than non-trans respondents to say they have had difficulties in the last five years with significant emotional distress, depression, anxiety, isolation, anger management, insomnia, fears/phobias, panic attacks, addictions/dependencies, and suicidal thoughts.
- No BME person said that they had not experienced any of the difficulties identified in the questionnaire in the last five years.
- Those who identify as disabled are more likely than those who do not identify as disabled to say they have experienced difficulties with significant emotional distress, depression, anxiety, isolation, confidence/self esteem, anger management, insomnia, fears/phobias, problem eating disorders, panic attacks, self harm, and suicidal thoughts.
- Those who are younger are more likely to report having experienced difficulties with confidence/self-esteem, stress, problem eating disorders and addictions and dependencies.
- Older people are more likely to consider their mental health and wellbeing in the past 12 months poor/very poor.
- Experiences of mental health difficulties varied by income, with those earning over £20,000 being more likely not to have experienced mental health difficulties.
- Those earning under £10,000 are much more likely to have experienced mental health difficulties – for some of the difficulties listed, more than twice as likely as those earning over £20,000. The difficulties concerned here are: isolation (in the past five years), fears/phobias, problem eating disorders, panic attacks, self harm, addictions/dependencies, and suicidal thoughts.
- Those who felt isolated are much more likely to report having experienced difficulties with significant emotional distress, depression,

anxiety, confidence/self esteem, anger management, insomnia, problem eating disorders, fears/phobias, panic attacks, self harm, addictions/dependencies, and suicidal thoughts.

Domestic violence and child abuse

- Those who have experienced domestic violence are more likely to report having experienced difficulties with their mental health in the past five years.
- 41% of this LGBT domestic violence and abuse survivor grouping reported having had serious thoughts of suicide in the last 5 years
- A higher proportion of domestic violence survivors reported that they attempted suicide in the last 5 years
- 48% (n. 107) of those who offered a response to the question said that they had experienced child abuse. This is equivalent to 13% of the entire sample.
- Those who reported having been abused as a child were not significantly more likely to report experiencing significant emotional distress, anger management, fears/phobias, problem eating/distress, panic attacks or addictions and dependencies compared to those who did not experience abuse as a child.
- Those who experienced child abuse were more than twice as likely to report experiencing depression, twice as likely to report experiencing anxiety problems, twice as likely to have had suicidal thoughts, and three times more likely to have engaged in self-harm than those who had not experienced child abuse.

Isolation

- 33% of the sample say they feel isolated in Brighton & Hove at least some of the time
- Those who identify as an 'other' sexuality are the most likely to feel isolated in Brighton & Hove
- 60% of those who are trans said that they felt isolated compared to 32% of those who are not trans.
- 75% of BME identified people and 50% of traveller and other ethnic groups stated that they felt isolated compared to 32% of white LGBT people.
- The majority of respondents who identified as deaf (57%) said that they felt isolated at least some of the time in Brighton & Hove, compared to less than a third (32%) of those who did not identify as deaf.

- Those who earn under £10,000 are more likely to feel isolated (47%) than those who earn over £40,000 (27%).
- 52% of those who identify as disabled say that they feel isolated compared to 29% of other LGBT people.
- Over half (52%) of those who state they feel isolated said this was because they had few friends or social contacts (17% of all respondents).
- Those who feel isolated pointed in the qualitative data to the LGBT commercial scene as both making people feel isolated and keeping them isolated.
- The most common reason cited for keeping people isolated was 'lack of confidence' (45%). Fear of not fitting in which could be closely related to 'lack of confidence' was the second most cited reason (39%)
- Those who feel isolated are less likely to enjoy using the LGBT scene and more likely to say that they don't use the scene that those who do not feel isolated in Brighton & Hove.

Management of and support for mental health difficulties

- 344 respondents felt the need for support around their mental health difficulties in the last five years.
- Almost a third (32%, n. 109) of those who felt the need for support said that they were unable to find it.
- Only 24% (n. 154) of respondents who experience mental health difficulties have used NHS mental health services in the last five years.
- While only 13% (n. 54) of those with mental health difficulties but no serious thoughts of suicide have used NHS services over the past five years, experiences of suicidal thoughts are associated with a higher uptake of NHS services. 51% (n. 66) of those who have experienced difficulties with serious thoughts of suicide but who have not attempted suicide, and 69% (n. 38) of those who have thought about and attempted suicide have used NHS services over the past five years.
- An experience of depression, fear/phobias, panic attacks, self-harm or suicidal thoughts significantly increases the likelihood of having visited the NHS mental health services in the last 5 years.
- Whilst 42% (n. 64) of those who reported experiencing mental health difficulties rated NHS mental health services poor or very poor, 37% (n. 56) rated NHS mental health services as good or very good.
- Those who have had serious thoughts of suicide in the last five years are somewhat more likely than those who have not had serious thoughts of suicide to rate NHS mental health services as poor or very poor.

- The qualitative data indicated that both formal support services and informal support networks were important in overcoming mental health difficulties.
- In qualitative responses, people cited factors that make it more difficult to manage mental health difficulties. These include: lack of understanding, waiting times and lists for services, poverty and stigma, intolerance, discrimination and harassment.
- Throughout the focus groups, Mind Out was mentioned as a service that LGBT people relied on for support.

Health

- Those who have reported experiencing some form of mental health difficulty are more likely to smoke than those who have not experienced mental health difficulties.
- Those who identify as experiencing mental health difficulties are more likely to be concerned with the amount of alcohol they drink than other LGBT people who drink alcohol.
- Those who identify as experiencing mental health difficulties are more likely to want greater control over their drug use than other LGBT people who use drugs.
- Those who identify as experiencing mental health difficulties are slightly more likely (82%, n. 435) than those who do not (73%, n. 184) to express a desire to be more physically active.
- Mental health is the most frequently cited 'top three' priority for the improvement of health and wellbeing in Brighton & Hove in the next five years.
- Almost half of those who report experiencing mental health difficulties (48%, n. 261) would like to use a GP clinic/service that specifically caters for LGBT people.
- Almost all of those reporting experiences of mental health difficulties want an LGBT healthy living centre.

Housing

- People identifying as experiencing mental health difficulties are more likely to live in areas of potential deprivation and to live in social housing.
- Those who report experiencing mental health difficulties were less likely (statistical significance $p<.05$) to live with same sex partners (35%) than those who had not reported experiencing mental health difficulties in the past 5 years (51%).

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- Those identifying as experiencing mental health difficulties (80%) were less likely to be happy in their accommodation than those who did not identify as experiencing mental health difficulties (90%).
- Those who say they experience mental health difficulties are more likely to struggle to get accommodation (31%), than those who do not identify as experiencing mental health difficulties (13%, p. <.0001)
- 22 people who report experiencing mental health difficulties have experienced abuse, discrimination or exclusion and/or have been unable to access services from housing in the past five years
- 26% of those who report experiencing mental health difficulties have also experienced homelessness, compared to 9% of those who have not experienced mental health difficulties
- 59% of those who have been homeless in Brighton & Hove in the past 5 years have had serious thoughts of suicide

Safety

- LGBT people who identify as experiencing mental health difficulties are more likely to say they have suffered from some kind of hate crime.
- Those who have experienced hate crime in the past five years are more likely to have thought about and attempted suicide in the past five years than those who have not.
- Those who feel isolated are more likely to have experienced all forms of hate crime in the past five years compared to those who do not feel isolated.
- Dealing with hate crime can take emotional 'toughness', yet not all have the ability to deal with these situations in 'tough' ways. For these people, the impact of hate crime can be more acute than for others who may have similar experiences of hate crime.
- Those who feel isolated feel less safe outside in Brighton during the day and outside in Brighton at night (both p = .0005). They are more likely to feel unsafe in services, facilities and places in Brighton & Hove and are significantly more likely to feel unsafe outside LGBT venues compared to other LGBT people.
- Those who identify as experiencing mental health difficulties are more likely to feel less safe in services, facilities or places in Brighton & Hove and are also more likely to feel unsafe outside of LGBT venues compared to other LGBT people.
- Those who identify as experiencing mental health difficulties and feeling isolated are more likely to avoid going out at night.
- Those who feel isolated are also more likely to avoid public displays of affection.

- Those who feel isolated and have mental health difficulties are more likely to perceive that there is prejudice against LGBT people within the police force.

Services

- Those who have thought about and attempted suicide in the last five years are the most likely (47%, n. 24) to find council and other public services LGBT unfriendly or very unfriendly.
- Those who report having experienced significant emotional distress, depression, stress, anger management, fears and phobias, problem eating/eating distress and panic attacks are less likely to find the council and other public services friendly.
- Those who have thought about and attempted suicide, or who have had serious thoughts of suicide but have not attempted it, are almost twice as likely to say they feel uncomfortable and/or excluded using mainstream public services compared to other LGBT people.
- Those who report having experienced significant emotional distress; depression; anxiety; stress; fears and phobias; problem eating/eating distress; panic attacks; self harm are more likely to say that they feel excluded or uncomfortable using mainstream services than other LGBT people.
- Those who are at risk of suicide are more likely to find the council and other public services unfriendly.
- LGBT people with mental health difficulties are more likely to say that their willingness to provide monitoring data depended on the LGBT friendliness of the service. They are also more likely to say that they will never give this information.

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1. Introduction

1.1. Introduction

Mental health is a key issue for LGBT people. Understandings of mental health have historically pathologised LGBT people, associating gender and sexual identities with psychological dysfunctions. Since the 1970s, understandings have shifted and suggest that, rather than being the result of individual pathology, the experience of mental health distress can be, but is not always, a result of discriminatory practices. This report examines the results of the Count Me In Too Research specifically addressing mental health difficulties amongst LGBT people and the differences between LGBT people who identify as experiencing mental health difficulties and LGBT people who did not report experiencing any difficulties with their mental health.

1.2. Count Me In Too: Background, Research Methods and Analysis notes

In 2000 the award winning Count Me In survey was developed from the grassroots of the then predominantly lesbian and gay communities (Webb and Wright, 2001). This research was used to form the LGBT community strategy for Brighton & Hove 2000-2006. Count Me In Too was initiated in 2005 as a joint venture between Spectrum[1] and the University of Brighton. It is a community led action research project that seeks to advance progressive social change in the city. The research phase ran from January 2006-October 2006. The research consisted of a large scale questionnaire with 819 respondents and 20 focus groups that had 69 participants. The questionnaire offers both qualitative and quantitative data. Many focus groups contained participants who identified as having mental health difficulties, and there were two focus groups that focused specifically on mental health difficulties (one mental health focus group, which consisted of 2 people, and the disabled focus group which consisted of 6 people, all of whom identified as experiencing mental health difficulties). The mental health data was analysed with the help of an analysis group that consisted of representatives from a broad range of statutory services and voluntary groups (see acknowledgements for details). During the analysis, the group advised on the information that would be most relevant to the analysis and

[1] Spectrum is Brighton & Hove's Lesbian, Gay, Bisexual & Transgender Community Forum established in 2002 to provide infrastructure and community development support to LGBT communities and promote partnership work and community engagement in the planning of services and policy. www.spectrum-lgbt.org

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progress positive social change for LGBT people. The report was written by Dr. Kath Browne and Dr. Jason Lim who consulted with the analysis group to establish key areas of analysis and explore the interpretations of the findings in the local context.

Count Me In Too allows an understanding of the diversity and complexity of LGBT communities in greater depth and detail than ever before. In this report, the focus on mental health enables an exploration of the diversity between LGBT people related to their mental health difficulties.

The questionnaire was routed, such that not all respondents answered every question. This is particularly important for this report as those who did not identify as having any difficulties with the mental health issues outlined in question 34 were not given the option of responding to a series of questions that addressed specific issues pertaining to mental health difficulties.

The quantitative data is analysed in SPSS software and we are operating at a significance level of $p<.05$. We have also used a predictor test: logistical regression analysis and linear regression analysis. This report includes the resulting complex statistical data, each part of which may be relevant for different readers. The results are also explained, rather than it being assumed that the reader will be able to engage with these specialist areas.

Logistical regression analysis and linear regression analysis predicts the likelihood of particular actions occurring (for example, using specific services) and can help in predicting the actions/experiences which may be influential in the use of services or having particular experiences or difficulties. Where the variables are binary (yes/no) a logistical regression analysis is used. Where the variables are continuous (e.g., age) a linear regression analysis is used. There are two important pieces of information to extract from the tables that use this analysis:

a. The 'B' values (beta values) and their associated S.E. (standard error) – and of course, their level of significance (p) which represents the change in the outcome variable (e.g., whether or not participants visited the NHS mental health clinic) resulting from a unit change in the predictor variable (e.g., significant emotional distress).

b. Exp(b) is a measure of the size of the effect of each predictor. It is the change in the odds that results from a unit change in the predictor variable. If a value is >1 then it indicates that as the predictor (e.g., significant distress) increases the odds of the outcome occurring increases. A value < 1 indicates that as the predictor increases the odds of the outcome occurring decreases.

Further details and up-to-date reports regarding the Count me In Too research can be found in the initial findings reports located at **www.countmeintoo.co.uk**

1.3. Key terms

1.3.1. Mental Health

The term 'mental health difficulties' or issues was not used in the question that routed respondents through the section on mental health and that gives rise to the mental health category used. This was because it was reasoned that LGBT people with mental health difficulties may not share this conceptualisation with researchers and service providers, and may not have a diagnosis, or access services. The term was also omitted from the question in order to avoid the stigma associated with this label.

This research used indicators that described experiences rather than asking people to label themselves as having mental health difficulties. Using symptoms and manifestations of mental health difficulties, the study was able to include people who would not respond to a question that required particular diagnoses and recognition of their difficulties and issues as 'mental health difficulties/issues'. Consequently the question posed was:

> Have you experienced difficulties with any of the following in the last 5 years? (please select all that apply):
>
> Responses were: depression, anxiety, significant emotional distress, suicidal thoughts, panic attacks, problem eating / distress, fears / phobias, addictions / dependencies, anger management, self harm, stress, insomnia, confidence / self esteem and isolation

However, this category caused quantitative problems in initial analysis. 643 respondents ticked at least one of these possible responses, with many ticking more than one (see chapter three). This meant that tests for differences between those who reported experiencing mental health difficulties and those who did not became problematic. Moreover, comments were written in the questionnaires such as - 'sometimes not being able to sleep or getting stressed does not mean one has mental health difficulties' (questionnaire 74). Such responses suggested that this question was read as 'have you ever experienced' any of these issues, rather than have you ever experienced *difficulties* with any of these issues. These complications caused the action group that directed the initial data analysis to seek advice from local specialists and rethink the category of 'mental health difficulties' for the purposes of the initial report, and particularly in the cross tabulating with other identity categories. This also created a more robust category that would be recognisable to mental health services.

The action group redefined the 'mental health difficulties' category so that it referred only to those who ticked that they had difficulties with any of the following: depression, anxiety, significant emotional distress, suicidal thoughts, panic attacks, problem eating/distress, fears/phobias, addictions/dependencies, anger management and self harm. The categories that were excluded from this were stress, insomnia, confidence/self esteem and isolation. This new definition of the 'mental health difficulties' category was often found to generate statistically significant differences from those 'without mental health difficulties' when examining the overall data.

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However, the category has been reconsidered once more in the writing of this report. This consideration took into account the multiple possible definitions and meanings of the excluded categories, such as 'stress'. Overall, it was decided that a report dedicated to considering mental health needed to be able to use both the broader definition first posed by the question, particularly when exploring the routed section and the narrower definition of 'mental health difficulties' first used in the initial report, in part because of the significant differences within the sample when this revised definition is deployed. The revised and narrower definition is more robust statistically, but it has excluded some of those who are living with mental health difficulties. It is recognised that services and those dealing with LGBT people living with mental health difficulties need to consider all the mental health difficulties LGBT people experience. However, where comparative data (between LGBT people with/without mental health difficulties) is used in this report the narrow definition offers more robust findings and therefore clear distinctions within this grouping.

To summarise, this report retains use of the broader definition of 'mental health difficulties' that includes difficulties with any of the following:

> depression, anxiety, significant emotional distress, suicidal thoughts, panic attacks, problem eating / distress, fears / phobias, addictions / dependencies, anger management; self harm; stress; insomnia; confidence / self esteem; isolation

The report also, however, uses the narrower and more robust definition to more sharply focus on those who have reported difficulties with their mental health and how they differ *as a group* from other LGBT people. This narrower revised definition of 'mental health difficulties' includes difficulties with any of the following:

> depression, anxiety, significant emotional distress, suicidal thoughts, panic attacks, problem eating / distress, fears / phobias, addictions / dependencies, anger management; self harm

and excludes the following difficulties:

> stress; insomnia; confidence / self esteem; isolation.

When the latter narrower definition is used in the report, this is indicated.

It should be noted that the category 'mental health difficulties' and each of the separate mental health categories that are discussed in this report are not diagnostic categories. The design of the questionnaire means that the analysis of 'mental health difficulties' is based here upon self reported data. Therefore, whilst for the sake of brevity much of the analysis discusses groups who have '*experienced*' 'mental health difficulties' or any specific mental health difficulty, this should be taken more precisely to refer to groups of respondents who '*identify with-*' or '*have reported-*' experiencing difficulties with these mental health issues.

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1.3.2. LGBT: Lesbian, Gay, Bisexual and Trans

The term LGBT is used for ease and understandability. The authors recognise the difficulties of categorising sexualities and gender identities in this way. The term includes those who are questioning, unsure, and do not identify with particular sexual or gender identities.

1.3.3. Other terms

There are some terms that are used in this analysis that are unique to the questionnaire or require some understanding at the outset. Other terms such as multiple marginalisation, tenure, and areas of potential deprivation that are used in the report are defined in chapter 2, in relation to the data presented. The latter terms are central to the report and should be understood before moving to other areas of the report.

Category	Definition
Sexual identity	The question used as the basis of this category asked for the sexual identity with which the respondent most closely identified. Those who defined as gay and female were recoded into the lesbian / gay woman category.
Trans	These were respondents who identified as being trans. Two of those who answered yes to the question 'Do you identify yourself as being trans or have you ever questioned your gender identity?' were removed from this category as they argued in comments sections that they were not trans but had questioned their gender identity.
Ethnicity	The question used for this category asked for ethnicities with which respondents most closely identified. Respondents were given four choices: White, BME (Black and Minority Ethic), gypsy traveller and other
Deaf, hard of hearing, deafened or deaf-blind	The question used as the basis of this category was 'Are you or do you identify yourself as being deaf, hard of hearing, deafened or deaf-blind?
Disability	This category includes those who answered yes to the question: 'are you or do you identify as having a long term health impairment or a physical disability?'
Age	This was done in numerically with the following categories used: young people were defined as those under 26 and older people defined as those over 55.

Income	Income levels were measured in categories that asked for income before deductions.
Living with HIV	This category was comprised of those who answered that their most recent HIV test result had been positive.
Isolation	Isolation was measured by those who answered yes / sometimes to the question 'Do you feel isolated in Brighton & Hove?' The figure was broken down into Yes / sometimes and no (the small category unsure (1.9%) was removed to ensure statistical significance). This captured current perception, and therefore was chosen over the question that asked about 'isolation' under mental health difficulties experienced in the past 5 years.
Domestic violence and abuse	This is defined as those who have experienced harassment, violence and/or abuse from a family member or someone close to the person (see Browne, 2007a)
Neighbourhood area	17% of our sample lived in St. James Street and Kemptown. 26% lived in 'areas of potential deprivation'; these are: North Portslade, Hangleton & Knoll, Brunswick (East), Hollingbury, Hollingdean, Saunders Park, St Peters, Tarner (South Hanover), Bristol Estate, Bevendean, Moulsecoomb, Whitehawk & Manor Farm, Queens Park & Craven Vale. 57% do not live in any of these areas and are categorised as living in 'none of the areas listed'.
Tenure	The majority of the sample lived in privately owned accommodation (47%). Just under a third (30%) lived in rented accommodation, and 7% lived in Council housing. A small number (5 people) lived in sheltered and supported accommodation. In order to describe the sample and undertake statistical tests, the tenure categories have been grouped into those that are meaningful for the data and housing services. Throughout this report social housing (9% of the sample) will be used to describe everyone who lives in rented Council housing, rented association, sheltered and supported housing, temporary accommodation or who is homeless. This will be compared to those who privately rent, those who own their own homes and those who exist in another of these categories.

1.4. Outline of the report

- Chapter two offers a basis from which to understand the prevalence of mental health difficulties amongst LGBT people, as well as the fear of using services and LGBT venues and events. After exploring some discriminatory factors that can result from and result in mental health difficulties, the chapter investigates discrimination that those with mental health difficulties felt as a result of being LGBT and having particular mental health issues.

- Chapter three provides an overview of the prevalence of those reporting mental health difficulties in this sample. It will firstly explore perceptions of health and wellbeing in the past 12 months. It will then go on to examine the prevalence of reported difficulties with a range of issues during the past five years. The chapter explores multiple reported experiences of diverse mental health difficulties.

- Chapter four explores suicidal thoughts and suicide attempts amongst LGBT people in this research. The chapter mainly focuses on those who identified as having some form of mental health difficulty, which included suicidal distress. It firstly addresses the prevalence of suicidal thoughts and attempting suicide amongst LGBT people. It investigates the differences between LGBT people and levels of risk. The chapter finishes by examining the links between suicidal thoughts and suicide attempts, and reported experiences of particular mental health difficulties.

- Chapter five examines the differences amongst those who are LGBT and their experiences of mental health difficulties. This chapter firstly investigates general differences between LGBT people and experiences of mental health issues. Then it explores the specific differences between LGBT people through breakdown of the categories used to identify these mental health difficulties.

- Chapter six examines domestic violence and abuse and experiences of mental health difficulties and suicide. It then details the Count Me In Too findings regarding child abuse and the significant relationships between experiences of child abuse and mental health difficulties.

- Chapter seven looks at isolation amongst LGBT people. The chapter firstly explores the differences within the LGBT grouping and experiences of isolation. The chapter reports on the reasons people said they feel isolated and what keeps LGBT people isolated. The latter is broken down in order to engage with differences between LGBT people and what keeps people isolated.

- Chapter eight explores the qualitative and quantitative data from the research in relation to the use of mental health services by LGBT people. The chapter firstly examines those who said that they needed support for their mental health difficulties, exploring diversity between LGBT people and the mental health

category used for this research. It then explores the avenues of support that people pursued, this focuses particularly on NHS services and the effectiveness of NHS services, before addressing the qualitative data regarding what was found to be helpful and unhelpful in managing mental health difficulties.

- Chapter nine addresses other health issues and their correspondence to mental health difficulties. The chapter explores the wider implications of mental health difficulties and the relationship of these to other indicators of healthy lifestyles and examines the relationships between smoking, drug use and alcohol use and mental health issues. It then outlines the priorities for health that LGBT people with mental health difficulties identified.

- Chapter ten examines the key issues relating to housing and mental health. It looks at area of residence and tenure, accommodation satisfaction and difficulties, homelessness and isolation and key housing issues.

- Chapter eleven explores the links between hate crime and mental health, suicide and isolation. The chapter finishes by exploring LGBT perceptions of hate crimes and the links to mental health difficulties and issues. It also examines ideas of resilience and 'mental toughness' in order to cope with daily experiences of hate crime.

- Chapter twelve explores the relationships between reported experiences of mental health difficulties among LGBT people and their experiences of using different services in Brighton & Hove. It will investigate: the friendliness of voluntary, council, and other services; how comfortable LGBT people identifying as experiencing mental health difficulties feel using these services; and finally how LGBT people who report experiencing mental health difficulties feel about the monitoring of their gender/sexual identities.

- In the conclusion, the main points of each chapter are drawn out, and key areas of marginalisation addressed.

2. Prejudice, discrimination & mental health difficulties

2.1. Introduction

At the outset, this report addresses the model of mental health deployed here, and examines the place of prejudice and discrimination in both creating mental health difficulties, and resulting from LGBT identities and mental health difficulties. The chapter gives a basis from which to understand the prevalence of mental health difficulties amongst LGBT people, as well as the fear of using services, and LGBT venues and events. After exploring some discriminatory factors that can result from and result in mental health difficulties, the chapter investigates discrimination that those with mental health difficulties felt as a consequence of being LGBT and having particular mental health issues.

2.2. Creating mental health difficulties

It is important from the outset to note that the model of mental health that we are working within is not one of the inherent psychological 'dysfunction' of LGBT people. Rather, this report seeks to progress social change by exploring mental health difficulties in relation to current evidence that suggests these can be linked to discriminatory practices and minority stress (Johnson et al., 2007; Warner et al., 2004). Johnson (2007: 11) notes 'whether these experiences cause mental health difficulties is less clear but they would inevitably exacerbate coexisting mental health issues'. Similarly, most of this research cannot point to the relationships between mental health and sexual and/or gender identities in terms of causes and effects. However, some participants offered their own experiences and interpretations of the links between their encounters with prejudice and mental health difficulties:

Peter: **Mental health is a huge issue for the community I think, because you grow up in a heterosexual society then, you know, that's going to have some mental health ramifications basically**

(Hate crimes focus group)

LGBT lives and identities have long been associated with problematic psychological understandings of pathology, abnormality and defects (see Johnson et al., 2007; Warner et al, 2004). However, in Peter's narrative, and other narratives in the research (some of which will be introduced later in this report), mental health difficulties are perceived to develop from intolerance, injustice and the experiences of growing up in a 'heterosexual society'. This is not to say that all mental health difficulties that LGBT people experience are related to the stigmatisation of LGBT people so stigmatisation should not be assumed in all cases.

It is also important to note that processes of coming out and using gay scenes can result in mental health difficulties:

Jack: **Well, I mean not kind of acute stuff, well, I think maybe it is acute. If you're coming out as a gay man at the age of 16 and you don't go to a pub or you end up going down the bushes or go round and do a bit of cottaging you know, that's not exactly good for your self-esteem is it? I mean in my case it wasn't. I came out thinking "Is this what it's like being gay, I have to go home with a man every time I meet him and have sex and then maybe I'll get his phone and we'll go out for a drink, or I'll meet his mates and then we'll become friends…" I mean that was just the normal process for me, when I was young. It just seems that if someone's doing that now, here, that's going to affect their mental health, it's going to affect their mental well being and how they see the gay scene, it's going to make them quite depressed. [We need] more about just that mental well being, but anything from depression to anxieties to, you know, not wanting to lose the health which could not happen very often but become quite acute as time goes on. You don't have to be a social fan, but the thing is like you do, if you want to go out and meet people you have to become quite social and you might not be, you might have issues about being social, which can cause you stress and things like that.**

(Pride in Whitehawk group)

Jack notes that coming out can be a isolating processes where finding spaces of belonging and acceptance, as well as friendship networks is not always easy or even possible. Using sex to find friends and partners can have implications for mental health. In addition, perceptions and use of the 'gay scene' can have isolating effects, as this report will show (see chapter 7), and this can result in and arise from mental health issues.

2.3. Mental health difficulties and LGBT Identities: Issues of multiple marginalisation

Table 2.3a On balance, how easy is it for you to be someone with mental health difficulties in Brighton & Hove?

	Frequency	Percent	Valid %
Very easy	22	3.4	6.1
Easy	60	9.2	16.6
Neither easy nor difficult	186	28.6	51.4
Difficult	72	11.1	19.9
Very difficult	22	3.4	6.1
Total	362	55.6	100.0
Missing	289	44.4	
Total	651	100.0	

Table 2.3a show how easy or difficult LGBT respondents who identify as experiencing mental health difficulties find it to live in Brighton & Hove as someone with mental health difficulties. Of those who offered a response to this question, the majority (51%, n. 186) thought it neither easy nor difficult to live in Brighton & Hove as someone with mental health difficulties. However, 26% (n. 94) of those who answered the question thought it difficult or very difficult to live in Brighton & Hove as someone with mental health difficulties, and 6% (n. 22) find it very difficult to live in Brighton & Hove with mental health difficulties. These findings are very different to the overall sample who were asked the question 'Is Brighton & Hove an easy place to live in as an LGBT person?. 76% of those who answered the question found it easy / very easy to live in Brighton & Hove. Only 5% of people declared Brighton & Hove a difficult or very difficult place to live. This points to issues of multiple marginalisation that make Brighton & Hove a very different place to live if you are both LGBT and have mental health difficulties.

Being an LGBT person with mental health difficulties can result in experiences of multiple marginalisation which can exacerbate mental health difficulties and lead to isolation:

Researcher: **And how about having mental health problems and using the scene, do you feel included?**

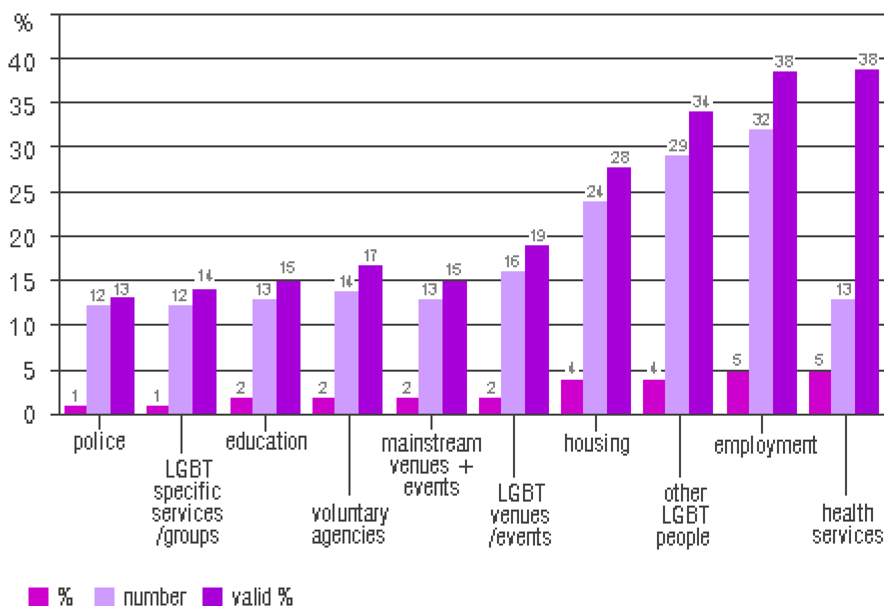
Tracey: **I find that unless you've had specific groups, you are quite excluded. When you start talking to people and you explain to them that you've got a mental health they start nodding their head and oh yeah right and they seem to disappear, they just don't seem to want to know.... I don't mention it very much because I find as soon as you mention you've got mental health problems no matter where you are or whatever you say to someone especially if you say what your diagnosis is, it**

is sort of oh right and they just sort of wonder off, they just don't want to know or they don't understand, you find a lot of people just don't understand or can't cope with it even. You are classed as nutter, as soon as you say you've got a mental health problem, oh you're a nutter.

(Mental health focus group)

38% of respondents with mental health difficulties who answered the question report experiencing abuse, discrimination or exclusion from, or a lack of access to, employment and to health services. 34% of those who answered the question report experiencing abuse, discrimination or exclusion from or a lack of access to other LGBT people, while 28% of those who answered the question report experiencing abuse, discrimination or exclusion from or a lack of access to housing (services). Figure 2.3a shows that 4.8% of respondents of those who were routed to this question said had experienced abuse, discrimination, exclusion from or lack of access to employment and health services. One of the exclusions and discriminations that were most cited in the quantitative data also related to other LGBT people. The numbers and percentages of respondents who report facing abuse, discrimination or exclusion from or lack of access to mainstream (non LGBT) venues and events (1.7%, n. 11) are similar to those relating to LGBT specific venues and events (2.2%, n. 14). The valid percentage is the proportion of respondents with mental health difficulties who gave a positive answer to the question out of all the respondents with mental health difficulties who gave a response to the question.

Figure 2.3a Experiences of abuse, discrimination or exclusion from and/or lack of access to selected services, events and groups in Brighton & Hove in the last 5 years among LGBT people with mental health difficulties



It should be noted that for figure 2.3a, the numbers may be low as people did not identify with the term 'mental health difficulties' in relation to their experiences of difficulties with the categories that routed respondents

through to this section. As Tracey notes, defining and labelling a mental health difficulty and letting someone know your 'diagnosis' can result in exclusion and isolation.

2.4. Conclusion

Understandings of mental health have historically pathologised LGBT people, associating LGBT gender and sexual identities with psychological dysfunctions. To some extent, these understandings continue and have implications not only for service provision, but can also result in mental health difficulties and vulnerabilities. Being an LGBT person with mental health difficulties can result in multiple issues of marginalisation which includes discrimination, prejudice and isolation from LGBT people, networks and spaces. Chapter 10 further explores these issues and the associations between mental health, suicide, isolation and hate crimes.

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3. Prevalence

3.1. Introduction

This chapter will explore the prevalence of mental health difficulties amongst LGBT people who live, work and socialise in Brighton & Hove, from the Count Me In Too data. It will firstly explore perceptions of health and wellbeing in the past 12 months. It will then go on to examine the prevalence of difficulties with a range of issues in the past five years amongst the sample. The chapter explores multiple reported experiences of diverse mental health difficulties. In this way, the chapter provides an overview of the prevalence of those reporting mental health difficulties in this sample.

3.2. Mental health and wellbeing in the past 12 months

Throughout the focus groups carried out as part of the Count Me In Too process, mental health repeatedly came up as one of the main issues for LGBT health and wellbeing. In the questionnaire results, almost one in five (19%) described their mental and emotional health as poor or very poor over the last twelve months (see table 3.2a).

Table 3.2a How would you describe your emotional and mental wellbeing over the last twelve months?

		Frequency	Percent	Valid %
Valid	Very good	191	23.3	23.4
	Good	315	38.5	38.6
	Neither good nor poor	153	18.7	18.8
	Poor	127	15.5	15.6
	Very poor	30	3.7	3.7
	Total	816	99.6	100.0
Missing	System	3	.4	
Total		819	100.0	

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3.3. Experiences of mental health difficulties in the past five years

Due to the stigma attached to labels such as 'mental health', this research used indicators that described experiences rather than asking people to label themselves as having mental health difficulties. The question asked 'have you experienced difficulties with any of the following'. The majority of LGBT people in this research reported experiencing difficulties with their mental health in the past five years. Only a fifth of respondents said they had *not* experienced any difficulties with emotional distress, depression, anxiety, anger management, fears / phobias, problem eating, panic attacks, self harm, addictions / dependencies, suicidal thoughts, stress, confidence / self-esteem, stress, insomnia in the last 5 years.

Table 3.3a shows the frequency of mental health difficulties reportedly experienced by respondents, and the percentage of respondents who said that they had experienced each of the categories of mental health difficulty. 60% of respondents reported experiencing stress, making this the most common form of mental health difficulty experienced. Self harm is the least common of the categories listed, but, even so, almost 9% of respondents reported having had difficulties with self harming over the past five years. Depression was reported as experienced by 361 people (44%), with 365 saying they had experienced significant emotional distress.

Table 3.3a Mental health difficulties experienced over the last five years

	Frequency	Per cent
Stress	491	60.0
Confidence/self-esteem	375	45.8
Depression	361	44.1
Anxiety	361	44.1
Significant emotional distress	274	33.5
Insomnia	274	33.5
Isolation	225	27.5
Suicidal thoughts	174	21.2
Panic attacks	150	18.3
None of the above	140	17.1
Problem eating/eating distress	119	14.5
Fears/phobias	111	13.6
Addictions/dependencies	94	11.5
Anger management	92	11.2
Self harm	73	8.9

Of those who reported having experienced these difficulties in the last five years, 46% stated their mental health had been good / very good in the past year. This illustrates how experiences of mental health difficulties can change over time.

As was explained in the introduction, 643 respondents ticked at least one category in this question. This meant that tests for differences between

those with and without mental health difficulties became problematic. Moreover, comments were written in the questionnaires such as - 'sometimes not being able to sleep or getting stressed does not mean one has mental health difficulties' (questionnaire 74). Consequently, the definition of 'mental health difficulties' used more often in this report is a category that refers to only to those who ticked that they had difficulties with any of the following: depression, anxiety, significant emotional distress, suicidal thoughts, panic attacks, problem eating/distress, fears/phobias, addictions/dependencies, anger management and self harm. The categories that were excluded from this were stress, insomnia, confidence/self esteem and isolation. This means that robust categories were used where necessary throughout this analysis. This is an area that needs further exploration.

3.4. Multiple mental health difficulties

This research was able to investigate the numbers of LGBT people who identified as experiencing multiple forms of mental health difficulties. This can give an indication of need and also establish the importance of addressing mental health difficulties amongst LGBT people.

In order to explore the numbers of those who reported experiencing multiple forms of mental health difficulties, Table 1.2 shows the distribution of the number of mental health difficulties experienced over the past five years – how many people reported to have experienced between one mental health difficulty to ten mental health difficulties. In this table, the difficulties that are included in the count are:

- Significant emotional distress
- Depression
- Anxiety
- Anger management
- Fears/phobias
- Problem eating/eating distress
- Panic attacks
- Self harm
- Addictions/dependencies
- Suicidal thoughts

This analysis only includes people saying they had one or more of these mental health difficulties (n. 548). The difficulties 'isolation', 'confidence/self esteem', 'stress', 'insomnia', as well as the category 'none of the above' are not included in this count due to the revisions of the mental health categories and the desire to use to more robust data (see above).

While those who experienced one mental health difficulty comprised the most frequent count category (25%, n. 139), it can be seen that the majority of those with mental health difficulties have experienced more than one mental health issue. Indeed, there is a slim majority of sufferers of mental health difficulties who have experienced three or more mental health difficulties (55%, n. 302) in the past five years.

A not dissimilar picture emerges if all fourteen of the mental health issues are included in the analysis (i.e. reinstating 'isolation', 'confidence/self esteem', 'stress', 'insomnia', as well as the category 'none of the above', into the analysis). Table 3.4a shows the distribution of the number of mental health issues reported to have been experienced over the past five years – how many people reported to have experienced each of a range from one mental health difficulty to fourteen mental health difficulties.

Table 3.4a: Distribution of number of mental health difficulties experienced from 'mental health issues' categories only

Count	Frequency	Valid %
1	139	25.4
2	107	19.5
3	93	17.0
4	65	11.9
5	50	9.1
6	39	7.1
7	25	4.6
8	16	2.9
9	10	1.8
10	4	.7
Total	548	100.0

When including other categories the number of those who said they only experience one mental health difficulty reduces. This indicates that the exclusion of particular categories of mental health difficulties from the categories does not necessarily lead to a removal of individuals that are of interest. It also points to how experiences of other mental health difficulties can be combined with difficulties with stress, insomnia and isolation and confidence/self-esteem.

Table 3.4b: Distribution of number of mental health difficulties experienced (all mental health difficulties)

Count	Frequency	Valid %
1	105	15.9
2	95	14.4
3	81	12.2
4	74	11.2
5	70	10.6
6	54	8.2
7	46	6.9
8	36	5.4
9	33	5.0
10	27	4.1
11	17	2.6
12	13	2.0
13	7	1.1
14	4	.6
Total	662	100.0

While those who reported experiencing one mental health difficulty comprised the most frequent count category (16%, n. 105), it can be seen that the majority of sufferers of mental health difficulties report having experienced more than one mental health difficulty (84%, n. 557). Indeed, when all the original categories are included, the majority of those identifying as experiencing mental health difficulties have experienced four or more mental health difficulties (58%, n. 381) in the past five years.

Although it was not possible to perform a full cluster analysis of the entire data set, one particular area of clustering was found. 38.5% of the participants who experienced mental health difficulties (n=211) reported having experienced depression, anxiety and stress together. It is not possible to deduce from this research if experiences of a mental health difficulty leads to other difficulties. However, it is possible to conclude that mental health difficulties are rarely experienced in isolation.

3.5. Conclusion

The majority of LGBT people in this sample reported experiencing mental health difficulties in the past 5 years. This varied from 60% for stress and 9% for self harm. Only 17% of the sample said that they had not experienced difficulties with any of the indicators listed. Most LGBT people who experience mental health difficulties experience more than one area of difficulty.

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4. Suicidal distress

4.1. Introduction

Tracy: **I might act you know, look alright, but deep down I'm not. I'm actually very suicidal, but not that suicidal to actually do anything.**

(Mental health, focus group)

Suicide and suicidal risk has long been identified as a factor for LGBT people who experience hate crime and other forms of violence, abuse and discrimination. This chapter will explore the risk of suicide for LGBT people in the Count Me In Too research. This chapter should be read with Johnson's (2007) research that details suicidal risk and distress amongst LGBT people. The chapter mainly focuses on those who identified as having some form of mental health difficulty, which included suicidal distress. It will firstly address the prevalence of suicidal thoughts and attempting suicide amongst LGBT people. It will then examine the differences between LGBT people and levels of risk. The chapter will finish by examining the links between suicidal thoughts and attempts and experiences of particular mental health difficulties.

4.2. Thinking of and attempting suicide

30% of those who identified with any of the mental health difficulties listed have had serious thoughts of suicide in the past five years (see table 4.2a). This constitutes 23% of the overall sample, but it should be noted that only those who identified with one or more of the mental health difficulties, including suicidal thoughts, were posed this question.

Table 4.2a: Have you had serious thoughts of suicide in the last 5 years?

		Frequency	Percent	Valid %	Cumulative %
Valid	Yes	192	23.4	29.8	29.8
	No	452	55.2	70.2	100.0
	Total	644	78.6	100.0	
Missing	System	175	21.4		
Total		819	100.0		

There were two questions asked about suicidal thoughts. The first was part of the question that routed people through the mental health difficulties section and asked about difficulties with suicidal thoughts. The second was within the mental health difficulties section and asked about serious thoughts of suicide. The majority (n. 153) of those who said that they had difficulties with suicidal thoughts in the past five years in the routing question, also said that they had serious thoughts of suicide in the past five years when they were asked in the routed section. This illustrates a robust finding. Table 4.2b shows that 39 people who said they had serious thoughts of suicide in the past 5 years did not say that they had difficulties with suicidal thoughts in the past five years when they were asked in the question regarding mental health difficulties. On the other hand, 19 people who have had difficulties with suicidal thoughts in the past five years, said that they have not had serious thoughts of suicide in the past five years. The reasons for these discrepancies can be attributed to many factors such as the perceived differences between 'serious thoughts of suicide' and difficulties with 'suicidal thoughts' or even questionnaire fatigue and the desire not to tick every box. The categories used here will be composed of all of those who identified as having mental health difficulties and answered the direct question 'Have you had serious thoughts of suicide in the last 5 years?'.

Table 4.2b: Have you had serious thoughts of suicide in the last 5 years? By have you experienced difficulties with any of the following in the last 5 years? [Suicidal thoughts]

In the last 5 years		Have you experienced difficulties with any of the following... - Suicidal thoughts: 0	Suicidal thoughts	Total
serious thoughts of suicide	No.	39	153	192
no serious thoughts of suicide	No.	420	19	439
Total	No.	459	172	631

4.3. Attempted suicide

26% (n. 55) of those who have had serious thoughts of suicide in the last five years, have attempted suicide (7% of the overall sample). 37% of these (3% of the sample) attempted suicide in the past year (n. 23). Using cross about suicide but not attempted it, those who have thought about and attempted suicide and compare these to those who identified as having mental health difficulties but did not think about or attempt suicide.

Table 4.3a shows that the majority of those who have experienced mental health difficulties have not thought about or attempted suicide (71%). However, 9% of those with some form of mental health issue (7% of the overall sample) have both thought about and attempted suicide in the past five years

Table 4.3a: Thinking of and attempting suicide in the past 5 years

in the last 5 years	Frequency	Percent	Valid %
Thought about suicide, but not attempted	135	16.5	21.0
Thought about and attempted suicide	55	6.7	8.6
Neither thought about nor attempted suicide	453	55.3	70.5
Total	643	78.5	100.0
System (not posed the question due to the routing of the questionnaire)	176	21.5	
Total	819	100.0	

Table 4.3b, extends the analysis of table 4.3a providing the frequencies of those who have thought and attempted suicide in the past 12 months. It takes the second row of table 4.3a (above) – 'Thought about and attempted suicide in the last 5 years' – and breaks down this figure of 55 respondents, distinguishing between those who have thought about and attempted suicide in the last five years but not in the last 12 months (n. 31; 5% of those experiencing mental health difficulties), and those who have thought of and attempted suicide in the last 12 months (n. 23; 4% of those experiencing mental health difficulties). One respondent from the 55 who attempted suicide in the last 5 years is missing from the responses regarding the last 12 months.

Table 4.3b: Thinking of and attempting suicide in the last 12 months

in the last 12 months	Frequency	Percent	Valid %
Thought and attempted suicide in the last 5 years, *but not in the last 12 months*	31	3.8	4.8
Thought and attempted suicide in the last 12 months	23	2.8	3.6

4.4. Diversity between LGBT people

In order to examine the differences between those who have mental health difficulties and do not have suicidal thoughts, those who have thought about and attempted suicide, those who have serious thoughts of suicide but have not attempted it, and those who do not have mental health difficulties, a new category was produced in order to undertake further analysis. The frequencies for this category are in table 4.4a. The frequencies for 'thought of and attempted suicide in the last five years' and 'serious thoughts of suicide, but did not attempt' are the same as for the corresponding categories in the tables above (tables 4.3a and 4.3b). The key difference with these new frequencies is the inclusion of those who have not experienced any mental health difficulties in the analysis, to show comparisons across the entire sample and offer percentages that relate to all of the categories we are addressing, not only those who have mental health difficulties.

Table 4.4a: Suicidal thoughts and attempted suicides re-categorised

in the last 5 years	Frequency	Percent	Valid %
Have not experienced any mental health difficulties[1]	139	17.0	18.1
Thought about and attempted suicide[2]	55	6.7	7.2
Serious thoughts of suicide, but did not attempt[3]	135	16.5	17.6
Mental health difficulties, but no serious thoughts of suicide[4]	439	53.6	57.2
Total	768	93.8	100.0
Missing	51	6.2	
Total	819	100.0	

The risk of suicide distress varies by identity category. The proportion who had serious thoughts of suicide rose to 45% for bisexual respondents, 44% for queer and 48% for who identified as 'other' in terms of sexuality. Trans people (56%) were almost twice as likely to have considered suicide in the last five years than non trans (28%) respondents who had mental health difficulties in the past five years. Those who identified as having a physical disability or long term health impairment (54%) were over twice as likely as those without a disability (25%) to have had serious thoughts of suicide. Young people (46%) were also more likely to have had serious thoughts of suicide than any other age category, although the figure is also higher for older people (35%). Those on a low income (49%) are twice as likely as those on a higher income (17%) to have serious thoughts of suicide. Respondents who said that they felt isolated or felt isolated sometimes (47%) were also more than twice as likely to say that they had serious thoughts of suicide as those who did not feel isolated (20%).

In the categories listed there were no significant differences when those who thought about suicide but not attempted it were compared only with those who thought about and attempted suicide. The rest of this chapter explains all of these figures in more detail.

4.5. Sexuality

Bisexual, queer and those who identified as 'other' in terms of sexuality are more likely to have serious thought of suicide and attempted suicide in the past 5 years and in the past 12 months. This suggests that these groups are more vulnerable and at risk of suicide than lesbians and gay men.

4.5.1. Serious thoughts of suicide

The table below (table 4.5a) shows that bisexual, queer and those of an 'other' sexuality (respondents who did not identify as lesbian, gay, bisexual or queer) are more likely to have had serious thoughts of suicide during the last five years (p = .007). 45% (n. 18) of bisexual respondents who

[1] Q34 'none of the above' only answers
[2] Q34a_5 'yes' and Q34a_6 'yes' answers
[3] Q34a_5 'yes' and Q34a_6 'no' answers
[4] Q34 any one of the answers ticked, except for 'none of the above and Q34a_5 'no' and Q34a_6 'no' answers]

answered this question, 44% (n. 11) of queer respondents and 48% (n. 15) of 'other' respondents have had serious thoughts of suicide in the last five years, compared to 27% (n. 58) of lesbians and 27% (n. 90) of gay men.

Table 4.5a Serious thoughts of suicide in the last five years by sexual identity

		Lesbian	Gay	Bisexual	Queer	Otherwise coded	Total
Yes	No.	58	90	18	11	15	192
	%	26.7	27.2	45	44	48.4	29.8
No	No.	159	241	22	14	16	452
	%	73.3	72.8	55	56	51.6	70.2
Total	No.	217	331	40	25	31	644
	%	100	100	100	100	100	100

Note that in the following tables and analyses the sexual identity categories of 'bisexual' respondents and 'queer' respondents have been combined on the basis that they share similar statistical patterns for this question.

4.5.2. Attempted suicide in the past five years

Table 4.5b shows that those who defined their sexuality as other are the most likely sexual identity group to have thought about and attempted suicide in the last five years (26%, n. 8). 15% (n. 10) of bisexual and queer respondents who answered this question have thought about and attempted suicide in the last five years, compared to 8% (n. 17) of lesbians and 6% (n. 20) of gay men ($p = .001$).

Table 4.5b: Attempted suicide in the last five years by sexual identity

in the last 5 years		lesbian	gay	bi & queer	others	Total
Thought about suicide, but not attempted	No.	40	69	19	7	135
	%	18.5	20.9	28.8	22.6	21.0
Thought about and attempted suicide	No.	17	20	10	8	55
	%	7.9	6.1	15.2	25.8	8.6
Neither thought about nor attempted suicide	No.	159	241	37	16	453
	%	73.6	73.0	56.1	51.6	70.5
Total	No.	216	330	66	31	643
	%	100.0	100.0	100.0	100.0	100.0

When the entire sample is included there is an even stronger relationship between sexual identity and the likelihood of having thought about and attempted suicide over the past five years ($p < .0001$, see table 4.5c). This is of course related to the prevalence of mental health difficulties within this grouping, but it emphasises the increased risks of suicide. 25% (n. 8) of those of an 'other' sexuality have thought about and attempted suicide in the past five years, compared with 14% (n. 10) of bisexual and queer respondents, 6% (n. 17) of lesbians and 5% (n. 20) of gay male respondents. 59% of lesbians and 58% of gay men did not have serious thoughts of suicide compared to 49% of bisexual and queer people and 50% of those who are who identified as 'other' in terms of sexuality.

Table 4.5c: Attempted suicide in the last five years by sexual identity including respondents who have not experienced any mental health difficulties

		Have not experienced any mental health difficulties	Thought about and attempted suicide in the last 5 years	Thought about suicide, but did not attempt	Mental health difficulties but no serious thoughts of suicide	Total
lesbian	No.	51	17	40	157	265
	%	19.2	6.4	15.1	59.2	100.0
gay	No.	80	20	69	231	400
	%	20.0	5.0	17.3	57.8	100.0
bi & queer	No.	7	10	19	35	71
	%	9.9	14.1	26.8	49.3	100.0
Otherwise coded	No.	1	8	7	16	32
	%	3.1	25.0	21.9	50.0	100.0
Total	No.	139	55	135	439	768
	%	18.1	7.2	17.6	57.2	100.0

4.5.3. Attempted suicide within the last 12 months?

When looking at only those who said they had experienced mental health difficulties, those of an 'other' sexual identity are the most likely to have a suicide attempts (16%, n. 5) in the past 12 months (p = .001). By comparison, 5% (n. 3) of bisexual and queer respondents, 3% (n. 7) of lesbian respondents and 2% (n. 8) of gay male respondents have thought about and attempted suicide in the last 12 months.

Table 4.5d: Attempted suicide in the last 12 months by sexual identity

in the last 5 years		lesbian	Gay	bi & queer	others	Total
Thought about and attempted suicide but not in the last 12 months	No.	10	11	7	3	31
	%	4.6	3.3	10.6	9.7	4.8
Thought about and attempted suicide in the last 12 months	No.	7	8	3	5	23
	%	3.2	2.4	4.5	16.1	3.6
Thought about suicide but not attempted	No.	40	69	19	7	135
	%	18.5	21.0	28.8	22.6	21.0
Mental health difficulties but neither thought about nor attempted suicide	No.	159	241	37	16	453
	%	73.6	73.3	56.1	51.6	70.6
Total	No.	216	329	66	31	642
	%	100.0	100.0	100.0	100.0	100.0

4.6. Trans identities

Those who identified as trans were twice as likely to have serious thoughts of suicide, more than three times as likely to have attempted suicide in the past five years and over five times as likely to have attempted suicide in the

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past twelve months than non-trans people. The trans focus group highlighted the vulnerability of trans people due to the lack of support systems and also pointed to the awareness of the levels of suicide amongst trans people:

Sasha: **If you're transsexual and because of the lack of support that you get from people and because you don't know where to turn, you know, some people would turn to drink, some people might turn to drugs, and then if they do get support, because of that, because of the alcoholism or the drug addiction then they say, "Oh it's because you're a transsexual," it's not because they didn't the help in the first place. And that can, lead you to think, you know, I mean it can lead people to suicide.**

Soraya: **It can and does.**

(Trans focus group 2)

4.6.1. Serious thoughts of suicide in the past five years

The table below (table 4.6a) shows that, amongst those who have experienced mental health difficulties, those who identify as trans are twice as likely (56%, n. 22) than non-trans respondents (28%, n. 168) to have had serious thoughts of suicide in the last five years (p = .0005).

Table 4.6a: Serious thoughts of suicide in the last five years by trans identity

		Trans identity	Not trans	Total
Yes	No.	22	168	190
	%	56.4	28.3	30
No	No.	17	426	443
	%	43.6	71.7	70
Total	No.	39	594	633
	%	100	100	100

4.6.2. Attempted suicide in the past five years

26% (n. 10) of trans respondents who have experienced mental health difficulties have thought about and attempted suicide in the last five years, making them much more likely to have done so than non-trans respondents (8%, n. 45) (p < .0001).

Table 4.6b: Attempted suicide in the last five years by trans identity

		Thought about suicide in the last 5 years, but not attempted	Thought and attempted suicide in the last 5 yrs	Never thought or attempted suicide	Total
Trans identity	No.	11	10	17	38
	%	28.9	26.3	44.7	100.0
Not trans	No.	122	45	427	594
	%	20.5	7.6	71.9	100.0
Total	No.	133	55	444	632
	%	21.0	8.7	70.3	100.0

When the entire sample is included, table 4.6c (below) shows that the difference between trans and non-trans respondents in the likelihood of thinking about and attempting suicide in the last five years is still very significant ($p < .0001$).

Table 4.6c: Attempted suicide in the last 5 years by trans identity including respondents who have not experienced any mental health issues

		Have not experienced mental health difficulties	Thought about and attempted suicide	Thought about but did not attempt suicide	Mental health difficulties but no serious thoughts of suicide	Total
Trans	No.	2	10	11	17	40
	%	5.0	25.0	27.5	42.5	100.0
Not trans	No.	135	45	122	413	715
	%	18.9	6.3	17.1	57.8	100.0
Total	No.	137	55	133	430	755
	%	18.1	7.3	17.6	57.0	100.0

25% of trans respondents have thought about and attempted suicide in the last five years, compared to 6% of non-trans respondents ($p < .0001$). In this analysis, 43% of trans people who said that they had experienced mental health difficulties but had had no serious thoughts of suicide, compared to 58% of non-trans respondents. This is of course related to the prevalence of mental health difficulties within this grouping, but it emphasises the increased risks of suicide.

4.6.3. Attempted suicide in the last 12 months

Amongst those who have experienced mental health difficulties, trans respondents are more likely (16%, n. 6) to have thought about and attempted suicide than non-trans respondents (3%, n. 17) ($p < .0001$).

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4.6.4. Male/Female/ No Gender

Perhaps unsurprisingly those who identified as having no gender or an 'other' gender were more likely to have serious thoughts of suicide in the past five years and attempted suicide in the past five years. (There was no significant differences found between those who had attempted suicide in the past 12 months).

4.6.5. Serious thoughts of suicide in the past five years

Table 4.6d shows that those who identified as having no gender or as of an 'other' gender than male or female are more likely (57%, n. 12) to have had serious thoughts of suicide in the last five years than either men (27%, n. 94) or women (31%, n. 85) (p = .01).

Table 4.6d: Serious thoughts of suicide in the last five years by gender

		Male	Female	No gender or 'other'	Total
Yes	No.	94	85	12	191
	%	27.0	31.4	57.1	29.8
No	No.	254	186	9	449
	%	73.0	68.6	42.9	70.2
Total	No.	348	271	21	640
	%	100.0	100.0	100.0	100.0

4.6.6. Attempted suicide in the past five years

Those who identify as of no gender or of an 'other' gender are more likely (14%, n. 3) to have thought about and attempted suicide in the last five years than female respondents (10%, n. 28) or male respondents (7%, n. 24) (p = .03).

Table 4.6e: Attempted suicide in the last five years by gender

in the last 5 years		Male	Female	No gender or 'other'	Total
Thought about suicide, but not attempted	No.	69	56	9	134
	%	51.5	41.8	6.7	100.0
Thought about and attempted suicide	No.	24	28	3	55
	%	43.6	50.9	5.5	100.0
Neither thought about nor attempted suicide	No.	254	186	9	449
	%	56.6	41.4	2.0	100.0
Total	No.	347	270	21	638
	%	100.0	100.0	100.0	100.0

When respondents who have not experienced any mental health difficulties are included in the analysis there are no substantial differences, 13% of those of no gender or of an 'other' gender have thought of and attempted suicide in the last five years, compared to 9% of female respondents and 6% of male respondents (p = .05).

Table 4.6f: Attempted suicide in the last five years by gender, including respondents who have not experienced any mental health difficulties

		Have not experienced mental health difficulties	Thought about and attempted suicide	Thought about but did not attempt suicide	Mental health difficulties but no serious thoughts of suicide	Total
Male	No.	83	24	69	244	420
	%	19.8	5.7	16.4	58.1	100
Female	No.	52	28	56	183	319
	%	16.3	8.8	17.6	57.4	100
No gender or 'other'	No.	4	3	9	8	24
	%	16.7	12.5	37.5	33.3	100
Total	No.	139	55	134	435	763
	%	100.0	100.0	100.0	100.0	100.0

4.7. Age

Young people are more likely to have serious thoughts of suicide, have attempted suicide in the past five years and in the past 12 months. Although older people (those over 55) make up the second most likely group to have serious thoughts of suicide, they are the age group that is the least likely to attempt suicide. Those aged between 36 and 45 are the most likely age group to have thought about and attempted suicide in the last 12 months.

4.7.1. Serious thoughts of suicide in the last 5 years

Those under the age of 26 are more likely (46%, n. 46) to have had serious thoughts of suicide in the last five years than those in other age groups (p = .004). The 36-45 year age group are the least likely to have had serious thoughts of suicide (25%, n. 49). Older people at 30% were the next group to have serious thoughts of suicide. See table 4.7a.

Table 4.7a: Serious thoughts of suicide in the last five years by age

		Under 26	26-35	36-45	46-55	55+	Total
Yes	No.	46	56	49	26	15	192
	%	45.5	28.7	24.5	26.8	30	29.9
No	No.	55	139	151	71	35	451
	%	54.5	71.3	75.5	73.2	70	70.1
Total	No.	101	195	200	97	50	643
	%	100	100	100	100	100	100

4.7.2. Attempted suicide in the past five years

Table 4.7b shows that, amongst those who have experienced mental health difficulties, those under 26 years of age are the most likely age group (18%, n. 18) to have thought about and attempted suicide over the past five years (p = .001). The least likely group are over 55s, of whom 4% (n. 2) have

thought about and attempted suicide in the last five years. 26% (n. 13) of over 55s have thought about suicide in the last five years but not attempted it, making over 55s the second most likely age group (after those under 26) to have thought about but not attempted suicide. Conversely, while those aged 36-45 are the least likely age group to have thought about but not attempted suicide (15%, n. 30), they are the second most likely age group to have thought about and attempted suicide in the last five years (9%, n. 18).

Table 4.7b Attempted suicide in the last five years by age

in the last 5 years		< 26	26-35	36-45	46-55	55+	Total
Thought about suicide, but not attempted	No.	28	44	30	20	13	135
	%	27.7	22.6	15.0	20.8	26.0	21.0
Thought about and attempted suicide	No.	18	12	18	5	2	55
	%	17.8	6.2	9.0	5.2	4.0	8.6
Neither thought about nor attempted suicide	No.	55	139	152	71	35	452
	%	54.5	71.3	76.0	74.0	70.0	70.4
Total	No.	101	195	200	96	50	642
	%	100.0	100.0	100.0	100.0	100.0	100.0

When the entire sample is added to the analysis (table 4.7c), the patterns are similar, but the strength of the relationship increases ($p < .0001$). Again, those under 26 are most likely to have thought about and attempted suicide in the last five years (16%), followed by those between 36 and 45 (8%), with those over 55 being the least likely age group (3%).

Table 4.7c: Attempted suicide in the last five years by age including respondents who have not experienced any mental health difficulties

in the last 5 years		< 26	26-35	36-45	46-55	55+	Total
No mental health difficulties	No.	15	39	40	23	22	139
	%	13.3	16.8	17.1	19.7	31.0	18.1
Thought about suicide, but not attempted	No.	18	12	18	5	2	55
	%	15.9	5.2	7.7	4.3	2.8	7.2
Thought about and attempted suicide	No.	28	44	30	20	13	135
	%	24.8	19.0	12.8	17.1	18.3	17.6
Neither thought about nor attempted suicide	No.	52	137	146	69	34	438
	%	46.0	59.1	62.4	59.0	47.9	57.1
Total	No.	113	232	234	117	71	767
	%	100.0	100.0	100.0	100.0	100.0	100.0

4.7.3. Attempted suicide within the last 12 months

While those under 26 are the most likely age group to have thought about and attempted suicide in the last five years but not in the last 12 months (14%, n. 14), this age group is not the most likely to have thought about and attempted suicide in the last 12 months, 4% (n. 4) of this age group having made such attempts in the last 12 months (see table 4.7d). Rather, those aged between 36 and 45 are the most likely age group to have thought about and attempted suicide in the last 12 months (6%, n. 12) ($p < .0001$). No respondents over 55 years of age had thought about and attempted suicide in the last 12 months.

Table 4.7d: Attempted suicide in the last 12 months by age

in the last 5 years		< 26	26-35	36-45	46-55	55+	Total
Thought about and attempted suicide but not in last 12 months	No.	14	8	6	2	1	31
	%	13.9	4.1	3.0	2.1	2.0	4.8
Thought about and attempted suicide in the last 12 months	No.	4	4	12	3	0	23
	%	4.0	2.1	6.0	3.1	.0	3.6
Thought about suicide but not attempted	No.	28	44	30	20	13	135
	%	27.7	22.6	15.0	20.8	26.5	21.1
neither thought about nor attempted suicide	No.	55	139	152	71	35	452
	%	54.5	71.3	76.0	74.0	71.4	70.5
Total	No.	101	195	200	96	49	641
	%	100	100	100	100	100	100

4.8. Isolation

Those who have answered 'yes' or 'sometimes' to the question 'Do you feel isolated in Brighton & Hove?' are more than twice as likely to have had serious thoughts of suicide, and are just under three times as likely to have attempted suicide in the past five years and past 12 months.

4.8.1. Serious thoughts of suicide in the last 5 years

Table 4.8a shows that 47% (n. 115) of those who feel isolated and who have experienced mental health difficulties have had serious thoughts of suicide in the last five years. This compares with 20% (n. 75) of those who do not feel isolated ($p = .0005$).

Table 4.8a: Serious thoughts of suicide in the last five years by isolation

		Yes/Sometimes	No	Total
Yes	No.	115	75	190
	%	46.7	19.9	30.5
No	No.	131	302	433
	%	53.3	80.1	69.5
Total	No.	246	377	623
	%	100	100	100

4.8.2. Attempted suicide in the past five years

14% (n. 35) of those who feel isolated have thought about and attempted suicide in the last five years, a higher likelihood than the 5% (n. 20) of respondents who do not feel isolated ($p < .0001$).

Table 4.8b: Attempted suicide in the last five years by isolation

in the last 5 years		Yes/sometimes	No	Total
Thought about suicide, but not attempted	No.	78	56	134
	%	32.0	14.4	21.1
Thought about and attempted suicide	No.	35	20	55
	%	14.3	5.1	8.7
Neither thought about nor attempted suicide	No.	131	314	445
	%	53.7	80.5	70.2
Total	No.	244	390	634
	%	100.0	100.0	100.0

4.8.3. Attempted suicide in the past 12 months

Those who feel isolated are over three times more likely to have attempted suicide in the past 12 month (7%) than those who do not feel isolated in Brighton & Hove, see table 4.8c (p < .004). This indicates clear suicidal risks for those who feel isolated, and could mean that some of those who are suicidal are also feel isolated.

Table 4.8c: isolation by attempted suicide within the last 12 months

			If yes, was it within the last 12 months?		
			Yes	No	Total
isolation	Yes / sometimes	Count	15	191	206
		%	7.3	92.7	100
	No	Count	8	345	353
		%	2.3	97.7	100
Total		Count	23	536	559
		% within isolation	4.1	95.9	100

4.9. Income

49% (n. 66) of respondents earning less than £10,000 a year and who had experienced mental health difficulties have had serious thoughts of suicide in the last five years. By contrast, the income group least likely to have had serious thoughts of suicide in the last five years are those earning more than £40,001 a year (17%, n. 12) (p = .0005).

Table 4.9a: Serious thoughts of suicide in the last five years by annual income

		<10k	10k – 20-k	20k - 40k	40k+	Total
Yes	No.	66	68	44	12	190
	%	49.3	33	19.6	16.7	29.8
No	No.	68	138	181	60	447
	%	50.7	67	80.4	83.3	70.2
Total	No.	134	206	225	72	637
	%	100	100	100	100	100

4.10. Disability and long term health impairments

Table 4.10a shows that amongst respondents who report experiencing mental health difficulties, respondents who identify as disabled are more than twice as likely (54%, n. 57) to have had serious thoughts of suicide than respondents with no disability (25%, n .129) (p = .0001).

Table 4.10a Serious thoughts of suicide in the last five years by disability

		Disability	No disability	Total
Yes	No.	57	129	186
	%	54.3	24.8	29.7
No	No.	48	392	440
	%	45.7	75.2	70.3
Total	No.	105	521	626
	%	100	100	100

As the disability and long term health impairments category in this research cannot be separated from the mental health category, further analyses were not undertaken. However this is an area for further in depth research.

4.11. Mental health difficulties and suicidal thoughts

When we take the category of mental health difficulties that are used for the Count Me In Too analysis, then we see that experiencing at least one of these mental health difficulties makes it much more likely (35%, n. 183) to have had *serious* thoughts of suicide in the last five years than not experiencing any of these mental health difficulties (3%, n. 3) (p = .0005) – see table 4.11a. Note this category consists of those who experience significant emotional distress, depression, anxiety, anger management, fears/phobias, problem eating/eating distress, panic attacks, self harm, addictions/dependencies, suicidal thoughts and excludes 'isolation', 'confidence/self esteem', 'stress' and 'insomnia'.

Table 4.11a Serious thoughts of suicide in the last five years by mental health difficulties

		No mental health difficulties	Mental health difficulties	Total
Yes	No.	3	183	186
	%	3.1	35	30
No	No.	95	340	435
	%	96.9	65	70
Total	No.	98	523	621
	%	100	100	100

Extending this analysis, the links between particular forms of mental health difficulties and LGBT suicidal distress can be examined through exploring the relationships between mental health difficulties and serious thoughts and attempting suicide.

4.12. Mental health difficulties predicting serious suicide thoughts

Using logistical regression analysis, it is possible to establish the relationships between suicidal thoughts and experiences of particular forms of mental health difficulty. This form of analysis differs from the chi square analyses that are used elsewhere in this report. It is used here to predict the likelihood of suicidal thoughts in the past five years given respondents' different mental health difficulties. Thus, the outcome will help in identifying which of these experiences are influential in predicting whether an individual will have suicidal thoughts.

There are two important pieces of information to note in this analysis:

a) The 'B' values (beta values) and their associated S.E. (standard error) – and of course, their level of significance (p) which represents the change in the outcome variable (i.e., whether or not participants had suicidal thoughts) resulting from a unit change in the predictor variable (e.g., significant emotional distress).

b) Exp(b) which is the change in the odds that results from a unit change in the predictor variable. If a value is >1 then it indicates that as the predictor increases (e.g., significant distress) the odds of the outcome occurring increases. A value <1 indicates that as the predictor increases the odds of the outcome occurring decreases.

Using logistical regression analysis, it is possible to conclude that those who identify as having experienced depression are almost 7 times more likely to have had serious thoughts of suicide in the last 5 years.

Those who experience difficulties with self-harm are 5.5 times more likely to have had serious thoughts of suicide.

Having experienced isolation makes one twice as likely to have serious thoughts of suicide.

The other mental health difficulties listed were not significant variables in predicting serious thoughts of suicide (see table 4.12a). This indicates that those who have depression, self harmed or who feel isolated are more likely to have serious thoughts of suicide.

Table 4.12a Likelihood of serious thoughts of suicide predicted by depression, isolation and self harm

	B	S.E.	Sig. (P. value)	Exp(B)
Depression	1.95	.29	.000	6.934
Isolation	.80	.24	.001	2.215
Self-harm	1.70	.37	.000	5.491

Note. The 'beta' values in the table tells us how strong the effect of each of the predictors is relative to the outcome. It tells us the number of standard deviations that the outcome variable will change as a result of one standard deviation change in the predictor variable.

When looking at those who only had serious thoughts of suicide in comparison with those who had thoughts and those who actually attempted in the last 5 years, those who have previously engaged in self-harm are 7 times more likely to have attempted suicide in the last 5 years than those did not (B.= 1.93, S.E.= .42, p<.0001, Exp(B) =6.902). This indicates that self harm can be a predictor of suicide attempts.

These areas of vulnerability should be noted when working with LGBT people who present with mental health difficulties. It is particular pertinent for those who present with histories of self-harm.

4.13. Conclusion

23% of LGBT people who completed this research have had suicidal thoughts, with 7% attempting suicide in the past 5 years. Risks of suicide and suicidal vulnerabilities vary within the LGBT collective. Bisexual, queer and those who identified as 'other' in terms of sexuality, trans people, young people, those who feel isolated, those on a low income and those who are disabled and/or long term health impaired are more likely to have experienced suicidal thoughts and often to have attempted suicide also. Predictors of suicidal thoughts are depression, self-harm and isolation. Self harm is also a predictor of suicidal attempts.

5. Mental health difficulties and diversity among the LGBT collective

5.1. Introduction

Mental health difficulties are not uniformly experienced across all LGBT people. This chapter will examine the differences between those who are LGBT and their experiences of mental health difficulties. This chapter will firstly examine general differences between LGBT people and experiences of mental health issues. It will then breakdown the categories used to identify these mental health difficulties and explore the specific differences between LGBT people. Differences in experience of suicidal distress were discussed in chapter 3.

5.2. Prevalence of mental health difficulties overall

Bisexual, queer and those who identified as 'other' in terms of sexualities, trans people, BME people, those with a low income and those who feel isolated are more likely than other LGBT people to have experienced difficulties with their mental health in the past five years. In addition to this those who are living with HIV are less likely to say that their mental and emotional health has been good or very good over the past twelve months.

5.2.1. Sexuality

Experiences of emotional and mental wellbeing and mental health difficulties varied by sexual identities. Lesbians / gay women (65%) and gay men (64%) were far more likely to describe their emotional and mental wellbeing as good / very good in the last 12 months compared to those identifying as bisexual (57%) and queer (48%). Bisexual and queer (88%, n. 64) respondents and those who identified as an 'other' sexuality (82%, n. 27) are more likely to have experienced mental health difficulties than lesbians (66%, n. 183) or gay men (66%, n. 274) ($p = .001$).

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5.2.2. Trans identities

Trans people considered themselves to have significantly poorer emotional and mental wellbeing in the last 12 months than those who were not trans ($p < .0005$). 26% of trans people described themselves as having good / very good emotional and mental wellbeing in the last 12 months compared to 62% of all respondents. 42% of trans respondents had poor or very poor emotional and mental wellbeing, compared to less than a fifth overall. Those who identified as trans are significantly more likely (84%, n. 36) to have experienced mental health difficulties than those who did not identify as trans (68%, n. 504) ($p = .03$).

In the trans focus groups the links to mental health were discussed and the pathologisation of trans people addressed. These offer some understanding as to the figures revealed in this data.

Sarah: **I mean if a trans person has mental health difficulties the first thing is to assume it's related to their transition, well that's rubbish. A lot of rubbish! People seem to think "Oh, it's because they're trans".**

Soraya: **If you get somebody that goes to the GP and says "I'm gay" and they say "Go to mental health". I mean that would be appalling, but with us, oh it's what they do. It's normal. It's almost similar to [saying] they must be completely mad. The thing is we don't need psychiatry anyway, we are not mentally ill. So the thing is the whole of the system is based around us being mentally ill. So the thing is that then people make decisions for us to judge whether we are suitable as they consider to have treatment. The whole of the system is so basically rotten and in treating people as mentally that that is the cause of most of the mental illness.**

There's no consistency, there's no overall strategy so that people. Mental health, every time, mental health, mental health, it's not a mental health issue. This causes distress, distress is then a mental health issue. It's caused by the system not by the trans-sexuality and the thing is that if this could be understood so that then people could really work with the people who are giving local treatment, the treatment is being given along way away from here. There's no way that they could match up with it. The whole system is splintered, broken up, inconsistent and not joined in any way and does not work, for people's safety, for their health, for their well being or anything.

Anne: **You can't be, you know, as much as you might look like it and it's always going to be there, it's always going to be there in the back of your mind. I'm 50 now and I've had it in my brainbox for, I don't know, 40 of them 50 years and it's been there constantly. Day in, day out,**

every waking moment and that must be the same for like, you know, the gay and lesbian people as well. It's possibly a different realisation like because you're gay, you're lesbian, that's it. If you come out and you're happy with yourself and you're okay in that respect, then fine. But we've still got hurdles to cover even though we come out. You know, we've still got stuff to face day in, day out, you know, it all comes down to that again.

(Trans group 2)

The trans focus groups were also at pains to point out that mental health difficulties did not necessarily arise from their gender identifications. Sarah calls this 'rubbish' and in defining trans identitifications as needing to be dealt with through mental health services Soraya argues that this creates trans people as mentally ill. She contends that the automatic presumption of the need for psychiatric intervention is 'appalling' and would not happen to others within the LGBT collective. Classifying trans people as mentally ill, it reduces their autonomy and the possibilities of deciding for themselves as to the treatments they receive. She goes on to explain how the splintering of health services and their disparate and inconsistent work does not support trans people. Similar to the quote that began this chapter Anne describes the daily feelings of difference that also contribute to mental health difficulties. She emphasises the similarities with coming out and alternative sexual identifications, but then sees this as different to the daily hurdles that are faced by trans people.

5.2.3. Ethnicity

All of those who identified as BME experienced some form of mental health difficulty in the past five years. The place of difference in causing mental health difficulties was highlighted in the BME focus group:

Zara: **Growing up different in a world that doesn't value difference is a mental stress and if it's your only mental stress you can probably cope with it, but it can be the thing that tips mild mental stress into unbearable mental stress**

(BME2 focus group)

5.2.4. Age

Older people's emotional and mental wellbeing in the past 12 months was poorer than the sample as a whole. Just over half (52%) of those aged over 55 considered their mental health and wellbeing to be good or very good in the past 12 months, compared to 62% overall. Over a quarter (27%) of over-55's considered it to be poor or very poor, whereas for the whole sample the proportion was less than a fifth (19%). However, older age groups were not significantly more likely to say that they had experienced mental health difficulties in the past five years.

Young people's emotional and mental wellbeing in the last 5 years was similar to the average score with no young people defining their mental health and wellbeing as very poor in the past twelve months. 13% of young people said they had experienced none of the mental health difficulties identified compared to 20% for the sample as whole.

5.2.5. Income

Levels of emotional and mental wellbeing over the past 12 months varied markedly according to income. Where income was less than £10,000, only 41% of respondents claimed good or very good emotional and mental wellbeing, compared to 73% of those with incomes more than £40,000. Similarly, the proportion with poor or very poor emotional and mental wellbeing ranged from 37% in the lowest income bracket to 5% in the highest. The data on experiences of mental health difficulties also varied by income, with those earning over £20,000 being more likely to have not experienced the mental health difficulties. Those earning under £10,000 were more than twice as likely to have experienced mental health difficulties.

5.2.6. Isolation

Feeling isolated is associated with poor or very poor emotional and mental wellbeing in the last 12 months ($p<.0005$). 38% of those who answered 'yes' or 'sometimes' to the question 'Do you feel isolated in Brighton & Hove?' also reported poor or very poor emotional and mental wellbeing, and only 33% of that group reported good or very good emotional and mental wellbeing. Where people do not feel isolated, the corresponding figures are 10.6% and 76%. A quarter of those who did not feel isolated had not, in the past five years, experienced mental health difficulties, compared to just 4% of those who did feel isolated ($p. = .0005$).

5.2.7. Living with HIV

There is a significant relationship between HIV positive status and emotional and mental wellbeing in the past 12 months ($p<.02$). One third (33%) of those who have tested positive to HIV described their mental and emotional health as good / very good compared to 65% of those who have not been tested or have tested negative.

5.2.8. Tenure

Housing tenure shows a highly significantly association with the likelihood of suffering mental health difficulties ($p < .0001$). Those living in social housing are most likely to have experienced mental health difficulties (82%, n. 61). The least likely to have experienced mental health difficulties are those who live in privately owned accommodation (60%, n. 227). 76% (n. 181) of those living in privately rented accommodation and 72% (n. 74) of those who have other kinds of housing tenure have experienced mental health difficulties over the past five years.

Table 5.2a Likelihood of suffering mental health difficulties by housing tenure

		social housing	privately owned	privately rented	all others	Total
No mental health difficulties	No.	13	152	58	29	252
	%	5.2	60.3	23.0	11.5	100.0
	%	17.6	40.1	24.3	28.2	31.7
Mental health difficulties	No.	61	227	181	74	543
	%	11.2	41.8	33.3	13.6	100.0
	%	82.4	59.9	75.7	71.8	68.3
Total	No.	74	379	239	103	795
	%	9.3	47.7	30.1	13.0	100.0
	%	100.0	100.0	100.0	100.0	100.0

This research suggests that experiences of multiple marginalisation may have implications for mental health and wellbeing. Although this cannot be established in this data, it is an area that requires further research.

5.3. Prevalence of specific mental health difficulties

This section offers an in-depth breakdown of the differences between LGBT people, looking at individual categories of mental health difficulties.

5.4. Sexual Identity

There were significant differences in relation to sexuality by all the categories of mental health difficulties, except stress. There were no significant differences across the categories with regard to not identifying any mental health difficulties.

5.4.1. Significant emotional distress

Lesbians are more likely (35%, n. 95) than gay men (29%, n. 122) to have experienced significant emotional distress, but those who identify as bisexual, queer or of an other sexuality are even more likely to have experienced significant emotional distress over the past five years ($p = .0005$). 64% (n. 18) of queer identified respondents reported having experienced significant emotional distress, while the figures for bisexual identified respondents is 51% (n. 23) and the figure for those who identified as an other sexuality is 50% (n. 16).

5.4.2. Depression

While the figures for lesbians (44%, n. 121) and gay men (42%, n. 177) are quite similar, the likelihood of bisexual respondents (56%, n. 25) and queer respondents (56%, n. 15) having experienced depression are noticeably

higher (p = .008). However, those who identify as an 'other' sexuality are even more likely to have experienced depression (72%, n. 23).

5.4.3. Anxiety

40% (n. 110) of lesbians and 44% (n. 184) of gay men reported having experienced difficulties with anxiety at some point during the past five years. The percentage of those identifying as bisexual (58%, n. 26) who had experienced difficulties with anxiety is noticeably higher, but those who identified as queer (70%, n. 22) or as of an other sexuality (69%, n. 22) are even more likely to have experienced difficulties with anxiety (p = .001).

5.4.4. Isolation

Using the measure of isolation taken from the question regarding the experience of mental health difficulties over the last five years (rather than using the question 'Do you feel isolated in Brighton & Hove?'), the likelihood of lesbians (22%, n. 59) and gay men (26%, n. 110) experiencing isolated are quite similar. By contrast, those who identify as bisexual (44%, n. 20) and those who identify as queer (48%, n. 13) are significantly more likely to have experienced isolated. However, the most likely group by far to have experienced isolation are those who identify as of an 'other' sexuality (70%, n. 23) (p = .0005).

5.4.5. Confidence/self esteem

43% (n. 118) of lesbians and 46% (n. 192) of gay men reported experiencing difficulties with confidence and self esteem over the past five years. Bisexual respondents (56%, n. 25) are more likely to have experienced difficulties with confidence and self esteem, and queer respondents (70%, n. 19) and those identifying as of an other sexuality (66%, n. 21) are even more likely to have experienced such difficulties (p = .009).

5.4.6. Anger management

11% (n. 30) of lesbians, 10% (n. 40) of gay men and 16% (n. 7) of bisexual respondents reported having difficulties with anger management. Queer respondents (26%, n. 7) and respondents who identify as an other sexuality (26%, n. 8) are significantly more likely to have experienced difficulties with anger management (p = .008).

5.4.7. Insomnia

28% (n. 75) of lesbians and 36% (n. 151) of gay men had experienced difficulties with insomnia at some point during the past five years. Bisexual and queer respondents are more likely to have experienced difficulties with insomnia: 42% (n. 19) and 44% (n. 12) of these groups of respondents respectively. Respondents identifying as of an 'other' sexuality are the most likely to have experienced difficulties with insomnia (52%, n. 17) (p = .012).

5.4.8. Fears/phobias

Gay men are the least likely group to have suffered difficulties from fears/phobias (9%, n. 39), followed by lesbians (15%, n. 40). A greater proportion of bisexual respondents (29%, n. 13) and queer respondents (26%, n. 7) reported experiencing difficulties with fears/phobias, but those who identify as an 'other' sexuality are the most likely group to have experienced such difficulties (38%, n. 12) ($p = .0005$).

5.4.9. Problem eating disorders

Lesbians (11%, n. 31) and gay men (14%, n. 57) are the least likely groups by sexual identity to have experienced problem eating disorders over the past five years ($p = .0005$). 22% (n. 7) of respondents who identify as an 'other' sexuality have suffered problem eating disorders, and the proportion rises to 31% (n. 14) for bisexual respondents and to 37% (n. 10) for queer respondents.

5.4.10. Panic attacks

There is a significant relationship between sexual identity and the likelihood of respondents having experienced panic attacks over the past five years ($p = .014$). 16% (n. 67) of gay men and 19% (n. 51) of lesbians reported having experienced difficulties with panic attacks over the past five years. 27% of bisexual respondents had had experiences of panic attacks, and the proportion rises to 33% (n. 9) for queer respondents and to 34% (n. 11) for respondents who identified as of an 'other' sexual identity.

5.4.11. Self harm

Gay men (5%, n. 22) are the least likely group by sexual identity to have self harmed. 11% of both lesbians (n. 31) and of bisexual respondents (n. 5) report difficulties with self harming. Queer respondents (22%, n. 6) are significantly more likely to have self harmed, as are respondents who identify as of an 'other' sexual identity (28%, n. 9) ($p = .0005$).

5.4.12. Addictions/dependencies

Lesbians (10%, n. 28) and gay men (10%, n. 43) are the least likely groups by sexual identity to have experienced difficulties with addictions or dependencies. 16% of bisexual respondents report experiencing difficulties with addictions or dependencies. The most likely groups to have experienced such difficulties are those of an 'other' sexual identity (25%, n. 8) and queer respondents (30%, n. 8) ($p = .004$).

5.4.13. Suicidal thoughts

The likelihood of having experienced difficulties with suicidal thoughts is significantly related to sexual identity ($p= .004$), with those who identify as of an 'other' sexual identity (41%, n. 13) and queer respondents (37%, n. 10) being more likely to have experienced such difficulties than other groups.

33% of bisexual respondents reported difficulties with suicidal thoughts. This compares with 20% (n. 55) of lesbian respondents and 19% (n. 81) of gay male respondents.

5.5. Trans identity

Trans people were significantly ($p < 0.05$) more likely to have had difficulties in the last five years with all the categories of mental health difficulties except confidence / self-esteem, problem eating / eating distress, self harm. Only 2 trans people (5%) had not experienced any of the difficulties listed.

5.5.1. Significant emotional distress

60% (n. 25) of trans respondents reported having experienced significant emotional distress, compared to 33% (n. 245) of non-trans respondents ($p = .001$).

5.5.2. Depression

76% (n. 32) of trans respondents had had difficulties with depression, compared to 44% (n. 322) of respondents who did not identify as trans ($p = .0005$).

5.5.3. Anxiety

Trans respondents are significantly more likely (71%, n. 30) to have experienced difficulties with anxiety over the past five years than non-trans respondents (44%, n. 327) ($p = .001$).

5.5.4. Isolation

Using the measure of isolation taken from the question regarding the experience of mental health difficulties over the last five years (rather than using the question 'Do you feel isolated in Brighton & Hove?'), trans respondents are significantly more likely (74%, n. 32) to have experienced isolation than non-trans respondents (26%, n. 189) ($p = .0005$).

5.5.5. Anger management

Trans respondents are significantly more likely (27%, n. 11) to have experienced difficulties with anger management than non-trans respondents (11%, n. 80) ($p = .005$).

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5.5.6. Insomnia

Trans respondents are significantly more likely (51%, n. 22) than non-trans respondents (33%, n. 245) to have experienced difficulties with insomnia over the past five years (p = .025).

5.5.7. Fears/phobias

Trans respondents are significantly more likely (41%, n. 17) than non-trans respondents (13%, n. 92) to have experienced difficulties with fears or phobias over the past five years (p = .0005).

5.5.8. Panic attacks

Trans respondents are significantly more likely (36%, n. 15) to have experienced difficulties with panic attacks than non-trans respondents (18%, n. 133) (p = .009).

5.5.9. Addictions/dependencies

Trans respondents are significantly more likely (24%, n. 10) to have experienced difficulties with addictions or dependencies than non-trans respondents (11%, n. 83) over the past five years (p = .029).

5.5.10. Suicidal thoughts

Trans respondents are also significantly more likely (50%, n. 21) than non-trans respondents (21%, n. 153) to have experienced difficulties with suicidal thoughts (p = .0005).

5.6. Ethnicity

No BME person said that they had not experienced any of the difficulties identified in the questionnaire in the last five years. The category other / traveller also experienced higher levels of problem eating and self harm in the last five years.

5.6.1. Significant emotional distress

Black and Minority Ethnic (BME) respondents (52%, n. 11) and respondents who identify as Travellers or of an other ethnic group (52%, n. 15) are more likely than white respondents (33%, n. 246) to have experienced significant emotional distress at some point over the past five years (p = .025).

5.6.2. Isolation

Using the measure of isolation taken from the question regarding the experience of mental health difficulties over the last five years (rather than using the question 'Do you feel isolated in Brighton & Hove?'), the data shows that BME respondents (48%, n. 10) and respondents who identify as Travellers or of an other ethnic group (48%, n. 14) are more likely than white respondents (27%, n. 199) to have experienced isolation at some point over the past five years (p = .006).

5.6.3. Anger management

BME respondents (29%, n. 6) are more likely to have experienced difficulties with anger management than respondents who identify as Travellers or of an other ethnic group (21%, n. 6). In turn, this latter group are more likely to have experienced difficulties with anger management than white respondents (11%, n. 80) (p = .014).

5.6.4. Problem eating disorders

Those who identify as Travellers or of an other ethnic group are more likely (31%, n. 9) to have experienced difficulties with problem eating disorders than either white respondents (15%, n. 109) or BME respondents (5%, n. 1) (p = .023).

5.6.5. Self harm

Those who identify as Travellers or of an 'other' ethnic group are more likely (24%, n. 7) to have experienced difficulties with self harming than either white respondents (9%, n. 65) or BME respondents (5%, n. 1) (p = .016).

5.6.6. Other mental health difficulties

There is no significant relationship between ethnicity and the likelihood of experiencing difficulties with any of the following: depression; anxiety; confidence/self esteem; stress; insomnia; fears/phobias; panic attacks; addictions/dependencies; suicidal thoughts. There is also no significant relationship between ethnicity and the likelihood of *not* having experienced any mental health difficulties (counts were too small in some cells for significance tests to be valid).

5.7. Deaf Identity

There is no significant relationship between deaf identity and the likelihood of experiencing difficulties with any of the following: significant emotional distress; depression; anxiety; isolation; confidence/self esteem; stress; insomnia; fears/phobias; problem eating disorders; panic attacks; suicidal thoughts; or not having experienced any of the mental health difficulties questioned about. There is also no significant relationship between deaf

identity and the likelihood of experiencing difficulties with any of the following because the counts in some cells were too small for a valid significance test: anger management; fears/phobias; and self harm.

5.7.1. Addictions/dependencies

Respondents who identify as deaf or hearing impaired are significantly more likely (27%, n. 7) to have experienced difficulties with addictions or dependencies over the past five years than those who do not identify as deaf or hearing impaired (11%, n. 85) ($p = .034$).

5.8. Disability and/or long term health impairment

Those who are disabled are more likely to have experienced all forms of mental health difficulties except stress and addiction or dependencies. Respondents who identify as disabled are less likely (8%, n. 9) than respondents who do not identify as disabled (20%, n. 131) to have experienced none of the mental health difficulties questioned about ($p = .003$). It should be noted that disabilities and long term health impairments can include mental health difficulties, and therefore these results should be taken as indicative.

5.8.1. Significant emotional distress

Respondents who identify as disabled are more likely (57%, n. 66) than those who do not identify as disabled (31%, n. 204) to have experienced difficulties with significant emotional distress at some point over the past five years ($p = .0005$).

5.8.2. Depression

77% (n. 89) of respondents identifying as disabled experienced difficulties with depression, compared with 40% (n. 263) of respondents who do not identify as disabled ($p = .0005$).

5.8.3. Anxiety

70% (n. 80) of respondents identifying as disabled experienced difficulties with anxiety, compared with 42% (n. 274) of respondents who do not identify as disabled ($p = .0005$).

5.8.4. Isolation

Using the measure of isolation taken from the question regarding the experience of mental health difficulties over the last five years (rather than using the question ‘Do you feel isolated in Brighton & Hove?’), 53% (n. 62) of respondents identifying as disabled had experienced difficulties with

isolation, compared with 24% (n. 155) of respondents who do not identify as disabled (p = .0005).

5.8.5. Confidence/self esteem

Respondents who identify as disabled are more likely (66%, n. 76) to have experienced difficulties with confidence or self esteem than respondents who do not identify as disabled (44%, n. 289) (p = .0005).

5.8.6. Anger management

Respondents who identify as disabled are more likely (21%, n. 24) to have experienced difficulties with anger management than respondents who do not identify as disabled (10%, n. 68) (p = .002).

5.8.7. Insomnia

Respondents who identify as disabled are more likely (60%, n. 70) to have experienced difficulties with insomnia than respondents who do not identify as disabled (30%, n. 198) (p = .0005).

5.8.8. Fears/phobias

Respondents who identify as disabled are more likely (33%, n. 37) than respondents who do not identify as disabled (11%, n. 73) to have experienced difficulties with fears and phobias over the past five years (p = .0005).

5.8.9. Problem eating disorders

Respondents who identify as disabled are more likely (29%, n. 32) than respondents who do not identify as disabled (13%, n. 84) to have experienced difficulties with problem eating disorders over the past five years (p = .0005).

5.8.10. Panic attacks

Respondents who identify as disabled are more likely (45%, n. 51) than respondents who do not identify as disabled (15%, n. 97) to have experienced difficulties with panic attacks over the past five years (p = .0005).

5.8.11. Self harm

Respondents who identify as disabled are more likely (21%, n. 24) than respondents who do not identify as disabled (7%, n. 49) to have experienced difficulties with self harming over the past five years (p = .0005).

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5.8.12. Suicidal thoughts

Respondents who identify as disabled are more likely (49%, n. 56) than respondents who do not identify as disabled (17%, n. 115) to have experienced difficulties with suicidal thoughts over the past five years (p = .0001).

5.9. Age

Those who are younger are more likely to have experienced difficulties with confidence/self-esteem, stress, problem eating disorders and addictions and dependencies. There is no significant relationship between age and the likelihood of experiencing difficulties with any of the following: significant emotional distress; depression; anxiety; isolation; anger management; insomnia; fears/phobias; panic attacks; or suicidal thoughts. Those aged over 55 were the most likely (29%, n. 22) to have experienced *none* of the mental health difficulties questioned about (p = .042). This compares to 13% (n. 15) for those under 26 years of age; 16% (n. 39) for those between 26 and 35 years; 17% (n. 40) for those aged 36 to 45; and 20% (n. 24) for those aged 46 to 55.

Figure 5.9a Likelihood of experiencing selected mental health difficulties by age group

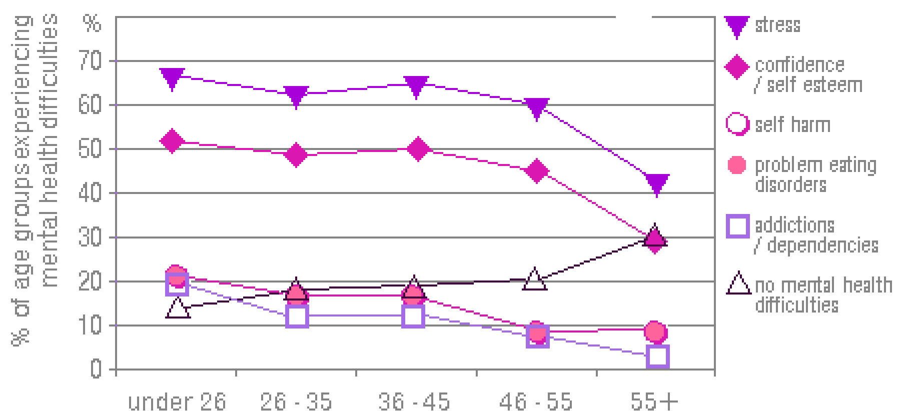

Figure 5.9a shows how the likelihood of experiencing a selection of mental health difficulties varies depending on the age group to which respondents belong. Note that the 'no mental health difficulties' category in figure x.x. refers to the category 'none of the above': positive responses to this question means that the respondents have not suffered during the past five years from any of the mental health difficulties asked about on the questionnaire. The data illustrated in figure x.x are further discussed below.

5.9.1. Confidence/self esteem

Those over 55 years of age are least likely (29%, n. 22) to have experienced difficulties with confidence or self esteem, compared with other age groups (p = .021). 51% (n. 60) of those under 26; 49% (n. 116) of those aged between 26 and 35 years; 50% (n. 121) of those aged between 36 and 45

years; and 45% (n. 55) of those aged between 46 and 55 had experienced difficulties with confidence and self esteem.

5.9.2. Stress

Those over 55 years of age are least likely (42%, n. 32) to have experienced difficulties with stress, compared with other age groups (p = .004). For each of the other age groups, the likelihood of experiencing difficulties with stress are as follows: 68% (n. 79) for those under 26; 62% (n. 149) for those aged between 26 and 35 years; 65% (n. 157) for those aged between 36 and 45 years; and 60% (n. 73) for those aged 46 to 55.

5.9.3. Problem eating disorders

Respondents under the age of 26 are the most likely (21%, n. 25) to have experienced difficulties with problem eating disorders, compared with 17% (n. 40) of those aged 26 to 35 years and 16% (n. 38) of those aged 36 to 45 years. Those aged 46 to 55 (8%, n .10) and over 55 (8%, n. 6) are the least likely age groups to experience difficulties with problem eating disorders (p = .022).

5.9.4. Self harm

As can be seen in table 5.9a., those under 26 years of age are significantly more likely (24%, n. 28) to have experienced difficulties with self harm, compared to other age groups (p = .0005). The likelihood of experiencing difficulties with self harm decreases with age, so that only 3% (n. 4) of those aged between 46 and 55 and none of those aged over 55 had experienced difficulties with self harm.

Table 5.9a Likelihood of experiencing difficulties with self harming by age group

		< 26	26-35	36-45	46-55	55+	Total
No	No.	89	217	219	118	73	716
	%	76.1	91.2	91.6	96.7	100	90.7
Yes	No.	28	21	20	4	0	73
	%	23.9	8.8	8.4	3.3	0	9.3
Total	No.	117	238	239	122	73	789
	%	100	100	100	100	100	100

5.9.5. Addictions/dependencies

The likelihood of experiencing difficulties with addictions or dependencies decreases with age (p = .004). 20% (n. 23) of those under 26 had experienced difficulties with addictions or dependencies, compared to 12% (n. 29) of those aged between 26 and 35 years and 13% (n. 31) of those aged between 36 and 45 years. 7% (n. 9) of those aged 46 to 55 and 3% (n. 2) of those over 55 had experienced difficulties with addictions or dependencies over the past five years.

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5.10. Income

Experiences of mental health difficulties varied by income. People who earn over £20,000 are less likely to have experienced mental health difficulties. Those earning under £10,000 are much more likely to have experienced mental health difficulties, in the cases of the following difficulties more than twice as likely as those earning over £20,000: isolation (in the past five years), fears/phobias, problem eating disorders, panic attacks, self harm, addictions/dependencies, suicidal thoughts. However, those in the highest income brackets and the lower income brackets experienced similar levels of stress and anxiety. There is no significant relationship between income and the likelihood of experiencing difficulties with either anger management or insomnia.

Only 12% (n. 19) of those earning less than £10,000 a year did not experience any of the mental health difficulties questioned about, making them the least likely income group to experience none of these mental health difficulties ($p = .025$). The most likely income group to experience none of the mental health difficulties questioned about are those who earn between £20,001 and £40,000 a year (22%, n. 67). 15% (n. 36) of those earning between £10,001 and £20,000 a year and 20% (n. 18) of those earning more than £40,001 a year experienced none of the mental health difficulties questioned about.

5.10.1. Significant emotional distress

The likelihood of experiencing difficulties with significant emotional distress decreases with increasing levels of income ($p = .0005$). 46% (n. 71) of those earning less than £10,000 a year have experienced significant emotional distress during the past five years. This falls to 39% (n. 94) of those earning between £10,001 and £20,000 a year and to 29% (n. 88) of those earning between £20,001 and £40,000 a year. Those earning more than £40,001 a year are the least likely (21%, n. 19) income group to have experienced significant emotional distress.

5.10.2. Depression

Those earning less than £10,000 a year are more likely (61%, n. 94) to have experienced depression than any other income group ($p = .0005$). 51% (n. 123) of those earning between £10,001 and £20,000 a year have suffered with depression over the past five years. There is a similar likelihood of experiencing depression for those earning between £20,001 and £40,000 a year (36%, n. 107) and those earning more than £40,001 a year (36%, n. 33).

5.10.3. Anxiety

Respondents earning less than £10,000 a year are more likely (54%, n. 84) to have experienced difficulties with anxiety over the past five years than any other income group ($p = .004$). By contrast, 50% (n. 120) of those earning between £10,001 and £20,000 a year experienced difficulties with anxiety, with 38% (n. 114) of those earning between £20,001 and £40,000 a year and 45% (n. 41) of those earning more than £40,001 a year experiencing difficulties with anxiety.

5.10.4. Isolation

The measure of isolation used here is taken from the question regarding the experience of mental health difficulties over the last five years (rather than using the question 'Do you feel isolated in Brighton & Hove?'). Respondents earning less than £10,000 per year are more likely (47%, n. 73) to have experienced difficulties with isolation than other income groups (p = .0005). 31% (n. 76) of those earning between £10,001 and £20,000 a year, and 19% both of those earning between £20,001 and £40,000 a year and of those earning more than £40,001 a year experienced difficulties with isolation (n. 56 and n. 17, respectively).

5.10.5. Confidence/self esteem

Those earning less than £20,000 a year are more likely to experience difficulties with confidence or self esteem than those earning more than £20,000 a year (p = .024). 53% (n. 82) of those earning less than £10,000 a year and 52% (n. 126) of those earning between £10,001 and £20,000 a year experienced such difficulties. By contrast, 41% (n. 123) of those earning between £20,001 and £40,000 a year and 44% (n. 40) of those earning more than £40,001 a year experienced difficulties with confidence or self esteem.

5.10.6. Stress

Those earning between £20,001 and £40,000 a year are less likely (55%, n. 166) to experience difficulties with stress than any other income grouping (p = .035). Nevertheless, the majority of respondents within this income bracket had experienced difficulties with stress in the past five years. By contrast, 64% (n. 153) of those earning between £10,001 and £20,000 a year experienced difficulties with stress. The most two most likely groups to experienced difficulties with stress are those earning less than £10,000 a year (67%, n. 104) and those earning more than £40,001 a year (67%, n. 62).

5.10.7. Fears/phobias

Those earning less than £10,000 a year are more likely (27%, n. 41) to experience difficulties with fears or phobias than other income groups (p = .0005). 15% (n. 36) of those earning between £10,001 and £20,000 a year, 9% (n. 26) of those earning between £20,001 and £40,000 a year, and 8% (n. 7) of those earning more than £40,001 a year experienced difficulties with fears or phobias.

5.10.8. Problem eating disorders

Those earning less than £10,000 a year are more likely (24%, n. 36) to experience difficulties with problem eating disorders than other income groups (p = .008). 15% (n. 37) of those earning between £10,001 and £20,000 a year, 12% (n. 35) of those earning between £20,001 and £40,000 a year, and 12% (n. 11) of those earning more than £40,001 a year experienced difficulties with problem eating disorders.

5.10.9. Panic attacks

Those earning less than £10,000 a year are more likely (29%, n. 44) to experience difficulties with panic attacks than other income groups (p = .002). 20% (n. 48) of those earning between £10,001 and £20,000 a year, 14% (n. 43) of those earning between £20,001 and £40,000 a year, and 16% (n. 15) of those earning more than £40,001 a year experienced difficulties with panic attacks.

5.10.10. Self harm

Respondents earning less than £10,000 a year are more likely (23%, n. 35) to experience difficulties with self harm than other income groups (p = .0005). 11% (n. 26) of those earning between £10,001 and £20,000 a year, 3% (n. 10) of those earning between £20,001 and £40,000 a year, and 2% (n. 2) of those earning more than £40,001 a year experienced difficulties with self harm.

5.10.11. Addictions/dependencies

Respondents earning less than £10,000 a year are more likely (20%, n. 31) to experience difficulties with addictions or dependencies than other income groups (p = .0005). 14% (n. 33) of those earning between £10,001 and £20,000 a year, 7% (n. 22) of those earning between £20,001 and £40,000 a year, and 8% (n. 7) of those earning more than £40,001 a year experienced difficulties with addictions or dependencies.

5.10.12. Suicidal thoughts

Those earning less than £10,000 a year are more likely (39%, n. 60) to experience difficulties with suicidal thoughts than other income groups (p = .0005). By contrast, 26% (n. 63) of those earning between £10,001 and £20,000 a year, 12% (n. 36) of those earning between £20,001 and £40,000 a year, and 14% (n. 13) of those earning more than £40,001 a year experienced difficulties with suicidal thoughts over the past five years.

5.11. Isolation

Isolation is significantly linked to all the kinds of mental health difficulties that were investigated in the questionnaire. Here, isolation is defined in terms of positive answers to the question 'Do you feel isolated in Brighton & Hove?' Those who felt isolated were significantly ($p<0.05$) more likely to have experienced one or more of the following: significant emotional distress, depression, anxiety, confidence / self esteem, anger management, insomnia, problem eating / distress, fears / phobias, panic attacks, self harm, addictions / dependencies, suicidal thoughts. Those who feel isolated are over five times less likely (4%, n.10) than those who do not feel isolated (25%, n. 127) to report not having experienced difficulties with any of the mental health difficulties (p = .0005).

5.11.1. Significant emotional distress

Those who feel isolated are more likely (51%, n .132) than those who do not feel isolated (27%, n. 137) to have experienced significant emotional distress in the past five years ($p = .0005$).

5.11.2. Depression

Those who feel isolated are more likely (68%, n. 178) to have experienced difficulties with depression over the past five years than those who do not feel isolated (35%, n. 178) ($p = .0005$).

5.11.3. Anxiety

Respondents who report feeling isolated are more likely (63%, n. 165) than respondents who do not feel isolated (37%, n. 188) to have experienced difficulties with anxiety during the past five years ($p = .0005$).

5.11.4. Isolation

Respondents who report *feeling* isolated (Q.19) are more likely (59%, n. 155) than respondents who report not *feeling* isolated (13%, n. 65) to say that they have experienced *difficulties with* isolation in their response to question 34 ('Have you experienced difficulties with any of the following in the last 5 years?...) ($p = .0005$).

5.11.5. Confidence/self esteem

Those who feel isolated are more likely (67%, n. 176) to have experienced difficulties with confidence or self esteem than respondents who do not feel isolated (37%, n. 188) ($p = .0005$).

5.11.6. Stress

Those who feel isolated are more likely (77%, n. 200) than those who do not feel isolated (54%, n. 276) to have experienced difficulties with stress over the past five years ($p = .0005$).

5.11.7. Anger management

Respondents who feel isolated are more likely (17%, n. 45) than respondents who do not feel isolated (9%, n. 45) to have experienced difficulties with anger management ($p = .001$).

5.11.8. Insomnia

Respondents who report feeling isolated are more likely (45%, n. 117) to experience difficulties with insomnia than respondents who do not report feeling isolated (29%, n. 149) (p. = .0005).

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5.11.9. Fears/phobias

Those who feel isolated are more likely (19%, n. 50) to have experienced difficulties with fears and phobias than those who do not feel isolated (12%, n. 59) (p = .005).

5.11.10. Problem eating disorders

Those who feel isolated are more likely (26%, n. 66) to have experienced difficulties with problem eating disorders than those who do not feel isolated (10%, n. 51) (p = .0005).

5.11.11. Panic attacks

Those who feel isolated are more likely (30%, n. 76) than those who do not feel isolated (14%, n. 72) to have experienced difficulties with panic attacks over the past five years (p = .0005).

5.11.12. Self harm

Those who feel isolated are more likely (16%, n. 41) than those who do not feel isolated (6%, n. 29) to have experienced difficulties with self harming over the past five years (p = .0005).

5.11.13. Addictions/dependencies

Respondents who feel isolated are more likely (18%, n. 46) to have experienced difficulties with addictions or dependencies over the past five years than respondents who do not feel isolated (9%, n. 46) (p = .001).

5.11.14. Suicidal thoughts

Those who feel isolated are more likely (38%, n. 100) than those who do not feel isolated (14%, n. 71) to have experienced difficulties with suicidal thoughts over the past five years (p = .0005).

5.12. HIV status

There is no significant relationship between HIV status and the likelihood of experiencing difficulties with any of the following specific mental health issues: significant emotional distress; depression; anxiety; isolation; confidence/self esteem; stress; anger management; fears/phobias; problem eating disorders; panic attacks; self harming; addictions or dependencies; suicidal thoughts or 'none of the above' mental health difficulties.

5.12.1. Insomnia

Those who have tested HIV positive are more likely (49%, n. 27) to experience difficulties with insomnia than those who have tested HIV negative or who have had no HIV test result (34%, n. 127) (p = .042).

5.13. Conclusion

Not all LGBT people experience difficulties with their mental health. Variation in experiences of difficulties often relates to areas of marginalisation. Bisexual, queer and those who identified as 'other' in terms of sexualities, trans people, BME people, those with a low income and those who feel isolated are more likely than other LGBT people to have experienced difficulties with their mental health in the past five years. Time can also be a factor. For example, there was no significant differences over the past five years in terms of older people's experiences of difficulties with their mental health; yet they were more likely to class their mental health and wellbeing in the past 12 months as poor/very poor. Similarly, while those living with HIV show no significant difference from other LGBT people in terms of their mental and emotional health over the last five years, they are less likely to say their mental and emotional health has been good or very good over the past twelve months.

6. Experiencing domestic violence & child abuse

6.1. Introduction

This chapter will examine domestic violence and abuse, and experiences of abuse during childhood. It will start by looking at the relationships between experiences of domestic violence and abuse and experiences of mental health difficulties and suicide. It will then detail the Count Me In Too findings regarding child abuse and the significant relationships between experiences of child abuse and mental health difficulties.

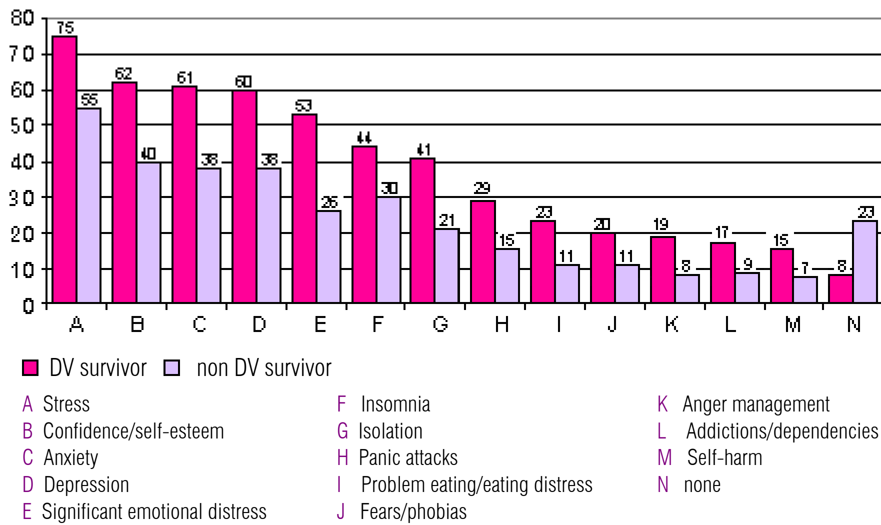
6.2. Domestic violence

For the purposes of this research the term domestic violence and abuse is used to represent the experiences of those who answered yes to the question; 'have you experienced abuse, violence or harassment from a family member or someone close to you?' Just under one third (31%) of (244) respondents said that they had experienced abuse, violence or harassment from a family member or someone close to them during their lifetime. Further findings are detailed in Browne (2007b). This section will explore the findings relating to mental health specifically.

6.3. Mental health difficulties

Those who have experienced domestic violence are more likely to have experienced difficulties with their mental health in the past five years. These significant differences pertain to all the difficulties listed in the questionnaire and detailed in figure 8.5a below. They are less likely to say they have not experienced any of the difficulties listed. Figure 8.5a illustrates that across the range of mental health difficulties listed, those who have experienced domestic violence and abuse are more likely to have issues with their mental health. They are also far less likely than LGBT people who have not experienced domestic violence and abuse to say that they have not experienced any of these difficulties in the past five years (8% compared to 23%).

Figure 6.3a: Mental health difficulties in last five years



Whilst it is clear that survivors of domestic violence and abuse are more likely than those who have not experienced domestic violence and abuse to have experienced mental health difficulties in the past five years, it cannot be ascertained from this data whether those who may have mental health difficulties are targeted for abuse, violence and/or harassment from someone close to them or if domestic violence and abuse caused mental health difficulties. One respondent said that domestic violence was not helping them to manage or overcome their mental health difficulties but this is clearly an area that requires further investigation and engagement from services.

These findings are important, both for those who work with LGBT survivors of domestic violence and abuse, and for those who work with people with mental health difficulties. They suggest particular risk factors for example self-harming, may be more prevalent amongst LGBT people who have experienced domestic violence and abuse.

6.4. Domestic violence and experiences and suicidal distress

Those who have experienced domestic violence and abuse are at a higher risk of suicide. 35% of domestic violence survivors reported having had difficulties with suicidal thoughts (compared to 15% of LGBT people who had not experienced domestic violence and abuse, $p<.001$). 41% of this LGBT domestic violence and abuse survivor grouping reported having had serious thoughts of suicide in the last 5 years, compared to 23% of LGBT people who have not experienced domestic violence and abuse ($p< .001$). A higher proportion of domestic violence survivors reported that they attempted suicide in the last 5 years (14.9%, compared to 10% of other LGBT people, although this difference is not statistically significant $p=.15$) or in the last 12 months (11.3%) compared to LGBT non-domestic violence and abuse survivors (5%, $p = .039$, see table 8.4a).

Although these figures are generally concerning, the differences between LGBT individuals in relation to experiences of domestic violence and abuse highlights a specific risk factor relating to survivors of domestic violence and abuse. This should be accounted for in the provision of services (It should be noted that the suicide questions were only posed to those who had said that they experienced difficulties with particular mental health issues, including suicidal thoughts in the last 5 years)

Table 6.4a: Domestic violence and abuse and risk of suicide

		Domestic violence and abuse survivor	Not reported domestic violence and abuse experience	Total
Difficulties with… Suicidal thoughts (question posed to entire sample)	No.	85	82	167
	%	35.1	15.5	21.7
Serious thoughts of suicide in the last 5 years	No.	88	95	183
	%	40.7	23.4	29.4
Attempted suicide in the past 5 years	No.	24	25	49
	%	14.9	10.1	12.0
Attempted in the last 12 months	No.	13	9	22
	%	11.3	4.9	7.4

These figures cannot be attributed directly to experiences of domestic violence and abuse. However, they point to areas of vulnerability when engaging with survivors of domestic violence and abuse, and those who are at risk of suicide.

6.5. Child abuse

People who had indicated that they had experienced abuse, violence or harassment from a family member or someone close to them were asked whether they had experienced abuse or violence from a family member or someone close to them (defined here as child abuse). Due to the sensitivities associated with this question, particularly amongst the LGBT population, where child abuse can wrongly be associated with formation of sexual/gender identities, it was felt appropriate to place question this question in the routed section where an association was hypothesised.

107 people indicated that when they were a child, they experienced abuse or violence from a family member or someone close to them (defined here as child abuse). This was just under half (48%) of those who answered the question 'when you were a child did you experience abuse or violence from a family member or someone close to you?' (see table 2.2d). This figure of 107 is also 13% of the entire sample, but as this question was posed to 244 people and not to the entire sample it may, therefore, be an undercounting of prevalence of experience of child abuse for the whole sample.

The National Society for the Prevention of Cruelty to Children (NSPCC) estimate that 7% of children experienced serious physical abuse at the hands of their parents or carers during childhood, 6% of children experienced serious absence of care at home during childhood, 6% of children experienced frequent and severe emotional maltreatment during childhood (Cawson et al, 2000). Although these figures are not comparable with the question asked here, they do highlight an area of need for LGBT young people, as well as adult who experience family violence and abuse because of their gender/sexual identity. The NSPCC figures and the Count Me In Too figures point to a need that may need to be addressed with LGBT young people and with LGBT people as adults.

Table 6.5a: When you were a child, did you experience abuse or violence from a family member or someone close to you? (% of those who answered 'yes' having experienced abuse, violence and/or harassment from family / someone close to them)

	Frequency	Percent	Valid %
Yes	107	43.9	47.6
No	102	41.8	45.3
Unsure	16	6.6	7.1
Total	225	92.2	100
Missing	19	7.8	
Total	244	100	

The categories of domestic violence was divided between those who experienced partnered abuse, those who experienced abuse from a family member and those who experienced domestic violence and abuse from another source. These categories were not exclusive as people could experience multiple forms of abuse (hence the percentages in table 2.2e do not equal 100%). Perhaps unsurprisingly there was a highly significant association between having experienced abuse during childhood and experiencing abuse from family members ($p < .0001$). 55% (n. 58) of those who experienced childhood abuse reported that they had experienced abuse from a close family member, compared to 25% (n. 25) of those who had not experienced childhood abuse. Also, 75% of those who were unsure about whether they experienced childhood abuse reported having experienced abuse carried out by family members. Where respondents report experiencing childhood abuse (or are not sure of whether they experienced childhood abuse) and report experiencing abuse from family members, it cannot be assumed that in every case the abuse they experienced as a child was carried out by family members. Nor can it be assumed that abuse from a family member was perpetrated during childhood. This is because the question regarding who carried out the abuse was not related specifically to *childhood* experiences of abuse, but rather to *all* experiences of abuse at any stage of the respondent's life.

Table 6.5b: Who the abuser was (for those who reported incident(s) of abuse during the last 5 years)

		Childhood abuse experience	No childhood abuse experience	Unsure	Total
Abused by family members	No.	58	25	12	95
	%	55.2	25.0	75.0	43.0
Abused by partner or ex-partner	No.	51	63	8	122
	%	48.6	63.0	50.0	55.2
Abused by others	No.	34	23	4	61
	%	32.4	23.0	25.0	27.6

It should be noted that 49% of those who have been abused by partner or ex-partners have also experienced child abuse. In addition, at least 25% of those who experienced violence and abuse from a family member did not experience child abuse. Consequently, along with child abuse, adult domestic violence and abuse from a family member is a significant issue that needs further investigation and services to support these survivors. This should include an exploration of the complexities, links and overlaps between LGBT experiences of adult domestic violence and abuse by a partner and child abuse (see also Browne, 2007).

6.6. Child abuse and mental health difficulties

The study explored the relationship between child abuse experienced by survivors of domestic violence and abuse, and mental health difficulties. It found that those who reported having been abused as a child were not significantly more likely to experience significant emotional distress, anger management, fears/phobias, problem eating/distress, panic attacks or addictions and dependencies compared to those who did not experience abuse. Using logistical regression analysis outlined in the introduction, it is possible to predict that:

- Those who experienced child abuse were more than twice as likely as those who did not to have experienced depression (B= .805; S.E. =.285, p=.004, Exp (B) =2.237).
- Those who experienced child abuse were more than twice as likely as those who did not to have experienced anxiety problems (B=.789, S.E. =.280, p.=.004, Exp(B)=2.221).
- Those who experienced child abuse were three times more likely than those who did not to have engaged in self-harm. (B=1.119, S.E. .416, p=.007, Exp(B) 3.062).
- Those who experienced child abuse were more than twice as likely as those who did not to have had suicidal thoughts (B = .829, S.E. .290, p=.004, Exp(B) = 2.291)

This clearly shows the links between mental health difficulties and experiences of child abuse from a family member or someone close to you. It is important to note that mental health difficulties may lead to vulnerabilities regarding child abuse. However, all of the sample were over 16 and whereas mental health difficulties were assessed in the past five years, the child abuse related to lifetime experiences. Consequently it is

possible to argue that child abuse can lead to an increased probability of experiencing depression, anxiety, self-harm and suicidal thoughts amongst LGBT people in this sample.

6.7. Conclusion

Those who have experienced domestic violence are more likely to have experienced difficulties with their mental health in the past five years. They are also more likely to have thought of and attempted suicide. Just under half (48%) of those who answered the question about experiences of abuse and violence during childhood said that they had experienced child abuse. This research found clear links between mental health difficulties and experiences of child abuse from a family member or someone close to you. The odds of experiencing depression, anxiety, self-harm and suicidal thoughts at least double when a person has experienced child abuse. This research therefore points to the significant risk factors of domestic violence and abuse and child abuse in mental health difficulties. Although a causal relationships cannot be ascertained for domestic violence and abuse and mental health difficulties (such that those who experience mental health difficulties may be more vulnerable to domestic violence and abuse and vice-versa), it is possible to contend that child abuse can predict risk in experiences of depression, anxiety, self-harm and suicidal thoughts.

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7. Isolation

7.1. Introduction

Asha: **I think there are other things that are general to mental health and apply very much to LGBT people, for example, isolation is a massive factor and most people with mental health problems suffer isolation at some time and I have. And if on top of being mentally ill and isolated, or depressed and isolated, you're also LGBT and you only feel safe in certain spaces, that's exacerbated. If the LGBT spaces don't feel safe to you, you can find yourself with nowhere to go.**

(BME 2 focus group)

Isolation can be a significant issue for those who are marginalised from mainstream society. This research has already indicated that those who feel isolated are more likely to have mental health difficulties and to be at risk of suicide than other LGBT people. Where there is a large and visible LGBT population such as in Brighton & Hove. As Asha argues even in a city such as Brighton & Hove, LGBT spaces may not feel safe to all LGBT people. Therefore, it cannot be presumed that LGBT people in Brighton & Hove do not feel isolated. Isolation can result from and lead to multiple marginalisations. Similar to the category of mental health difficulties, those who were classified as isolated in this research were also found to be vulnerable in numerous ways. The chapter firstly explores the differences within the LGBT grouping and experiences of isolation. Those who answered yes to the question 'Do you feel isolated in Brighton & Hove' were posed further questions regarding their experiences of isolation in Brighton & Hove and the chapter reports on the reasons people said they feel isolated and what keeps LGBT people isolated. The latter is broken down in order to engage with differences between LGBT people and what is keeping people isolated.

7.2. Prevalence and Differences within the LGBT grouping based on isolation

This chapter is based on the question 'Do you feel isolated in Brighton & Hove'. Table 9.7 shows that 33% of the sample who answered

yes/sometimes are categorised as 'isolated', 65% said no and 2% said unsure.

Table 7.2a: Do you feel isolated in Brighton & Hove?

	Yes	No	Sometimes	Unsure	Total
No.	50	527	217	15	809
%	6.2	65.1	26.8	1.9	100

There were clear differences in terms of feelings of isolation according between different LGBT groups. It is impossible to tell whether experiences of isolation can lead to the differences that will be outlined here, or whether these are factors that cause isolation.

7.3. Sexuality

Those who are who identified as 'other' in terms of sexuality in terms of sexuality are the most likely to feel isolated in Brighton & Hove (61%). This is over twice the proportion of lesbians (30%) and gay men (34%, p. = .002). Bisexual (41%) and queer (46%) people are also more likely to feel isolated in Brighton & Hove than lesbians and gay men (see table 7.3a).

Table 7.3a: Do you feel isolated in Brighton & Hove? By sexuality

		Lesbian	Gay	Bisexual	Queer	Otherwise coded	Total
Yes/sometimes	No.	92	125	18	13	19	267
	%	33.9	29.8	40.9	46.4	61.3	33.6
No	No.	179	295	26	15	12	527
	%	66.1	70.2	59.1	53.6	38.7	66.4
Total	No.	271	420	44	28	31	794
	%	100	100	100	100	100	100

p=.002 hence there is a significant relationship between sexual identity and isolation.

7.4. Trans

Trans respondents were just under twice as likely to state they felt isolated, than other respondents: p<0.0001. 60% of those who are trans said that they felt isolated, compared to 32% of those who are not trans.

Table 7.4a: Do you feel isolated in Brighton & Hove? By gender identity

		Trans identity	Not trans	Total
yes/sometimes	Count	25	239	264
	% within trans	59.5	31.8	33.2
no/unsure	Count	17	513	530
	% within trans	40.5	68.2	66.8
Total	Count	42	752	794
	% within trans	100.0	100.0	100.0

7.5. Ethnicity

There was a statistically significant difference in feeling isolated in Brighton & Hove by ethnicity ($p < .0005$). Table 7.5a shows that 75% of BME identified people and 50% of traveller and other ethnic groups stated that they felt isolated in Brighton & hove, compared to 32% of white LGBT people.

Table 7.5a: Do you feel isolated in Brighton & Hove? By ethnicity

		White	BME	Traveller/Other	Total
Yes/sometimes	No.	236	15	14	265
	%	31.8	75	50	33.5
No	No.	506	5	14	525
	%	68.2	25	50	66.5
Total	No.	742	20	28	790
	%	100	100	100	100

7.5.1. Deaf, deafened, hard of hearing

The majority of respondents (57%) who were deaf answered either 'yes' or 'sometimes' when asked if they felt isolated, compared to less than a third (32%) of other respondents ($p=0.003$).

Table 7.5b: Do you feel isolated in Brighton & Hove? By deafness

		Yes/sometimes	No/ unsure	Total
Deaf	No.	16	12	28
	%	57.2	42.9	100
Not Deaf	No.	244	524	768
	%	31.8	68.2	100
Total	No.	260	536	796
	%	32.6	68.4	100

7.5.2. Income

There was an association between income and higher rates of feelings of isolation. Those who earn under £10,000 are more likely to feel isolated (47%) than those who earn over £40,000 (27%). Just over half (55%) of those in the lowest income bracket did not feel isolated compared to just under 73% of those in the £40,000 + category ($p<0.0001$). No one in the categories of those earning over £40,000 said yes to the question.

Table 7.5c: Do you feel isolated in Brighton & Hove? by income

		<10k	10 – 20k	20 - 30k	30 - 40k	40k+	Total
Yes	No.	72	84	60	23	25	264
	%	47.1	35.4	32.1	19.8	26.8	33.6
No	No.	87	158	129	94	68	521
	%	54.7	65.3	68.3	80.3	73.1	66.4
Total	No.	153	237	187	116	93	785
	%	100	100	100	100	100	100

7.5.3. Physically Disabled or long term health impairment

Those who are physically disabled or have a long term health impairment are more likely to feel isolated in Brighton & Hove than other LGBT people ($p < .0001$). 52% of those who are disabled or have a long term health impairment say that they feel isolated compared to 29% of other LGBT people.

Table 7.5d: Do you feel isolated in Brighton & Hove? by disability

Isolated?		Are you or do you identify yourself as having a long-term health impairment or physical disability? yes	no	Total
Yes/sometimes	No.	62	196	258
	%	52.1	29.2	32.7
No/ unsure	No.	57	475	532
	%	47.9	70.8	67.3
Total	No.	119	671	790
	%	100	100	100

The data therefore shows a clear relationship between isolation and disability. This is supported by the focus groups:

Dan: **Just recently there was two kiddies from across the road, they were standing there for well over an hour and half throwing stones at the car. The man knew his kids were doing it, he even threw one and it hit a bus. It's intimidation. I've had my car, damage done to my vehicle, they just plonk their arse, ram right up to the back of it. They take my disabled parking bay, half in and half out and block me in so I can't get out - but why? What have I done? I've only been there, what, 2 years. I hardly go out the house. I very occasionally see the neighbours and if I do go out it's usually late at night when they're all in bed.**

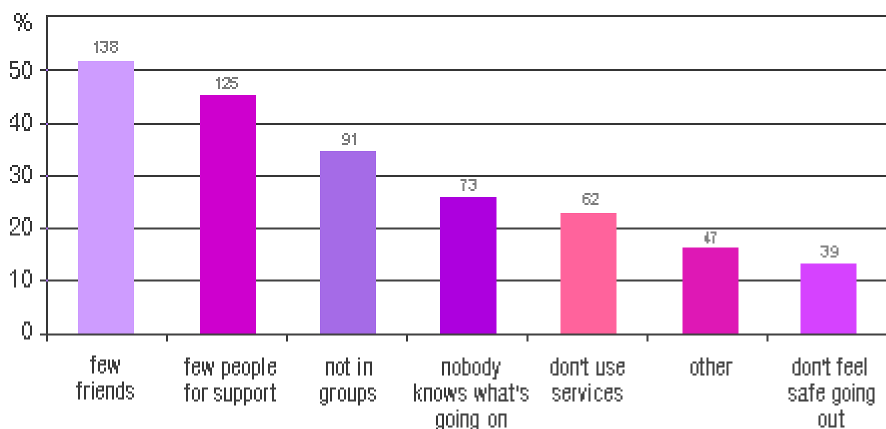
(Disabled focus group)

In the disabled focus group Dan discussed isolation and continued harassment and their feelings of uncertainty and helplessness. The link between hate crime and isolation is made clearly here. Dan sees his isolation in part as not 'upsetting' his neighbours and therefore as their aggression being unprovoked.

7.6. Reason for feeling isolated

The questionnaire offered some responses for 'what keeps you isolated' for those who said that they sometimes or often felt isolated in Brighton & Hove. Over half (52%) of those who state they feel isolated said this was because they had few friends or social contacts (17% of all respondents). Only 14% (5% of all respondents) said this was because they did not feel safe going out (see figure 7.6a).

Figure 7.6a: In what ways do you feel isolated?



The questionnaire also offered the option of completing an 'other' response. Grouping similar classes of response, it can be seen that there were three main categories, and 8 responses were associated with each (see table 7.6a): difficulties with the LGBT scene; residential location or distance from Brighton or the 'gay village'; and not being able to find others of the same identity or finding that one is not include because of one's identity. Three responses explicitly mention how experiencing difficulties with their mental health contributed to their feelings of isolation. Another three mention explicit discrimination or exclusion on the basis of age, bisexual identity and deafness, respectively.

Table 7.6a: Major categories from qualitative data: 'In what ways do you feel isolated?'

Categories		No. of responses
Location/distance:		8
Of Which	Not living in Brighton	3
	Friends live elsewhere	3
	Not living near 'gay village'/scene	1
	Living in countryside	1
	Live in 'straight' area	1
Difficulties with LGBT scene		8

Of Which	Dislike of alcohol culture	3
	Dislike of people I meet on scene	2
	Difficult to make new friends on scene	2
	Discomfort in male oriented venues	1
	Most people I meet just want sex	1
Cannot find others of same identity/not included on basis of identity		8
Of Which	Like minded lesbians	3
	Trans	2
	Trans male	1
	BME	1
	Bisexual	1
Discrimination/exclusion on basis of identity		3
Of Which	Age	1
	Bisexual	1
	Deaf	1
Mental health difficulties		3
Of Which	Hiding mental health difficulties	1
Living alone		2

7.6.1. Difficulties with LGBT scene

Feelings of isolation can relate to a dislike of or discomfort with the LGBT scene. Some people may feel isolated because their preferences for socialising are not met by what is on offer in mainstream LGBT spaces. Those who identify as lesbian or gay might also feel isolated because they feel they do not identify with the majority of other lesbians or gay men on the LGBT scene or that they are unwilling to participate in the activities or lifestyles offered by the LGBT scene.

there seems to be no network of HEALTHY and SPIRITUALLY minded lesbians, it's alcoholics or nawt!

(Questionnaire 602)

I am not able to meet many lesbians of interest to me in the commercial gay scene

(Questionnaire 668)

The drinking and drug culture mentioned elsewhere (see Browne, 2007a) can mean that LGBT people don't access or use the scene:

meeting people centres around drinking predominately which is not always appealing

(Questionnaire 532)

Social networks and 'breaking into' the scene can also be a factor in created or exacerbating isolation. This may be connected with the sexual emphasis of scene places that do not prioritise social networks and friendships, but are rather based on 'pulling' and sexual encounters:

Its hard 2 make friends if u don't live there but only work, especially ones who don't just want sex

(Questionnaire 195)

Questionnaires 195's desire to find friendship in a place you 'work in but don't live in' points to how Brighton & Hove can be seen as a place to develop social networks, even where you do not live in the city (see also Browne and Davis, 2008). Isolation could be counteracted by social spaces that are not based on sex, drugs or alcohol.

7.6.2. Cannot find others of same identity/not included on basis of identity

8 responses suggest that those who belong to groups that are marginal within the LGBT population can find it difficult to find inclusion within LGBT communities or spaces. As with mental health difficulties, such difficulties in finding inclusion are compounded by the problem of facing discriminatory practices and judgements within the LGBT communities:

I know few other out bi people and the LG friends i have are often judgemental about my sexuality

(Questionnaire 646)

Biphobia can mean that isolation from lesbian and gay friends and spaces due to judgemental attitudes. However, such feelings of isolation do not only arise because of explicit practices of exclusion or discrimination, but are rather often to do with not being able to find others of the same identity:

I can't seem to find any other trans people

(Questionnaire 284)

Although the LGBT collective in Brighton &Hove can offer some solidarity, this respondent suggests that there is also a desire for trans specific space and interactions with those who are the 'same'. Trans people however are not homogenous and as this respondent suggests:

no trans male community

(Questionnaire 142)

The existence of multiple identities within the LGBT collective, means that there is a need to address diverse needs and experiences. It cannot be assumed that a homogenous LGBT 'community' will cater for all of those who may fall under this label. Therefore, it is important to consider difference as well as similarities when addressing LGBT isolation and mental health difficulties.

7.6.3. Location/distance

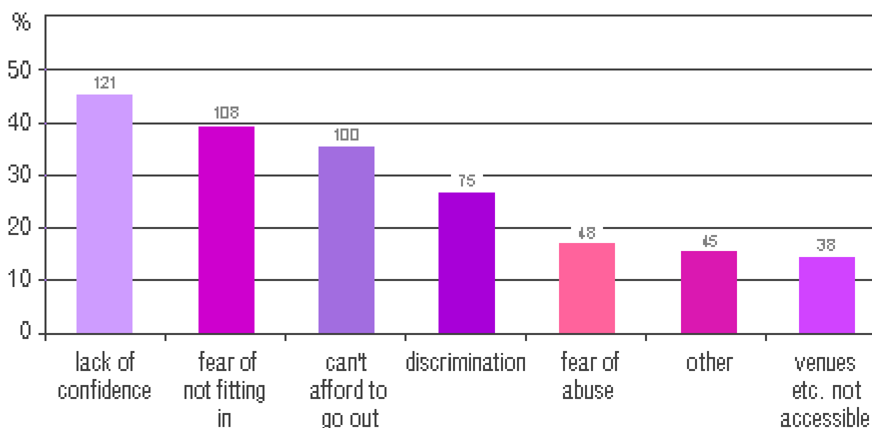
There were 8 responses related to location or distance from Brighton & Hove or the 'gay village'. Three of these responses mention not living in Brighton & Hove as a way in which isolation is felt. These responses indicate the desirability of living in Brighton & Hove as an LGBT person (see also Browne and Davis, 2008). The needs of those who work and/or socialise or who use private and public services in Brighton & Hove, but who do not live in the city are important to account for when addressing Sussex wide services and provision. Social networks are key to this form of isolation. Three respondents mention that their friends live far away from them. Brighton & Hove's expensive accommodation and inequalities of wealth are all contributing factors:

> **Friends keep moving out of the area due to cost of housing**
>
> *(Questionnaire 610)*

7.7. Factors that keep people isolated

The questionnaire then asked what 'what keeps you isolated'? Figure 7.7a outline the main reasons given for keeping people isolated. The most common cause of isolation selected by the respondents was 'lack of confidence' (45%). Fear of not fitting in which could be closely related to 'lack of confidence' was the second most cited reason (39%) The inaccessibility of venues, groups and services was the least common reason selected (14%).

Figure 7.7a: What keeps you isolated?



7.8. Other factors that keep people isolated

The questionnaire also allowed participants to write their own reasons for remaining isolated. These highlight the LGBT scene as a key area that perpetuates isolation (see table 7.8a).

Table 7.8a: Major categories from qualitative data: 'What keeps you isolated?'

Categories		No. of responses
Difficulties with LGBT scene		13
Of Which	General dislike of scene	4
	Being excluded from scene	3
	Dislike of alcohol culture	2
	Age of others on scene	2
	Lack of alternatives for socialising	2
	Most people I meet just want sex	1
	Other	1
Partner/relationships		3
Identity (miscellaneous)		2
Lack of trans community/other trans people nearby		2
Health		2
Mental health difficulties		2

Table 7.8a summarises responses to the question of 'what keeps you isolated?'. There was considerable repetition of the kinds of answers (or in some cases the actual answers) given in the qualitative data to the previous question ('In what ways do you feel isolated?'). As with the previous question, many of the answers pointed to difficulties respondents have with the LGBT scene in Brighton & Hove. In addition to the earlier remarks on the centrality of alcohol and finding sexual partners to socialising on the LGBT scene (see section on 'Reasons for feeling isolated' above), the responses to this question also raised the issues of the lack of alternatives for socialising, the age of the majority of those socialising in mainstream LGBT venues, and problems arising from exclusion from scene spaces.

While one respondent who remarked on the lack of alternative spaces for socialising did so in general terms, another respondent mentions a desire for a more specific space.

Lack of a holistic lesbian network or meeting place

(Questionnaire 602)

These holistic network and other spaces that could contribute to mental health and wellbeing could be part of a broader space that caters for LGBT people. Among the responses that indicate that being excluded from the LGBT scene contributes to their isolated, the exclusion takes place on the basis of income/inequalities of wealth, disability, and stereotypes of who belongs in LGBT spaces.

Pubs seem be all/end all, other events are expensive unless u r 2 high income professionals

(Questionnaire 695)

Nowhere for disabled gay man to go really

(Questionnaire 715)

Frequently not allowed to gay venues as NOT GAY ENOUGH?

(Questionnaire 730)

These responses lead on to a wider consideration of the relationship between the LGBT scene and isolation. They also point to the need to develop inclusive LGBT spaces in order to tackle isolation.

7.9. Differences between those who feel isolated

The reasons given for 'what keeps you isolated' on the questionnaire (see figure 7.7a above) are broken down by different identity groups, however, it should be noted that only those who felt isolated were included in this analysis. Within those who feel isolated- bisexuals and those of a sexuality other than lesbian, gay or bisexual, trans people, those in the lowest and highest income categories and those who have a physical disability or are long term health impaired were more likely to cite discrimination and exclusion as a reason for their experiences of isolation.

Table 7.9a: What keeps you isolated? By sexuality identity

%	Lesbian	Gay	Bisexual	Other	Chi Square
Discrimination/exclusion	27	24	50	47	P=0.019
Lack confidence	38	59	44	39	P=0.015
Fear of not fitting in	31	50	50	38	P=0.046

Experiences of discrimination / being excluded was selected as the most common reason by bisexual (50%) and other (47%) (i.e. all groups except for lesbian, gay and bisexual) respondents. Half of the bisexual respondents who said they felt isolated however also selected 'Fear of fitting in', whilst 47% of 'other' respondents also selected 'Can't afford to go out'. Not being able to afford to go out was also selected as the most common reason by lesbian respondents (45%), whilst the majority (59%) of gay men were most likely to say their sense of isolation was because of a lack of confidence. There was a statistically significant association in the proportion of respondents by sexuality who chose this reason (p=0.015) as well as 'Fear of fitting in' (p=0.046) and 'Experiences of discrimination' (p=0.019). There was no statistical significance in the proportion selecting the other reasons except for 'Venues / groups / services are not accessible' but the expected counts were too low for a valid chi square test.

Table 7.9b: What keeps you isolated? By gender identity

%	Trans	Not trans	Chi Square (Continuity Correction*)
Discrimination/exclusion	56	27	P=0.006
Lack confidence	25	51	P=0.028
Fear of abuse etc.	44	16	P=0.002

Respondents who were not trans and felt isolated were most likely (51% compared to 25% of trans respondents: p=0.028) to choose ;'Lack of confidence' (since gay respondents accounted for a large proportion (47%) of all who felt isolated). The majority of trans respondents on the other hand were most likely to select 'Experiences of discrimination' or 'Can't afford to go out' (both 56%). The difference in likelihood of choosing the latter, however, was not significant, whilst there was a significant difference in the likelihood of trans/not trans respondents choosing 'Experiences of discrimination' (p=0.006). Trans respondents were also significantly more likely to select 'Fear of not fitting in' as a reason for keeping them isolated (p=0.002). There was no significant difference for any of the other causal reasons except for 'Venues / groups / services are not accessible' but the expected counts were too low for a valid chi square test.

Table 7.9c: What keeps you isolated? By ethnicity

%	White	Other	Chi Square (Continuity Correction*)
Lack confidence	51	24	P=0.01
Other	16	31	P=0.045

** Computed for a 2X2 table*

Reasons that respondents gave for 'what keeps you isolated' were compared by ethnicity, with categories other than 'white' combined into one. Whilst the majority 'white' group were most likely to select 'Lack of confidence' (51% compared to 24% from all other ethnic groups: p=0.01), BME/traveller/other respondents were most likely to choose 'Experiences of discrimination' (41% compared to 28% of 'white' respondents), but the difference was not statistically significant. No statistical significance was found in relation to any of the other reasons except for 'Other' (p=0.045). There was also a statistically significant result for 'Venues / groups / services are not accessible' but this was invalid since the expected counts were too low.

Table 7.9d: What keeps you isolated? By age

%	<26	26-35	36-45	46-55	55+	Chi Square
Lack confidence	33	55	57	32	58	P=0.013

Reasons that respondents gave for 'what keeps you isolated' were analysed by age with the top three and bottom two age groups combined. All age groups except the 'under 26' and '46-55' age group were most likely to choose 'Lack of confidence', whilst the other two age groups were most likely to select 'Can't afford to go out'. The only statistical significant relationship found was between age and likelihood of selecting 'Lack of confidence' (p=0.013).

Table 7.9e: What keeps you isolated? By income

%	<10k	10 – 20k	20 - 40k	40k+	Chi Square
Discrimination/exclusion	42	21	27	35	P=0.04
Can't afford to go out	71	43	20	0	P<0.0005
Venues etc. inaccessible	26	8	16	4	P=0.006

Reasons that respondents gave for 'what keeps you isolated' by income categories combined (Under 10,000; 10,000-20,000; 20,001-40,000; Over 40,000). Those in the highest (61%) and those in the 10-20,000 income bracket (55%) were most likely to select 'Lack of confidence' as a reason, whilst those in the 20,001 – 40,000 income bracket were most likely to choose 'Fear of fitting in' (49%). Respondents in the lowest income bracket were most likely to select 'Can't afford to go out' (71%: p<0.0005). Those in this income bracket were almost more likely to select 'Experiences of discrimination' than other respondents (p=0.04) and 'Venues / groups / services are not accessible' (p=0.006). There was no statistical association found between any of the other reasons selected and income.

Table 7.9e: What keeps you isolated? By physical disability / long term health impairment

%	With disability	Other	Chi Square (Continuity Correction*)
Discrimination/exclusion	42	25	P=0.017
Venues etc. inaccessible	32	10	P<0.0005
Fear of abuse etc.	29	16	P=0.042

** Computed for a 2X2 table*

Both those who had and did not have a physical disability or long-term health impairment were most likely to select 'Lack of confidence' as the cause of their factors in their isolation (52% of disabled and 47% of other respondents). However, there was a significant difference in the proportion selecting 'Experiences of discrimination' (p=0.017), 'Venues / groups / services are not accessible' (p<0.0005) and 'Fear of abuse / harassment / violence' (p=0.042) with those who had a physical disability / health impairment being more likely to select these reasons. Those with a disability were also more likely to select 'Can't afford to go out' and 'Fear of fitting in' than other respondents, but the difference was not statistically significant.

7.10. The LGBT scene and isolation

Table 7.10a: 'I enjoy going to LGBT venues and events' by isolation

		Yes/Sometimes	No	Total
Agree	No.	156	421	577
	%	58.9	80	72.9
Disagree	No.	33	22	55
	%	12.5	4.2	7
I don't use	No.	41	59	100
	%	15.5	11.2	12.6
Unsure	No.	35	24	59
	%	13.2	4.6	7.5
Total	No.	265	526	791
	%	100	100	100

p=.0005 hence there is a significant relationship between enjoying LGBT venues and events and feeling isolated.

As the quote that began this chapter illustrated, isolation from LGBT spaces can result from, and be a part of, multiple marginalisations. There were significant differences found between enjoyment of the scene and isolation. Those who feel isolated are less likely to enjoy using the LGBT scene and more likely to say that they don't use the scene that those who do not feel isolated in Brighton & Hove (see table 7.10a above). 59% of those who said that they felt isolated enjoyed using the scene compared to 80% of said that they did not feel isolated in Brighton & Hove.

Some of the focus groups spoke of the difficulties of multiple marginalisations and accessing the LGBT scene:

Susan: **One of the things that's really surprised me is that there does appear to be a much stronger phobia towards the bisexual group and to some degree the trans-gender group as well from the lesbian and gay sections of the community, which I didn't notice as strongly in London. I had many, many good lesbian friends, it just wasn't the same, even when I see Mind advertising, you know, it's specific statements about lesbian and gay men who have got mental health problems and the other bits of the community aren't included.**

(Bisexual focus group)

Getting involved in the LGBT scene and finding safe LGBT spaces can be very important for mental health and reducing isolation. However, where individuals feel marginalised from lesbian and gay venues, the experiences of Brighton & Hove can be alienating and isolating.

Finding somewhere you are welcome was desired by the disability focus group. Although the discussion began by looking for ways with those who have diverse forms of disability and mental health difficulties to get together, it developed into some ways of combating and overcoming isolation amongst LGBT people more generally:

Chris: **I know of an enormous number of people in Brighton & Hove area who are affected by mental health difficulties and I see no reason why those two [those with physical disabilities and those with mental health difficulties] don't work together because although they won't cross over in all areas…**

Eddie: **They should work together.**

James: **The general thing is that they are people who are isolated from the mainstream out there for … whatever way. I'd love there to be refuge in Brighton that you can go to when you are feeling shit. I'm sure that that's not necessarily going to be available but if they have got £13½ million of money for vulnerable people…**

Researcher: **So what would be available at this refuge?**

Chris: **Just a place where you can go and escape.**

Tom: **Yeah I don't know for me it would be a pub with no beer. I mean a social place where alcohol isn't on the agenda so you haven't got to go to a pub, that you can just jolly go somewhere and chat with people and play a bit of snooker or something like that and with table tennis or just sit in a corner and sob your heart out if you want to. Some sort of social space, that are not saying a lot of idealistic nonsense.**

I would hope that it would be its own thing rather than tucked into that premises which also does this, this and this. If say for example there was an LGBT centre put in with there I would probably feel, well it's not a place for me to go to because…the thing that appealed about this, it would be a gay space like MIND on Tuesdays.

Researcher: **And not going through a straight space to get to a gay place.**

Tom: **Yeah, because I mean I'm a person who in the past has found it very difficult to even get to things like MIND LGBT and centres like the one that's being talked about. So it occurs to me that there might well be other people who would also find it problematic getting to something like that and if, if…if anything like this was ever built that needs to be thought about when it's being designed as it were, how best to make it the sort of place that vulnerable people are going to be able to get to.**

(Disability focus group)

Although there were some mixed views on the ideas of an LGBT healthy living centre, most people in the focus groups supported the concept of a social space where LGBT people could come together outside the perceived 'alcohol and drug fuelled' scene. This would need to account for vulnerable LGBT people and not be tucked away behind other services that require a movement through straight space before 'safe' LGBT space is accessed.

The disability focus group also highlighted that isolated people and those who don't use the scene can miss out on sex and relationships. This has clear implications for quality of life.

Bill: **The thing is that if you are isolated and you don't get out and you don't meet people, a part of having a well balanced life is having a relationship. I feel quite strongly, even though some of these groups are no pick up joint, I think it is very easy to dismiss that people with disabilities have sexual needs also and that should be included in service providing areas**

(Disability focus group)

7.11. Conclusion

This chapter has shown that feeling isolation is a key issue for some LGBT people. There is evidence to suggest that there is a link between multiple marginalisations and feelings of isolation. As chapter 3 shows those with mental health difficulties are more likely to feel isolated in Brighton & Hove, here those who are who identified as 'other' in terms of sexuality, who are trans, BME identified people and traveller and other ethnic groups, deaf LGBT people, those on a low income and those who are disabled or long term health impaired, are more likely to feel isolated. Following from this, those who feel isolated are less likely to enjoy using the LGBT scene and more likely to say that they don't use the scene that those who do not feel isolated in Brighton & Hove. This can result from and lead to further experiences of isolation. A suggested way of overcoming the isolation felt by some LGBT people was a move away from the focus on the scene for LGBT activities. Qualitative data noted the place of the LGBT scene in creating and maintaining feeling of isolation in some people, answers pointed to economic issues as well as cultural constraints and exclusions. Spaces for other leisure activities were desired. There should not be centred on alcohol or drugs, but should include the possibilities of forming of sexual and other relationships.

8. Management of and support for mental health difficulties

8.1. Introduction

This chapter explores the qualitative and quantitative data from the research in relation to the use of mental health services by LGBT people. Although often causal relationships cannot be established, it will indicate key areas of need. The chapter will also address some of the negative experiences LGBT people have had with mental health services and explore what participants said about the Mind Out, LGBT mental health service. This chapter will examine some of the perceived support needs of those with mental health difficulties, including the use of NHS mental health services. The chapter will firstly examine those who said that they needed support for their mental health difficulties, exploring diversity between LGBT people and the mental health category used for this research. It will then explore the avenues of support that people pursued: this focuses particularly on NHS services and the effectiveness of NHS services, before addressing the qualitative data regarding what was found to be helpful and unhelpful in managing mental health difficulties.

8.2. Needing support

344 respondents felt the need for support around their mental health difficulties in the last five years. This amounted to 53% of respondents with mental health difficulties (or 54% of these respondents who answered the question about the need for support).

If we consider the 'mental health difficulties' category that is used for this research, (that is only the following mental health difficulties: significant emotional distress, depression, anxiety, anger management, fears / phobias, problem eating / eating distress, panic attacks, self harm, addictions / dependencies, suicidal thoughts, and excludes isolation, confidence / self esteem, stress and insomnia from the analysis) then it is clear from table 8.2a that those we classed as having mental health difficulties (64%) were far more likely to perceive the need for support for one or more of these difficulties than those we excluded from this category 8%, n. 9, $p<.0001$).

Table 8.2a: Experiences of mental health difficulties by the perceived need for support around mental health difficulties in the last five years

categories		Yes	No	Total
No mental health difficulties	No.	9	102	111
	%	8.1	91.9	100.0
Mental health difficulties	No.	343	190	533
	%	64.4	35.6	100.0
Total	No.	352	292	644
	%	54.7	45.3	100.0
	%	100.0	100.0	100.0

8.3. Multiple marginalisation and the need for support

The provision of services for LGBT people needs to recognise issues of multiple marginalisation. As has been highlighted in previous chapters, bisexual and other sexualities and trans people along with those who are multiply marginalised are more likely to be isolated and experience difficulties with their mental health. They are also more likely to be at risk of suicide. The qualitative research pointed to the need for services that could address these issues, but suggested that many of those who are bisexual, of other sexual identities, trans or multiply marginalised are unable to find such services.

Bridget: **Yeah, because these things are hard enough and there is enough, there's enough stigma around mental health and if you suffer from mental health, like I'm on incapacity benefit for depression and if you suffer from mental health problems it's hard enough accessing help, because it's hard enough to feel that you deserve it or for whatever reasons it's very hard to access help in the first place and then you have to jump through the hoops of trying to access help when there isn't help designed for you. I mean as far as I'm aware I know of one or two openly bisexual counsellors in Brighton, but then I know that because I work in counselling and because I'm inside the loop already and I think it would be quite hard, just if you didn't… I'm not aware of any of the straight of lesbian and gay, LGBT mental health services having a bisexual person you can go and talk to and stuff like that makes such a difference.**

… it doesn't matter because if it had been an issue for me I wouldn't be able to access a bi person anyway and with mental health stuff it's so, you have to make this stuff as easy… I think things like the bi-phobia stuff really, really hit hard on stuff like this if you went… if you go to a lesbian and gay service and you experience bi-phobia in the place where you're trying to be your most open and you're at your most vulnerable,

that's really dangerous. I mean I might be a bit over dramatic but it is really dangerous that sort of stuff. It really does wreck people's lives and mental health services need to a) be more educated about bisexuals; and b) to just have people that you can go and see, especially LGBT services, because they're already setting up for this niche thing. I think it's a real responsibility for those services to say, as they already do, "If you'd like to speak to a lesbian woman, you can." Again they should also be saying "If you'd like to speak to a bisexual man, if you'd like to speak to a trans-woman"

(Bisexual focus group)

This quotation draws attention to how LGBT services often offer a services tailored to lesbian and gay users. While the speaker quoted here suggests a desire to be able to choose to see a bisexual mental health professional, this should not be taken as suggesting that all bisexual people would want to consult a bisexual male mental health professional; indeed some users of mental health services may want to see a professional of another identity to their own. Rather, the issues raised here regard a desire for a choice of whom service users are able to consult, and, moreover, the need for training for all mental health professionals so that they are able to offer services and advice appropriate for bisexual service users.

This desire for service providers to have an appropriate understanding of the specific needs of multiply marginalised groups and groups marginalised within the LGBT collective (such as bisexual, those identifying as of an other sexuality, and trans people) recurred in other focus groups. The deaf focus group, for instance, suggested that those who identify as Deaf may have particular issues with mental health difficulties due to multiple marginalisations.

Researcher: **And you mentioned mental health earlier, is that an issue do you think for deaf LGBT people?**

Andrew: **I think sometimes it's like sort of double difficulties really with being, you know, the deafness and then on top of that the sort of lesbian and gay, or the sexuality about who do I talk to, where do I locate that support, who do I talk to? So like, do you go to somebody within the deaf community who's a lesbian or gay person, but also then they might be able to offer you counselling but then they're within your community so there's issues of confidentiality. Do you go to a hearing person who's very knowledgeable about LBGT issues but has no understanding of deafness at all? Or do you go to a deaf straight person or, you know, I think there is some real issues about where you access those services. Like there's the British Deaf Association that provides mental health service, but I wouldn't go and use those; and there's a national deaf service and there is a counsellor from there, who comes every two weeks to**

provide counselling service. But none of that is LBGT specific.

(Deaf focus group)

The absence of appropriate LGBT support for Deaf people and Deaf support for LGBT people means that LGBT Deaf people can struggle to find support for their mental health difficulties and LGBT issues. The lack of support for those experiencing multiple marginalisation was not limited to Deaf people and was identified in other focus groups such as the BME focus group.

Trans people also have specific needs, but despite often being seen by psychiatrists through their transition, they still may not be having their mental health needs addressed:

Sue: **So one of the issues around trans, there's the issue of identification in the first place, particularly amongst our young people. [There] is a whole mental health space, because that process from childhood through to completing one's change is a very, very painful, confusing, depressing a lot of the time, situation. We know that there's very, very high instance of suicide within the trans community, even post completing the process. So I think we need a huge support system that goes from identification, through to coming to terms [with it], to post coming to terms with ones change and how we can mitigate some of the stress in that system through informed GPs, blah-de-blah, about this particular condition**

(Trans group 1)

The health report that forms part of this research will further address the health needs of trans people.

8.4. Finding support

Table 8.4a shows the proportion of those who felt the need for support around their mental health difficulties who were able to find the support they needed. Almost a third (32%, n. 109) of those who felt the need for support said that they were unable to find it.

Table 8.4a Were you able to find the support you needed?

	Frequency	Percent	Valid %
Yes	230	66.9	67.8
No	109	31.7	32.2
Total	339	98.5	100.0
Missing	5	1.5	
Total	344	100.0	

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A need for services, then, does not mean that they will be found, or that they will be suitable or even adequate to deal with the multiple issues many LGBT people with mental health difficulties need support with:

Sarah: **I was sort of having slight mental health problems [and] I found it really hard to find support and then I found it even harder to come out. Then I got confused because I'd got the two problems, being gay and having a mental health problem. I got very, very confused and I thought there is really seriously something wrong with me here. … I have come across barriers with certain people in the Psychiatric Service before and I've mentioned that I am gay and it is 'oh right yeah' and they've changed. Their attitude towards you has changed as if to say 'oh my God this person has not just got a mental health problem but she is gay as well', I can't cope with this. It was as if they just didn't want to know me any more, they didn't want to handle my case any more, they couldn't cope with me being gay.**

(Mental health focus group)

For Sarah being gay affected her use of services and her perceptions of having 'two problems'. She felt it also altered how people dealt with her in mental health services. She went on in the focus group to say how she would not reveal her sexual identity in the mainstream services that she uses, only in LGBT space, such as Mind Out. This has clear implications in terms of how LGBT people are treated, and supports other evidence of discrimination against LGBT people in mental health services (see Johnson et al., 2007). Here Sarah felt that 'certain people' couldn't cope and attempted to get rid of her case. Another participant said that Mind Out was the only place they had not been rejected (see chapter 8.10, below).

The need for support may not always be met by attempting to improve access to services:

Zara: **Oh, in my accessing of services definitely, there is a striving to cure is probably the best way to put it, which is not to say that people say "Oh God, your homosexuality, your queerness, your bisexuality are a disease", but it is suggested. It is implied often that you are making life hard for yourself than it need be and that I've certainly experienced. ..**

Kriti: **... and, you know, I don't want to start cataloguing them, but there are so many things that had I gone to services I probably would have received treatment. I think the other reason I don't have mental health difficulties is because I haven't engaged mental health services and I think that's true for a lot of LGBT people … really we don't have any idea of the prevalence of mental health difficulties because we haven't really [known] what mental health difficulties are and I think part of the issue there is I feel completely… have no**

confidence engaging the statutory services about the difficulties I've had

(BME focus group 2)

Zara once again highlights the assumptions that can be made in mental health support settings that link LGBT identities and lives and experiences of mental health difficulties. Here, she interprets this as service providers suggesting she is 'making life hard for herself', and she feels that this individualisation, in part, blames the individual for their experiences of both their own mental health difficulties and also other people's prejudicial and discriminatory actions. However, Kriti points out that a lot of LGBT people may be defined as having mental health difficulties if they used the services to support their needs. She says that she will not use these services because of a lack of confidence with the service they would provide and their ability to engage with her as a BME lesbian.

8.5. NHS services

Angela: **Right at the very beginning [of the focus group] I remember a statement was made that there's many people who are bisexual who maybe aren't connecting to the bisexual network, but nevertheless from both a sexual health and mental health thing, are facing the same issues. So therefore it's would seem that it's important for the national health community to reach out and provide actively that information just to manage it in a way which is beneficial to everyone.**

(Bisexual focus group)

Table 8.5a shows that 24% (n. 154) of respondents who experienced mental health difficulties have used NHS mental health services in the last five years (or 26% of those who answered the question regarding use of NHS mental health services).

Table 8.5a: Have you used NHS mental health services in the last 5 years?

	Frequency	Percent	Valid %
Yes	154	23.7	25.5
No	451	69.3	74.5
Total	605	92.9	100.0
Missing	46	7.1	
Total	651	100.0	

There is a strong relationship ($p < .0001$) between whether respondents have used NHS mental health services and whether they have experienced suicidal thoughts over the past five years (table 8.5b). Of those who have used NHS mental health services over the past five years, 65% (n. 104) have experienced difficulties with suicidal thoughts, while only 18% (n. 83)

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of those who had not used NHS mental health services over the past five years had experienced difficulties with suicidal thoughts.

Table 8.5b Use of NHS mental health services by experience of suicidal thoughts in the last five years.

Suicidal Thoughts		Used NHS mental health services Yes	No	Total
Yes	No.	104	83	187
	%	65.0	18.0	30.1
No	No.	56	379	434
	%	35.0	82.0	69.9
Total	No.	160	462	621
	%	100.0	100.0	100.0

While table 8.5b (above) shows that those who have used NHS mental health services are significantly more likely to have experienced difficulties with suicidal thoughts than those who have not used NHS mental health services, table 8.5c (below) shows that those who said that they had serious thoughts of suicide are also more likely to have used NHS mental health services ($p < .0001$). This is a very strong association. While only 13% (n. 54) of those with mental health difficulties but no serious thoughts of suicide have used NHS services over the past five years, 51% (n. 66) of those who have experienced difficulties with serious thoughts of suicide but who have not attempted suicide, and 69% (n. 38) of those who have thought about and attempted suicide have used NHS services over the past five years ($p<.0001$).

Table 8.5c Breakdown of experiences of suicidal thoughts over the past five years by use of NHS mental health services (Q34a_8)

		Thought and attempted suicide in the last 5 years	Serious thoughts of suicide, but did not attempt	Mental health difficulties, but no serious thoughts of suicide	Total
Yes	No.	38	66	54	158
	%	69.1	50.8	12.8	26.1
No	No.	17	64	367	448
	%	30.9	49.2	87.2	73.9
Total	No.	55	130	421	606
	%	100.0	100.0	100.0	100.0

While this analysis cannot ascribe a direction of causality between suicidal thoughts and the use of NHS mental health services, it does suggest that suicidal thoughts are an indicator of mental health difficulties appropriate to NHS mental health services. The research points to a clear need for services to recognise the risk factors associated with LGBT experiences and suicidal thoughts.

8.6. Predicting use of NHS services

A logistical regression analysis was used to investigate if particular mental health difficulties could predict the use of NHS services. Table 8.6a shows that an experience of depression, fear/phobias, panic attacks, self-harm or suicidal thoughts significantly increases the likelihood of having visited the NHS mental health services in the last 5 years.

Table 8.6a: Mental health predicting use of the NHS mental health services in the last 5 years

	B	S.E.	Sig.	Exp(B)
Depression	1.53	.30	.000	4.617
Fears/phobias	.67	.29	.020	1.962
Panic attacks	.68	.26	.008	1.969
Self-harm	.69	.34	.039	2.000
Suicidal thoughts	.75	.25	.003	2.120

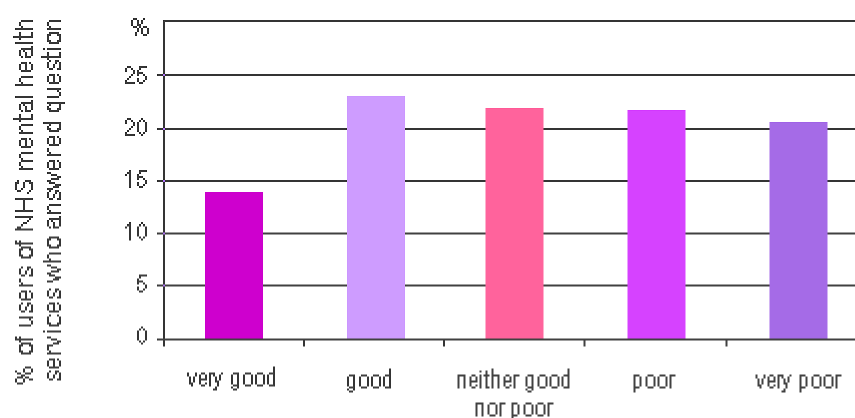
Table 8.6a (above) shows that those who experience depression are over 4 times as likely to use NHS services that those who experience other mental health difficulties (Exp(b) = 4.6). Those who experience fear/phobias, panic attacks, self-harm or suicidal thoughts are all around twice as likely to use NHS services (Exp(b) ~ 2.0 for all these experiences). There were no significant differences in relation to the experiences of other mental health difficulties.

This should be read in line with the data that shows that depression and self harm can predict thinking about and attempting suicide in the past five years. Again a causal relationship cannot be proved, that is whether experiences of these difficulties lead to the use of NHS services or whether using NHS services lead to these difficulties. However, it is also possible that NHS services are not reaching those who experience other forms of mental health difficulties.

8.7. Effectiveness of NHS services

There were mixed opinions about the effectiveness of NHS mental health services from LGBT people who used them. Although 42% (n. 64) rated NHS mental health services poor or very poor, 37% (n. 56) rated NHS mental health services as good or very good, composed of 23% (n. 35) who rated them as good and 14% (n. 21) who rated them as very good. Figure 8.7a shows the percentage of users of NHS mental health services who rated the effectiveness of these services as 'very good', 'good', 'neither good nor poor', 'poor', or 'very poor'. 20% (n. 31) rated NHS mental health services as very poor, and 22% (n. 33) rated them poor.

Figure 8.7a How would you rate the effectiveness of NHS services? (note: only those who had used NHS services were included in the question)



Those who have had serious thoughts of suicide in the last five years are somewhat more likely than those who have not had serious thoughts of suicide to rate NHS mental health services as poor or very poor ($p = .03$). 79% (n. 26) of those who rate NHS mental health services as 'very poor' and 77% (n. 27) of those who rate them as 'poor' have had serious thoughts of suicide over the last five years. By contrast, 58% (n. 21) of those who rate NHS mental health services as 'good' and 44% (n. 10) of those who rate them as 'very good' have had serious thoughts of suicide. This is a key area to address, as those who have serious thoughts of suicide are more likely to use NHS services.

Despite the relationships between the use NHS services and depression, fear/phobias, panic attacks, self-harm or suicidal thoughts, there are no relationships between any of the predictors and the effectiveness ratings. Thus, the variations in experiences of mental and emotional difficulties are irrelevant to how effective respondents feel the NHS mental health services are.

8.8. Managing mental health difficulties

8.8.1. What has helped you manage or overcome your mental health difficulties?

Table 8.8a shows the main categories arising from the qualitative data respondents provided regarding what had helped them manage or overcome mental health difficulties. Table 8.8b shows all the categories derived from the analysis of the qualitative data. These, of course, can be tied to personal biographies and histories and therefore contain complex intersections and overlaps. However, there are clear trends in the data that can offer insights into LGBT needs.

Table 8.8a: Major categories from qualitative data: 'What has helped you manage or overcome your mental health difficulties?'

Categories	No of responses
Counselling/GP/NHS/psychotherapy/cognitive behavioural therapy/clinical psychology/other mental health services	154
Informal Support	120
Own resources/self help etc/self knowledge/development/ strength of character/soldiering on	53
Voluntary and Community Sector (VCS) organisations and support groups	36
Medication	36
Work: change or assistance at/of or time off	18
Changes in lifestyle	16
Miscellaneous alternative therapies (including healing/healers/meditation)	14
Time	11
Learning to live with difficulties/developing coping strategies	7
Change in circumstances/getting out of situation that presented or prompted difficulties	6
Religion/Spirituality	6
Meeting/talking to people	6
Talking to other LGBT people	4
Nothing	4
Coming out	3

Table 8.8a shows the categories that respondents found helpful in managing or overcoming mental health difficulties. Formal support was hugely important and the help was received from professional mental health services, with 154 respondents mentioning some form of mental health therapy and counselling. Such answers indicate a reliance on formal services and that these can be effective in helping LGBT people manage their mental health difficulties. This shows the importance of services in Brighton & Hove engaging effectively with LGBT people.

Appropriate help - very specific counselling when I had health anxieties, clinical psychologist's help when I had PTSD

(Questionnaire 533)

There was some indication that this was not always public services and financial factors can have a huge impact (see below also):

Private counselling, but can't afford it anymore. Borrowed money to have counselling

(Questionnaire 241)

The voluntary and community service sector (VCS) are also mentioned by 36 people. Migration to Brighton & Hove to use LGBT specific services can be very important for some LGBT people (see Browne and Davis, 2008):

Coming to a safe place (Brighton), overcoming substance & alcohol abuse, shopping, smoking, support in the community (Clare Project)

(Questionnaire 241)

The Clare project for this respondent was important in helping them to overcome their mental health difficulties. Groups like this can offer services in Brighton that cannot be found elsewhere.

'Informal' support was clearly important and table 8.8b below shows the sources that this was obtained from including friends, family and/or partners. This illustrates the importance of social and support networks and their place in promoting mental health and wellbeing as well as supporting those who are experiencing mental health difficulties.

Talking to my partner who is Trans (some of the stress is because of her and the transition)

(Questionnaire 67)

For some respondents, there was an individualisation of support and 53 responses mentioned the importance of the respondent's own individual efforts to manage or overcome their mental health difficulties. Use of their own resources or efforts and stoicism, 'strength of character', or 'soldiering on' can be important in not dealing with services that could have potentially harmful impacts (see tables 8.8c and 8.8d):

I talk sensitively to myself & counsel myself

(Questionnaire 54a)

Table 8.8b: Major categories from qualitative data: 'What has helped you manage or overcome your mental health difficulties?'

Categories		No. of responses
Counselling		81
Of Which:	*Voluntary and Community Sector provided*	9
	Private counselling	9
	Employer provided	3
	University provided	3
	LGBT targeted	4
	Co-counselling communities	1
Psychotherapy		28
Cognitive Behavioural Therapy		6
Clinical psychology		3
Other mental health services		10
Of Which:	*Brighton & Hove mental health services*	1
	Child and Adolescent Mental Health Service (CAMHS)	1
	Community Psychiatric Nurse	2
GP		37
Other NHS (e.g. Lawson unit; Claude Nichol)		2

Medication		36
Of Which:	*Antidepressants*	14
Voluntary and Community Sector (VCS) organisations		26
Of Which:	*Mind Out*	9
	Brighton & Hove LGBT switchboard (counselling service)	6
	Terrence Higgins Trust	1
	Open Door	2
	Sussex Beacon	3
	Addaction	2
	Clare project	1
	Brighton Women's Centre	1
	Threshold	2
	Pathways (alternative therapies)	2
Support from:		
	Family/relations	28
	Partner	30
	Friends	85
	Colleagues	3
	Misc support groups (incl VCS)	10
	Misc 'support'	8
Meeting/talking to people with similar difficulties (not mentioning support groups)		5
Talking to other LGBT people		4
Talking to people (generally)		2
Courses		2
Time management		1
Anxiety management		2
Books/reading up		4
Internet		2
'Stability'		2
Of Which:	*Home*	1
Coming out		3
Of Which:	*As trans*	1
Gender transition		1
Drugs (non-prescription)		1
Alcohol		1
Smoking		2
Overcoming substance dependency/addiction		2
Overcoming alcohol dependency		1
Overcoming smoking		1
Change in circumstances/getting out of situation that presented or prompted difficulties		6
Moving home		2
Changes in lifestyle		16
Of Which:	*Changes in diet*	6
	Sport/exercise	9
	Relaxation	1
	Music	1
	Getting out more/going out	2

Work: change or assistance at/of	16
Time off work/studying	2
Work (generally; no specific change mentioned)	2
Learning to live with difficulties/developing coping strategies	7
Strength of character/soldiering on etc	20
Own resources/self help etc	29
Self knowledge/development	7
Time	11
Safe place	1
Acupuncture	2
Meditation	4
Misc alternative therapies (incl healing/healers)	6
Religion/Spirituality	6
Nothing	4

***Notes to table 8.8b*:**

1. Where responses fall into more than one category they are counted in each category that they fall into.

2. Where a response falls into one or more category and contains a comment that does not fall into one of the major categories, the response is counted within the major categories it falls into, and is listed under 'Other responses'.

3. Subsets of a major category (marked by 'Of Which') enumerate responses where respondents have specified a kind or type of the major category.

4. Subsets of a major category (marked by 'Of Which') are not mutually exclusive with respect to other subsets of the same major category: a single response (counted only once under the major category) may fall into more than one subset of the major category.

5. The total of the subsets (marked by 'Of Which') for any major category do not necessarily enumerate the total number of responses for that major category. This is because only significant subsets are listed.

8.8.2. What has been unhelpful in managing or overcoming your mental health difficulties?

Table 8.8c shows the major categories arising from the qualitative data respondents provided regarding what had been unhelpful in managing or overcoming their mental health difficulties. This table has collapsed some categories and table 8.8d lists all of the categories that were derived from the analysis in a thematic order.

Table 8.8c: Major categories from qualitative data: What has been unhelpful in managing or overcoming your mental health difficulties? (main categories)

Categories	No. of responses
Lack of understanding or sympathy (re: LGBT issues/ mental health issues/generally)	25
Waiting lists/time	21
Intolerance/stigma/discrimination/harassment/ abuse/ignorance	20
GPs	19

Poverty/lack of money/misc financial problems/cost of living/unemployment/benefits system	19
Lack of support/action	14
Cost of counselling/psychotherapy	11
Isolation/not having (enough) friends	10
Attitude of others	9
Stress/stressful life/work stresses	9
Medication	6
Lack of access to counselling/talking therapy etc	6
Lack of specialist services (incl. women's and LGBT specific)	6
The LGBT scene	6
Standard of care/service etc	5
Alcohol/drugs/smoking	5
Dismissal/trivialisation etc of difficulties	5
Accommodation issues	5
Lack of resources (general)	5
Mode of diagnosis/assumptions made by health care professionals/pathologisation	5

Table 8.8 c shows lower frequencies of response than table 8.8a indicated that there are a wider range of things that might be unhelpful with managing or overcoming mental health difficulties than there are potentially helpful factors. The two most frequent kinds of responses made mention the lack of understanding and the waiting times and lists for services. Stigma, intolerance, discrimination and harassment also had a significant role to play. This clearly has implications across service provision as well as in terms of the broader acceptance of LGBT people and those with mental health difficulties.

Chapters 3 and 4 have highlighted that trans people are far more likely to experience mental health difficulties and suicidal distress than other LGBT people. The qualitative data pointed to specific issues that can shed some light on this vulnerable groups engagement with services and the effects it has had on their mental health and wellbeing:

> **Firstly, at a very vulnerable time. With the lifelong dam, built to hold back the 'trans' waters finally breaking... i was confronted by an unsympathetic, obstructing & patronising GP. This was followed by the PCT's insistence on using a single care pathway to charing cross gic [Gender identity Clinic]. An unimaginable delay through the system and worst of all actually attending the draconian charing cross gic. Then having to fight my PCT & the GIC the whole time for the simplest of care. There is so much wrong with the PCT/GIC system, there is not enough space on here. That's what has made me suicidal.**
>
> *(Questionnaire 275)*

This quote highlights the ways in which the health system can result in suicidal distress due to inefficient services and a lack of 'simple care'. Delays, a lack of understanding and ongoing 'fights' left this person suicidal. Trans people can be wary of further engaging with health services, after these experiences:

> **I have always been reluctant to seek help from medical professionals, therapists, counsellors, etc, because of their beliefs about the causes of transsexualism and how it should be treated. Although there are some enlightened professionals, nowadays, many still treat trans people as though we have no rights and are incapable of making our own decisions.**
>
> *(Questionnaire 328)*

The absence of specialist local services that cater for trans people is a clear issue and one that needs to be addressed. However, it is not only trans people who found that the absence of services that cater for LGBT people was unhelpful in managing mental health difficulties:

> **No one has a clue how to speak to a Gay man with an eating disorder.**
>
> *(Questionnaire 492)*

When questionnaire 492 says 'non one has a clue', he is not only referring to mainstream services, intolerance from LGBT people can also act as a barrier to managing mental health difficulties (see chapter 2):

> **peoples ignorance and fear of mental health difficulties, being outed on the scene as having these difficulties.**
>
> *(Questionnaire 414)*

The term 'outed' is used here but not in relation to sexuality- rather being outed with mental health difficulties on the scene is a huge issue for some LGBT people due to the ignorance and fear of other LGBT people.

Although for many people informal support networks were very important in managing their mental health, fear of rejection and judgement, can mean that LGBT people hide their difficulties and do not find support from these important networks:

> **Family judgement and fear of discrimination if I tell people of my distress**
>
> *(Questionnaire 659)*

GPs are key points of initial contact and can be helpful in managing mental health difficulties and enabling people to manage their mental health difficulties. However, this important contact can also be hugely detrimental to LGBT people with mental health difficulties:

> **I told my doctor about my difficult relationship and all he said was "I didn't mean to pry".**
>
> *(Questionnaire 14a)*

My doctor implying I was lying and attention-seeking and trivialising my concerns.

(Questionnaire 61a)

The doctor that i visited to explain my feelings to was very quick to dismiss me and did not refer me to anywhere, so i had to go looking for support myself.

(Questionnaire 580)

The dismissal of concerns and relationships can mean a reliance on avenues of support that are found by the individual or paying for support (see below). This illustrates a failing at the point of contact for LGBT people with mental health difficulties.

Respondents gave a range of different reasons as to why GPs have been mentioned as unhelpful in managing or overcoming mental health difficulties including: standard of care/service; lack of support/action; lack of understanding/sympathy; lack of understanding of LGBT issues; dismissal/trivialisation of difficulties (see table 8.8d below)

Waiting lists and times, along with an absence of services, can mean that formal support systems that are cited as important above, are not available when they are needed:

Lack of services provided by the NHS. Getting into the system and making progress through the system is tortuous and stressful in itself. You have to be prepared to be extremely tenacious.

(Questionnaire 122)

Getting a counsellor is really difficult. I've still been unable to get one, despite being on waiting lists.

(Questionnaire 12)

Having to wait for an appointment for a long time at Threshold counselling (3 months minimum waiting list)

(Questionnaire 65)

Waiting times not only relate to statutory services. They can also be an issue if one is seeking a specialist service, including those only provided by Voluntary and Community Sector organisations.

Some resorted to private avenues in order to access the support they needed:

GP in Brighton is a waste of space.. ended up paying for help having been told "service in B&H are stretched, you could be waiting two years, best to either go private or just get on with it".. Old Steine Surgery

(Questionnaire 413)

Stretched mental health services may not have the capacity to provide short waiting lists, or offer continuous support:

> **The duration of the counselling. A set number of sessions, and then there had to be a waiting period and then I could apply for it again, but there was no guarantee I would be getting the same counsellor again.**
>
> *(Questionnaire 225)*

LGBT services that cater for those with mental health difficulties In Brighton & Hove do not have recurrent funding, but rather rely on time limited grants. This can mean severe limitations are placed on these services and those who need them.

There are also income-related concerns. Costs of counselling or psychotherapy present difficulties when taken with the challenges presented by poverty, a lack of money or other financial problems. Where services need to be bought (as above), those on low incomes and/or facing financial problems are particularly vulnerable when it comes to managing or overcoming mental health difficulties:

> **No support from the NHS, with my physical or mental needs - apart from a prescription for antidepressants. Living close to poverty due to the little money i get from benefits. Not having a choice of place to live due to not having money.**
>
> *(Questionnaire 30)*

Table 8.8d: Major categories from qualitative data: What has been unhelpful in managing or overcoming your mental health difficulties? (all categories)

Categories	No. of responses
Standard of care/service etc from:	6
NHS (general)	1
Gender Identity Clinic (Charing Cross)	2
GP	2
Community psychiatric nurse	1
Lack of support/action from:	16
NHS (general)	2
GP	3
St James's Hospital	1
Police	1
Family	1
General (mental health service/professionals)	2
General	6
Lack of understanding/sympathy (generally) from:	11
GP	5
Counsellor	1
A&E at RSC Hospital	1

Police	1
Friends	1
General	2
Lack of understanding of LGBT issues from:	11
GP	4
Psychotherapist	2
Community mental health nurses	1
Counsellor	1
Medical professionals (general)	1
General	2
Lack of understanding of mental health difficulties from:	4
Family	1
Friends	1
Police	1
General	1
Dismissal/trivialisation etc of difficulties by:	5
Health care professionals (general)	2
GP	3
Mode of diagnosis/assumptions made by health care professionals/pathologisation	5
Waiting lists/time for:	22
NHS Counselling	3
NHS Psychotherapy	3
Other NHS psychology & CBT	2
Counselling (general)	8
Counselling (VCS)	1
Gender reassignment surgery	1
General (mental health services)	4
Number of counselling sessions offered too few	4
Lack of (Mental health) services operating outside normal working hours	1
Systemic/organisational problems with:	4
NHS/local health authority (general)	2
NHS/local health authority wrt mental health	1
Counselling	1
Lack of resources (general)	5
Lack of LGBT-specific mental health services	2
Lack of women-specific mental health services	2
Lack of specialist services	3
Lack of access to counselling/talking therapy etc	6
Falling through gaps in mental health service provision	1
Not knowing who to approach for help	2
Cost of counselling/psychotherapy	11
Cost (general)	2
Medication	6
Of Which: Antidepressants	5
Miscellaneous specific organisations/individuals:	
Health service (general)	7
GP	3
Counsellor/counselling	1

Mental health services (general)	2
Support groups	1
Employer/former employer	2
Mind Out	1
Psychiatrist	1
Partner	1
Ex-partner	3
Family	6
Friends	5
Cost of living	2
Poverty/lack of money/misc financial problems	14
Unemployment	3
Benefits system (incl moving those with mental health difficulties into work)	3
Of Which: *Moving those with mental health difficulties into work*	1
Accommodation issues:	5
Gender issues	1
Being unable to move due to poverty/lack of money	1
Being unable to move (general)	1
Cost of accommodation	1
General	1
Isolation/not having (enough) friends	11
Alcohol/drugs/smoking	6
Alternative therapies	1
Intolerance/Stigma/discrimination	13
Of which associated with LGBT identities	5
associated with mental health difficulties	3
Attitude of others	9
Ignorance of others	3
Harassment/abuse	4
The LGBT scene:	6
Availability of drugs	1
Norms/expectations/stereotypes	2
Intolerance (general)	1
Intolerance of mental health difficulties	1
'Promiscuity'	1
Life circumstances	4
Stress/stressful life/work	9
End of relationship	2
Myself (general)	3
Negative thoughts/cycles of thought and behaviour	2
Difficulties with talking to others/professionals	4

Notes to table 8.8d

1. Where responses fall into more than one category they are counted in each category that they fall into.

2. Where a response falls into one or more category and contains a comment that does not fall into one of the major categories, the response is counted within the major categories it falls into and is listed under 'Other responses'.

3. Subsets of a major category (marked by 'Of Which') enumerate responses where respondents have specified a kind or type of the major category.

4. Subsets of a major category (marked by 'Of Which') are not mutually exclusive with respect to other subsets of the same major category: a single response (counted only once under the major category) may fall into more than one subset of the major category.

5. The total of the subsets (marked by 'Of Which') for any major category do not necessarily enumerate the total number of responses for that major category. This is because only significant subsets are listed.

6. Lists of dependent categories (headed by an introductory clause e.g. 'Lack of Support/Action from:') are not necessarily mutually exclusive.

8.9. Mind out

Throughout the focus groups, Mind Out was mentioned as a service that LGBT people relied on. Mind Out is a local LGBT mental health project. Since 2000 Mind Out has continued to support larger and larger numbers of LGBT people with mental health difficulties with an expanding group work service. The organisation has piloted complimentary therapies and developed mental health promotion materials, and run successful Pride events. In 2007, Mind Out published a research report on suicidal distress and survival in LGBT communities, with Allsorts and the University of Brighton (see Johnson et al., 2007). In the disability focus group there was a celebration of Mind Out as a means of reducing isolation (as well as Spectrum's access tent at Pride):

Tom: **Well, there are one or two things that I can think of that I think are fantastic about Brighton & Hove, are the fact that there is the Mind LGBT project because there isn't, I believe, anywhere else in the country that has such a project so that's an excellent resource, and on the day of Brighton Pride, I think the access tent is also fantastic and has certainly enabled me to go to something that in the past I have found very difficult to go to and often not gone to despite it being an outdoor space because I am not entirely comfortable in outdoor spaces, I am just better in outdoor spaces than indoor spaces, and the spectrum has been I think very effective with the access tent. It's fantastic.**

Terry: **Without Mind Out we'd be completely isolated. The Mind Out has been a saviour to me and I tired of getting rejected, rejected, rejected, rejected and it is the one place that I haven't been rejected. I keep waiting for it [laughter]. I wait for it but it hasn't happened.**

(Disability focus group)

Mind out clearly provides an important service for I3 and a place where rejection has not come, although he continues to wait. Similarly spaces that cater for LGBT people who cannot be part of important events such as Pride are appreciated. The access tent (and Mind Out bus) are such spaces that enables participation in the Brighton Pride park and parade event. These would otherwise be inaccessible spaces.

There was an appreciation of the care given by Mind Out not only in terms of services provided but also the care for the wellbeing of its service users:

Terry: **Health and well-being … I think it is very important and I think MIND Out try to look after our well-being when we are at the group. They always make sure there's fresh fruit, it's good for you and try and steer you in the right direction but again that's a charity doing it's best. But where's the mainstream? where is the equivalent in the mainstream? There just isn't. You might be able to get a leaflet may be at your doctor's surgery or something. It is just, my experience is it is just not there, it is just not there. It is the voluntary groups, the agencies that are doing all the work and the rest of them I don't know what they are doing, they are getting the money but they are just sitting on their hands and just doing nothing.**

(Disability focus group)

In contrast to Mind Out and other charity and voluntary organisations, I3 believes that there is an absence of appropriate mainstream services. The appreciation for these services recognises their low funding and the absence of something that is accessible for all. In this focus group there was also a discussion of how Mind Out can reduce isolation by acting as a portal to other services, activities and events. However, Mind Out itself may not be known to all:

Eddie: **[My partner] found a website. He knew he had mental health difficulties and he went to them and they suggested he came along to this group and it is only through this group that we actually find out things otherwise we wouldn't know, you know. Nobody ever tells us.**

Terry: **[There are] periods of my life which have amounted to years where I've not been able to go to places where you can pick up Gscene. So it would have only been in a period where I was able to that I would have come across the MIND Out article in G Scene. So it does occur to me that perhaps MIND Out information could be available in other sources if it isn't, I mean it might be.**

James: **Yeah the MIND Out Group, I mean that when I found out about it; that was from a visit to Brighton before I moved here. I picked up a G Scene, saw about it in there and I got in touch with the telephone number that was on there again before I moved here. Then I came to meet the, [names a worker] anyway and that was one of the main reasons why I moved to Brighton anyway because of this group, there was nothing like it anywhere else.**

(Disabled focus group)

James says that he would not have come to Brighton if it has not been for Mind Out. He sees it as 'one of the main reasons' he migrated to the city. The uniqueness of this service, whilst a testament to Brighton & Hove is also worrying for the national mental health and wellbeing of LGBT people. However, there is a desire to see Mind Out publicised more broadly and perhaps in areas where those who feel isolated can access it. This may be particularly important for those who feel isolated and are less likely to use the LGBT scene. Other focus groups referred to referrals from friendly GP's, however, there was clearly a feeling of 'finding' Mind Out.

For some Mind Out has not been used, despite experiences of mental health difficulties. This points to issues regarding avoidance of LGBT spaces because they may not be safe:

Researcher: **Have you used Mind Out or anything like that?**

Zara: **No, actually and I'm not sure why. Again I think [PAUSE] I didn't know about it for years because I wasn't going anywhere near LGBT… I lived in Brighton for a couple of years and this is a bisexuality thing with a male partner, with a monogamous male partner. I'd moved from somewhere, I'd had a big queer circle of friends but it's incredibly hard to walk into an LGBT service when you're a girl going out with a boy and feel like you belong there. It's incredibly hard to do that. So I didn't go anywhere near anything LGBT**

Kirti: **Do you feel confident it would be appropriate for you…**

Zara: **No.**

Kriti: **.. to go to Mind Out?**

Zara: **No, actually, on grounds of bisexuality and of ethnicity stuff, both and there is a bit of me that probably should. I should go and test this out but you ask and my instinctive response is just no.**

Kriti: **Yeah, but why do you think you should go and test it out, because my instinctive response is *not* to go and test it out [LAUGHTER] because if I need support it's everything you said, you don't wanna go in there, that's the worst possible time to test it, is when you need support.**

(BME2 focus group)

For these participants going to Mind Out would need to be 'tested' out, in order to see how this service deals with bisexuality and issues of ethnicity. However, paradoxically 'trying' a service such as this out in a time when support is needed could be a potentially very damaging experience. I1 points to how difficult it is as a 'girl going out with a boy' to go anywhere near LGBT services. She also highlights issues of marginalisation that

mean that LGBT services may not be known about if you are not 'going near anything LGBT'.

However, participants realised that Mind Out cannot and should not do it all: it is only one service and there could and, perhaps, should be others to help LGBT people with mental health difficulties. Moreover, there was some indication that work should be done to avoid LGBT people having to deal with mental health difficulties by themselves. In this respect, participants drew attention to the need for better and broader understanding and appreciation of specific LGBT issues, as well the need for informal support networks that engage with different sectors of the LGBT population:

Elizabeth: **There's Mind Out, but Mind Out is only one service and obviously it has, or can have, a waiting list, there is only that service. I think it's about acceptance from others because I think that has an impact on kind of our mental health but also kind of more support available, even in the form of something informal, if that makes sense, you know, maybe a support group for… I know there's one for gay men, but there's not really anything for lesbians.**

(Pilot focus group)

8.10. Conclusion

Qualitative data indicated that the use of mental health services for LGBT people may be problematic. Yet, most of the respondents who experience some form of mental health difficulty said that they felt the need for support around their mental health difficulties in the last five years. This was particularly pertinent for those who were re-categorised into the 'mental health' category for this research. Almost a third (32%, n. 109) of those who felt the need for support said that they were unable to find it. In addition to this only 24% (n. 154) of respondents who have experienced mental health difficulties have used NHS mental health services in the last five years. An experience of depression, fear/phobias, panic attacks, self-harm or suicidal thoughts significantly increases the likelihood of having visited the NHS mental health services in the last 5 years. There was a mixed response to experiences of using NHS mental health services. Although 42% (n. 64) rated NHS mental health services poor or very poor, 37% (n. 56) rated NHS mental health services as good or very good. Those who have serious thoughts of suicide are more likely to have used NHS services over the past five years but are somewhat more likely than those who have not had serious thoughts of suicide to rate NHS mental health services as poor or very poor. Formal and informal support mechanisms were important to LGBT people in to managing their mental health difficulties. However, lack of understanding, waiting times, and stigma affected LGBT people in unhelpful ways. Throughout the focus groups Mind Out was mentioned as a service that LGBT people relied on.

From this research, it is clear that there is a need to address those who do not use mental health services, including those who may feel that they 'don't need them' because they find them unsafe. There should be a definite requirement to consider the effectiveness of NHS mental health services experienced by those who have seriously considered suicide, particularly as this group is more likely to engage with these services.

9. Housing

9.1. Introduction

Housing is a key issue for LGBT people. Count Me In Too has published a full report regarding housing and LGBT people (see Browne and Davis, 2008). This chapter will examine the key issues relating to housing and mental health. It will look at area of residence and tenure, accommodation satisfaction and difficulties, homelessness and isolation and key housing issues.

9.2. Housing composition, area of residence and tenure

People with mental health difficulties are more likely to live in areas of potential deprivation and to live in social housing. However, the majority of those who say that they need support for their mental health difficulties do not live in social housing. Those who had mental health difficulties were less likely (statistical significance $p<.05$) to live with same sex partners (35%) than those who had not experienced mental health difficulties in the past 5 years (51%).

There was a statistically significant relationship found between area of residents and mental health difficulties. Those who live in areas of potential deprivation are the most likely to have mental health difficulties (25%). 16% of those who lived in Kemptown and St. James Street have mental health difficulties and 17% of those who do not live in any of these areas. It is not possible to ascertain whether this is because LGBT people who have mental health difficulties do so because they live in these areas, or LGBT people with mental health difficulties come to live in these areas.

Similarly there are statistically significant differences between tenure and mental health difficulties. 39% of those in social housing have had difficulties with their mental health, compared to 12% of those who own their own homes and 22% of those who rent privately. Again a causal relationship cannot be established from the data and further research should explore the links between tenure and mental health difficulties. Specifically, research should explore if mental health difficulties lead to particular tenures and dependencies on social housing or if tenures can have an effect on LGBT people's mental health difficulties. 72% (n. 29) of LGBT people in social housing who have experienced mental health difficulties in the past five years have felt that they needed support for their mental health. Clearly, these difficulties need to be accounted for, supporting those in social housing.

It should be noted that in the overall sample 80% of those with mental health difficulties do not live in social housing and therefore mental health services, whilst aware of the challenges of social housing should not be limited to this tenure: in fact, 87% of those who feel that they need support for their mental health needs do not live in social housing. There was qualitative evidence that neighbourhood harassment effected mental health amongst homeowners and not only those who relied on state supported housing (see also the safety chapter).

> **Ongoing problems with a neighbour who is very homophobic. Didn't realise until after I bought my home. Don't want to give in by selling but is having a serious impact on my mental health**
>
> *(Questionnaire 519).*

22 people who have mental health difficulties have experienced abuse, discrimination or exclusion and/or have been unable to access services from housing in the past five years. Although this is not a large figure, it indicates an area of concern, particularly where housing difficulties may exacerbate mental health difficulties or mental health difficulties may result from housing difficulties.

9.3. Accommodation satisfaction and difficulties

Those with mental health difficulties (80%) were less likely to be happy in their accommodation than those who did not have mental health difficulties (90%). There were also significant differences between those who have mental health difficulties (80%) and those who do not (90%), in being satisfied with their household composition. Accommodation problems can result in, or exacerbate existing, mental health difficulties. Conversely, mental health difficulties may be an aspect of accommodation difficulties. Clearly inter agency working to support LGBT people are necessary in such circumstances.

Chapter one pointed to discrimination and prejudice as a factor in experiences of multiple marginalisation for LGBT people with mental health difficulties. Here discrimination and prejudice may play a part in explaining why those who have mental health difficulties are more likely to struggle to get accommodation (31%), than those who do not have mental health difficulties (13%, $p. < .0001$).

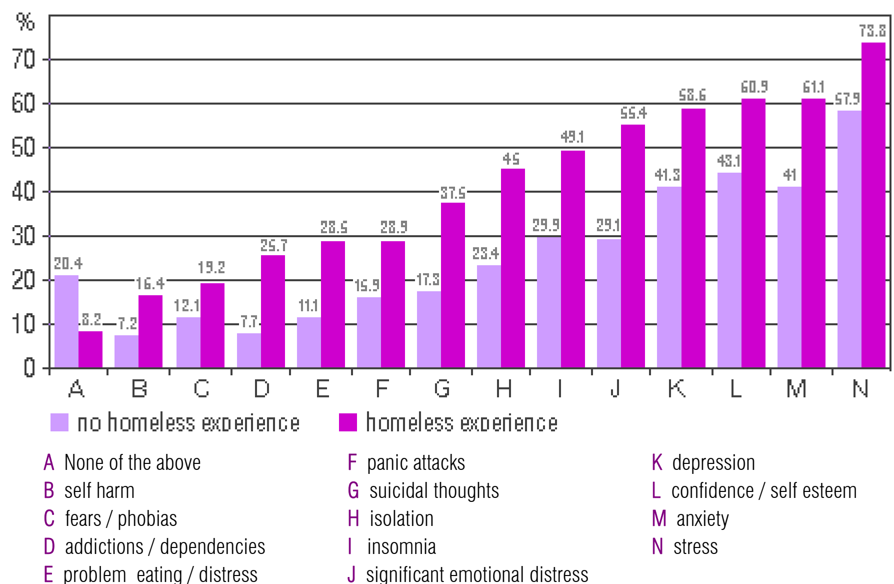
A significantly ($p < .0001$) higher proportion of LGBT people with mental health difficulties (17% compared to 5% of those who had not had mental health difficulties in the past 5 years) have specialist housing needs. Landlords can be reluctant to let to people with mental health difficulties perhaps due to concerns about the ability of those with mental health needs to manage their accommodation. This kind of discrimination is a form of ablism and should be challenged.

9.4. Homelessness

34% of those who have been homeless in Brighton & Hove in the past five years have experienced difficulties with their mental health in the past five years. 26% of those who have experienced mental health difficulties have also experienced homelessness, compared to 9% of those who have not experienced mental health difficulties (statistically significant p<.0005).

There is a statistical association between experiences of homelessness and mental health difficulties (all of the mental health difficulties listed in figure 5.12 have a significance level of p <.0001 all significant association, except anger management). Thus, those who have experienced homelessness are more likely to have had difficulties in the past five years with their mental health. Figure 5.12 illustrates the range of these difficulties and highlights the differences between those who have experienced homelessness and those who have not.

Figure 9.4a: experiences of homelessness by mental health difficulties



This data does not indicate whether experiences of homelessness have resulted in LGBT people having more difficulties with their mental health, or whether mental health difficulties have left LGBT people vulnerable to homelessness. Services dealing with LGBT people with mental health difficulties therefore should be aware of mental health difficulties associated with homelessness. Services should be aware that there could be risk of homelessness from those who have experienced mental health difficulties.

9.5. Suicide and homelessness

59% of those who have been homeless in Brighton & Hove in the past 5 years have had serious thoughts of suicide (n. 33), compared to 23% of those who have never been homeless (and have moved to Brighton & Hove in the past 5 years, $p. <.0001$). In the general population, also, those who have been homeless are at a high risk of suicide. These figures indicate a significant contemporary support need in this area.

9.6. Isolation and housing

People who felt isolated also had specific housing needs and experiences that related closely to those with mental health difficulties. Those who answered 'yes' or 'sometimes' to the question 'Do you feel isolated in Brighton & Hove?' are more likely to have changed where they live in the past five years and more likely to live alone. Those who said that they felt isolated in Brighton & Hove were also far (11%) more likely to describe the city as worse than other places they have lived in compared to those who did not feel isolated (2%), $p. =.0005$.

9.7. Conclusion

This chapter clearly illustrates that those with mental health difficulties are also more likely to have problems getting accommodation, are more likely to be dissatisfied with their place of residence and are more likely to experience homelessness. Not only does this point to experiences of multiple marginalisation, it highlights the need for effective inter agency working. Furthermore, those who are homeless are more likely to be a risk of suicide. There is some evidence that LGBT people with mental health difficulties may be unable to access services that they need in order to deal with their housing issues.

10. Safety

10.1. Introduction

Chapter one explored some of the intersections between discrimination, prejudice and exclusion and the prevalence of mental health difficulties amongst LGBT people. This chapter extends this analysis by focusing specifically on hate crime. In this research the question to assess levels of hate crime that was posed was: Have you experienced any of the following in the last 5 years that was due to your sexual orientation or gender identity:

- verbal abuse
- physical violence
- criminal damage
- harassment
- sexual assault
- negative comments
- teasing
- bullying
- other

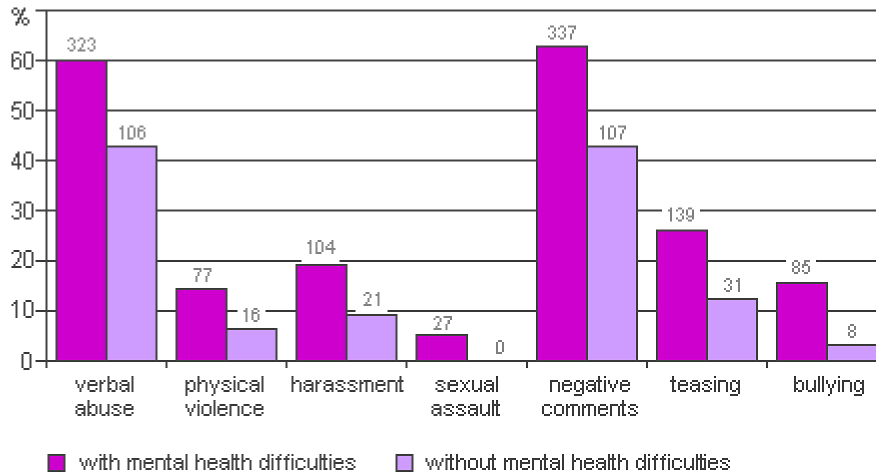
Therefore, the definition of hate crime used here is the experience of any of these forms of violence and abuse where the violence or abuse was related to the gender identity and/or sexuality of the respondent. Only the experience of hate crime in the past five years was considered in the study. This chapter will explore the links between hate crime and mental health, suicide and isolation. Although causal links cannot be established through the quantitative data, the chapter finishes by exploring LGBT perceptions of hate crimes and the links to mental health difficulties and issues. It also examines ideas of resilience and 'mental toughness' in order to cope with daily experiences of hate crime.

10.2. Mental health difficulties and hate crime amongst LGBT people

LGBT people with mental health difficulties are more likely to say they have experienced some kind of hate crime: only 22% (n. 116) of those with mental health difficulties say they had experienced no kind of hate crime over the last five years, compared to 38% (n. 95) of LGBT people with no mental health difficulties ($p = .0005$).

Those with mental health difficulties are at least twice as likely to have experienced physical violence, harassment, teasing and bullying compared with those who do not have mental health difficulties. Indeed, all the 27 respondents who say they have experienced sexual assault within the last five years also say they have experienced mental health difficulties.

Figure 10.2a: Experience of hate crime by mental health difficulties

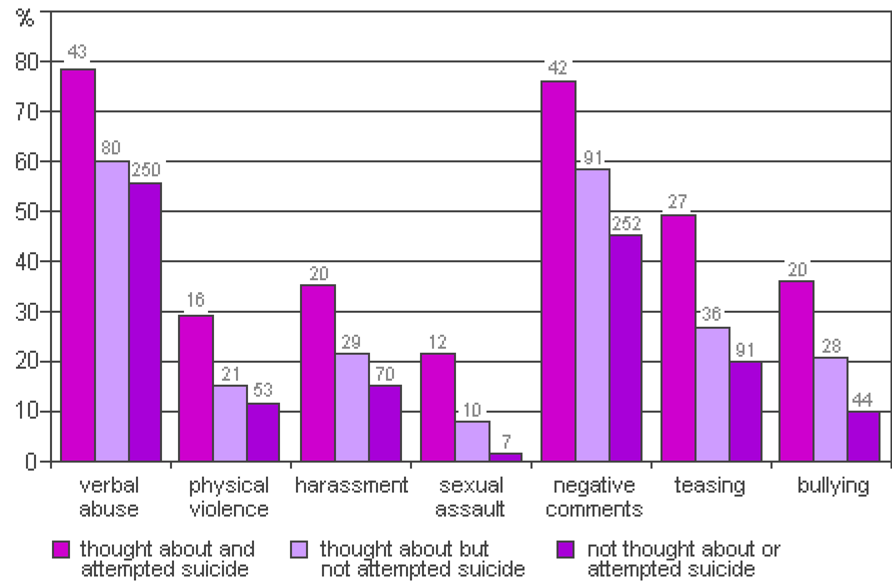


Although it cannot be ascertained whether mental health difficulties result in particular vulnerabilities to hate crime, or if hate crime results in mental health difficulties, these figures indicate a risk factor both for hate crime victims and those with mental health difficulties. Chapter 2 has explored some of the impacts of hate crime, mental health and isolation. The importance of this discussion is clear when examining these prevalence figures.

10.3. Suicide

The research indicates that those who have experienced hate crime in the past five years are more likely to have thought about and attempted suicide in the past five years than those who have not. Those who have thought about and attempted suicide in the last five years are the least likely to have experienced no incidents of hate crime on the basis of their gender or sexual identity in the last five years (7%, n. 4), with those who have thought about suicide but not attempted it within the last five years being somewhat more likely (17%, n. 23), and those who have never thought of or attempted suicide being most likely to have not experienced such hate crime within the last five years (26%, n. 118) ($p = .002$). This links to Johnson's (2007) investigation of suicidal risks amongst LGBT people. More generally, apart from criminal damage, those who have thought about and attempted suicide over the past five years are more likely to have experienced each of the categories of hate crime than those who have thought about but not attempted suicide who are, in turn, more likely to have been victims of hate crime than those who have never thought about or attempted suicide.

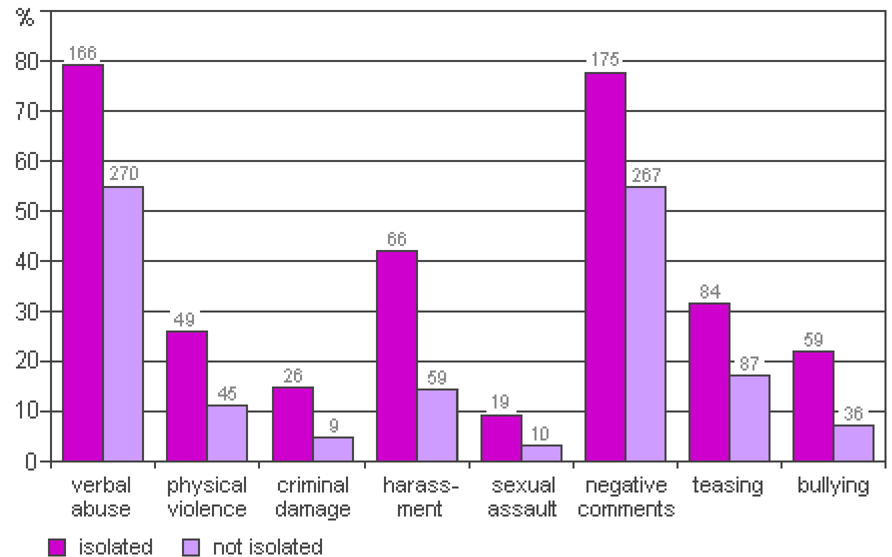
Figure 10.3a: experience of hate crime by suicidal thoughts and attempted suicide



These figures indicate that those who have experienced hate crime in the past five years are more likely to have thought about and attempted suicide in the past five years than those who have not. However, a causal relationship cannot be established and vulnerability to hate crime may result from suicidal thoughts and attempts. These figures should be read in association with Johnson's (2007) work on suicide and LGBT people.

10.4. Isolation

Figure 10.4a: experience of hate crime by feeling isolated



Those who answered 'yes' or 'sometimes' to the question 'Do you feel isolated in Brighton & Hove?' are more likely to have experienced all forms of hate crime in the past five years compared to those who have not felt isolated. Only 17% of those who feel isolated in Brighton & Hove have not

experienced hate crime, compared to 32% of those who are do not feel isolated.

Feeling isolated also has a significant relationship with the likelihood of having experienced hate crime in the following places:

10.4.1. Inside a home

19% (n. 39) of those who feel isolated have experienced hate crime inside a home in the last 12 months, compared with only 6.1% (n. 21) of those who do not feel isolated ($p < .0001$).

10.4.2. In an LGBT venue or event

Those who feel isolated are more likely (20%, n. 42) to have experienced hate crime in an LGBT venue or event than those who do not feel isolated (7%, n. 24) ($p < .0001$).

10.4.3. In a mainstream venue or event

22% (n. 45) of those who feel isolated have experienced hate crime within a mainstream venue or event within the last 12 months, compared to 15% (n. 50) of those who do not feel isolated ($p = .02$).

10.4.4. At school/college/university

11% (n. 22) of those who feel isolated have experienced hate crime at school, college or university within the past 12 months, compared to 6% (n. 19) of those who do not feel isolated ($p = .05$).

10.4.5. In your neighbourhood

Those who feel isolated are more likely (31%, n. 64) to have experienced hate crimes within their local neighbourhoods than those who do not feel isolated (16%, n. 56) ($p < .0001$).

10.4.6. Mental Health

Those with mental health difficulties are more likely to report an incident (29%) compared to those who have not had difficulties with their mental health in the past five years (15%; $p = .001$).

10.4.7. Isolation

There was a significant difference between those who feel isolated and those who do not feel isolated in the reporting of hate crimes ($p = .02$). 31% of those who feel isolated and who had experienced hate crime had reported an incident (n. 68). This compares to 21% (n. 77) of those who do not feel isolated in Brighton & Hove.

10.5. Emotional 'toughness' and mental health and wellbeing

Dealing with hate crime can take emotional 'toughness':

> **Just that there are some silly people about and don't back down to them. I'm a tough person emotionally.**
>
> *(Questionnaire 833)*

Coping with hate crime from 'silly people' may require confrontation and 'not backing down', but this may only be achieved through particular emotional stability and resilience. In this questionnaire, the person needed to be 'tough' to cope with the experiences that were downplayed in the phrase 'silly people'.

This emotional toughness can also have emotional costs:

> Sue: **I'm thankfully in a relationship where we just carry on as normal really and if we want to hold hands we do. However, I mean there can be incidents can't there and, you know, there still are. I don't think it's that safe, only a year ago my - well, less than that maybe - my partner was challenged by three teenage girls, "Are you a lesbian?" you know, "Are you a dyke?" in the street, and she took a long route home, she didn't even walk home, really like to lose them and I think there's a lot of fear out there. Although I go out there and I'm myself and I'm buggered really if the world's going to not allow me to be who I am, but there is a cost isn't there, there's an emotional [cost], I think.**
>
> *(Pilot focus group)*

Sue acknowledges that there will be 'incidents' and in her challenging of these incidents she realises there are emotional costs to both her and her partner. This may mean having to walk a long way home to avoid being followed and also perseverance with strategies that require 'toughness'. Where the 'world' does not allow her to be 'who she is', there is a constant tension and battle. This can go unnoticed, unremarked upon or simply be ignored, yet there are emotional costs to all these strategies.

Not all have the ability to deal with these situations in 'tough' ways. For these people the costs can be far higher than for others who may have similar experiences:

> **Extra support for vulnerable people that may be affected by what may be a minor incident to others but that can greatly affect a vulnerable person, i.e. verbal homophobia could trigger off severe anxiety attacks in a vulnerable person**
>
> *(Questionnaire 16)*

Questionnaire 16 notes that there are people who are emotionally vulnerable such that experiences of hate crime may result in increased support needs and these cannot simply be 'ignored' or downplayed. In these contexts, hate crime can have very different effects depending on the vulnerability of people and can seriously affect a person's mental health and well being. It is again important to note that mental health difficulties can both result from, and be caused by, experiences of hate crime.

Hate crime attacks can result in isolation and a need for statutory services and support networks:

> **This attack, by the partner of a one-time friend left me badly shaken. It happened during a hot August afternoon on Brighton seafront. I didn't go out on the scene for two years and have been depressed and needed counselling**
>
> *(Questionnaire 285)*

Isolation can result from hate crime, as well as depression. In this respondents case this left them needing counselling and support for their mental health difficulties that resulted from an attack. In addition, other respondents reported that attacks left them depressed, anxious and suicidal with post-trauma problems including avoiding going out and keeping away from areas of the city perceived to be unsafe.

Ongoing harassment can have serious implications for mental health and wellbeing amongst LGBT people. Although often associated with street crime, experiences of hate crime can be exacerbated when the harassment occurs in the home and particularly for those who are vulnerable and in social housing:

Tracey: **…getting shouted out you know like on the balcony as you are walking down the road, 'oh you fucking poof' and all that and 'go back to Lesbos land' and you know it was getting … it went on for about six years and it was just having all these hassles and that, they were writing dirty letters to me and everything…**

(Mental Health Focus Group)

The impacts of hate crime, mental toughness and emotional costs can also have effects on people's responses to other forms of crime that are unrelated to their sexuality. Such crimes can have effects directly upon a person's life and health, and other effects can include not reporting/talking about these crimes, a level of tolerance and acceptance of all crime, and a fear of reporting to the police because of who you are rather than the crime committed. This all needs further exploration.

10.6. Feelings of safety and avoidance behaviours

Safety is not simply an absence of violence. Fear of crime can have implications for quality of life and avoidance of particular spaces, venues and behaviours has implications for quality of life. This can also result in, and from, isolation and increase mental health difficulties. Dan (above, chapter 7) spoke of his isolation and the relationships between this and his experiences of hate crime. In this section, the focus is on the qualitative data which highlights a clear link between fear of crime, avoidance behaviours and isolation and mental health difficulties.

10.6.1. Isolation

Those who answered 'yes' or 'sometimes' to the question 'Do you feel isolated in Brighton & Hove?' feel less safe outside in Brighton during the day and outside in Brighton at night (both $p = .0005$). They are more likely to feel unsafe in services, facilities and places in Brighton & Hove and are significantly more likely to feel unsafe outside LGBT venues.

While 74% (n, 193) of those who feel isolated at least some of the time felt safe outside in Brighton during the day, 93% (n. 486) of those who do not feel isolated felt safe outside in Brighton during the day. 6% (n. 15) of those who feel isolated at least some of the time felt unsafe outside in Brighton during the day, compared to 1% (n. 5) of those who do not feel isolated.

29% (n. 76) of those who feel isolated at least some of the time felt safe outside in Brighton during the night, compared to 56% (n. 290) of those who do not feel isolated. A similar strong contrast is apparent in the figures for feeling unsafe: 33% (n. 85) of those who feel isolated feel unsafe outside in Brighton at night, compared to 11% (n. 57) of those who do not feel isolated.

Those who feel isolated are more likely to feel unsafe in some places, services or facilities in Brighton & Hove (67%, n. 145) than those who did not feel isolated (47%, n. 16, $p < .0001$).

Those who feel isolated are significantly more likely (32%, n. 48) to feel unsafe outside LGBT venues than those who did not feel isolated (20%, n. 34) ($p = .03$). This clearly has implications for the use of these venues and connections to LGBT communities. This issues of multiple marginalisation are apparent here and can both result from and result in further isolation from networks and communities.

10.6.2. Mental health difficulties

Those who have mental health difficulties are more likely to feel less safe in services, facilities or places in Brighton & Hove and are also more likely to feel unsafe outside of LGBT venues compared to other LGBT people. 36% (n. 88) of those who have no mental health difficulties do not feel safe in some places, services or facilities in Brighton & Hove, compared to over half (52%, n 273) of those who have experienced mental health difficulties

(p.=.0005) Those with mental health difficulties (30% n. 79) are more likely to feel unsafe outside LGBT venues than those who do not have mental health difficulties (22%, no. 10 p. =.004)

10.7. Avoidance behaviours

There are differences between different groups of LGBT people in terms of their likelihood of avoiding going out at night. Those who have mental health difficulties and who feel isolated are more likely to avoid going out at night. Those who feel isolated are also more likely to avoid public displays of affection.

Those who do not have mental health difficulties (20%, n. 49) are less likely to avoid going out at night than those that have mental health difficulties (34%, n. 177). Similarly there is a significant relationship between feelings of isolation and the avoidance of going out at night ($p < .0001$). The data shows, quite starkly, that those who feel isolated are much more likely to avoid going out at night at least sometimes (53%, n. 115) than those who do not feel isolated (19%, n. 68).

Those who feel isolated are more likely to avoid public displays of affection than other LGBT people. 87% (n. 186) of those who feel isolated also at least sometimes avoided public displays of affection. This compares with 74% (n. 262) of those who do not feel isolated ($p < .001$).

This of course has implications on quality of life and it is perhaps unsurprising that the responses of those who feel isolated are starkly different from those who are not. It is not possible to conclude whether avoidance of going out at night because of safety fears lead to isolation or if feeling isolated resulted in fears of going out at night. Similarly for mental health, it cannot be ascertained whether fear of going out results from mental health difficulties or mental health difficulties result from fears of going, although for some their attribution was clear:

> **My anxiety disorder is largely to blame for my feeling unsafe in public places, straight places, or around common people. Or feeling trapped**
>
> *(Questionnaire 207)*

10.8. Police and prejudice

Despite the positive accolades for recent police improvements and the general sense that the police are getting better, those who feel isolated and experience mental health difficulties are more likely to perceive that there is prejudice against LGBT people within the police. 21% of all respondents agreed that there was prejudice against LGBT people from the police, with 37% saying that there wasn't, with 42% unsure. This response varied between LGBT people. Those who feel isolated (33%) are more likely to say that there is prejudice in the police services than LGBT respondents who do not feel isolated (20%, $p<.0001$). Those who experience mental health

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difficulties are also more likely (24% compared to 13%) to say that there is prejudice against the LGBT people by or from the police ($p<.0001$). Tracey in the mental health focus group said:

Tracey: **The police don't do much. They love arresting you but they don't do much and they …**

(Mental health focus group)

Clearly people with mental health difficulties can have different experiences of the police and police services. However, it should also be noted that police interactions with those who have mental health difficulties may not always be positive. For Tracey, whilst the police 'love arresting you' they don't do 'much' about hate crime. She drew on her experiences of hate crime to illustrate this.

These figures and experiences can indicate an alienation from police services where individuals are already vulnerable to experiences of hate crime. It can also point to the importance of other services in reporting hate crime.

10.9. Conclusion

This chapter highlights that those with mental health difficulties may also experience increased levels of hate crime. It suggests that hate crime can lead to increased suicidal risks and isolation. Moreover, it supports the assertions from chapter one and in some literature (Johnson et al., 2007, Warner et al., 2004) that mental health difficulties can result from hate crime experiences. Yet it should not be forgotten that mental health difficulties can result in the targeting of individuals and increase vulnerabilities to abuse, violence and discrimination. Fear of crime can also result in a reduced quality of life and result in and from mental health difficulties and isolation. This chapter has shown that those who feel isolated can fear crime more and use avoidance behaviours to avoid particular places and activities. This can result in further isolation and potentially increased mental health difficulties. Finally, the chapter pointed to the negative associations between LGBT people who experience mental health difficulties and those who feel isolated, and the perceptions of prejudice within the police against LGBT people. This clearly has ramifications for the reporting of hate crime and how LGBT people who feel isolated and who experience mental health difficulties engage with the police.

11. Services and people with mental health difficulties

11.1. Introduction

This chapter will explore the relationships between experiences of mental health difficulties among LGBT people and their experiences of using different services in Brighton & Hove. It will investigate the friendliness of voluntary and council and other services, how comfortable LGBT people with mental health difficulties feel using these services and finally how LGBT people with mental health difficulties feel about the monitoring of their gender/sexual identities.

11.2. Friendliness of services

Table 11.2a outlines the perceptions of the LGBT friendliness of voluntary sector services by LGBT people. This shows that the majority of respondents either had no opinion (neither friendly nor unfriendly) or found these services friendly/very friendly.

Table 11.2a: Voluntary Sector services

	Frequency	Percent
Very friendly	155	18.9
Friendly	295	36.0
Neither friendly nor unfriendly	278	33.9
Unfriendly	8	1.0
Very unfriendly	2	.2
Total	738	90.1
Missing	81	9.9
Total	819	100.0

Opinions of LGBT people with mental health difficulties, who have thought about suicide and who have attempted suicide are not significantly different about how friendly they find voluntary services. There were also no significant relationships between any specific category of mental health difficulty and how LGBT friendly respondents found LGBT specific services and groups. If we take the following groups:

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- those who have not experienced any mental health difficulties;
- those who have experienced mental health difficulties but have had no serious thoughts of suicide;
- those who have had serious thoughts of suicide but have not attempted suicide; and
- those who have thought about and attempted suicide in the last five years,

over 70% of respondents in each of these groups found LGBT specific services and groups LGBT friendly or very LGBT friendly; and less than 30% of respondents in each of these groups found LGBT specific services and groups unfriendly or very unfriendly.

11.3. Council and Other Public Services

Moving from the voluntary to the statutory sectors, those who are at risk of suicide are more likely to find the council and other public services unfriendly. There are also differences by mental health difficulties, namely, those who have experienced significant emotional distress, depression, stress, anger management, fears and phobias, problem eating/eating distress and panic attacks are less likely to find the council and other public services friendly. This of course has implications for the use of these services and their engagements with LGBT people at risk of suicide and with mental health difficulties.

Those who have thought about and attempted suicide in the last five years are the most likely (47%, n. 24) to find council and other public services LGBT unfriendly or very unfriendly. These rates are not dissimilar to those of people who have had serious thoughts of suicide but not attempted it (45%, n. 55). Those with mental health difficulties but who have had no serious thoughts of suicide (46%, n. 188) also found council and public services LGBT unfriendly or very unfriendly. The group significantly least likely to find council and public services LGBT unfriendly or very unfriendly are those who have not experienced any mental health difficulties in the last five years (35%, n. 45) ($p < .0001$).

11.3.1. Significant emotional distress

Compared to those who have not experienced difficulties with significant emotional distress over the past five years, those who have experienced this are slightly more likely to find council and other public services LGBT unfriendly (5%, n. 12 compared to 2%, n. 8) or very LGBT unfriendly (2%, n. 6 compared to <1%, n. 4). However, these rates are low for both groups. More notably, while a slightly higher proportion of those who have experienced significant emotional distress found council and other public services LGBT friendly (38%, n. 100 against 35%, n. 168 for those who had not experienced significant emotional distress), a significantly lower proportion (11%, n. 29) compared to those who had not suffered significant emotional distress (20%, n. 97) found council and other public services very LGBT friendly ($p = .001$).

11.3.2. Depression

Respondents who have experienced depression over the past five years are significantly less likely to find council and other public services very LGBT friendly (13%, n. 42, compared to 20%, n. 84 for those who are not depressed) ($p = .004$). They are also slightly more likely than those who do not experience depression to find council and other public services LGBT unfriendly (4%, n. 14, compared to 2%, n. 6) or very LGBT unfriendly (2%, n. 6, compared to 1%, n. 2).

11.3.3. Stress

Respondents who experience difficulties with stress are less likely than those who do not experience stress to find council and other public services very LGBT friendly (14%, n. 66, compared to 21%, n. 60) or LGBT friendly (34%, n. 157, compared to 39%, n. 111) ($p = .008$). They are also slightly more likely than those who do not experience difficulties with stress to find council and other public services LGBT unfriendly (4%, n. 16, compared to 1%, n. 4) or very LGBT unfriendly (2%, n. 7, compared to <1%, n. 1).

11.3.4. Anger management

Those who experience difficulties with anger management are less likely to find council and other public services very LGBT friendly (10%, n. 9, compared to 18%, n. 117) than those who do not experience difficulties with anger management ($p = .002$). They are also slightly more likely to find council and other public services LGBT unfriendly (6%, n. 5, compared to 2%, n. 15) or very LGBT unfriendly (4%, n. 4, compared to 1%, n. 4).

11.3.5. Fears and phobias

Those who experience fears and phobias are less likely than those who do not experience fears and phobias to find council and other public services very LGBT friendly (12%, n. 13, compared to 18%, n. 113). They are also more likely than those who do not experience difficulties with fears and phobias to find council and other public services LGBT unfriendly (8%, n. 8, compared to 2%, n. 12) or very unfriendly (4%, n. 4, compared to 1%, n. 4) ($p < .001$).

11.3.6. Problem eating/eating distress

11% (n. 12) of those who experience problem eating or eating distress find council and other public services very LGBT friendly, significantly less than the 18% (n. 114) of those who do not experience problem eating or eating distress. They are also slightly more likely than those who do not experience problem eating or eating distress to find council and other public services LGBT unfriendly (5%, n. 6, compared to 2%, n. 14) or very unfriendly (4%, n. 4, compared to 1%, n. 4) ($p = .005$).

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11.3.7. Panic attacks

Those who experience panic attacks are less likely to find council and other public services LGBT friendly (31%, n. 44) or very LGBT friendly (14%, n. 20) than those who do not experience panic attacks (37%, n. 224 and 18%, n. 106, respectively). They are also slightly more likely than those who do not experience panic attacks to find council and other public services LGBT unfriendly (4%, n. 6, compared to 2%, n. 14) or very LGBT unfriendly (4%, n. 5, compared to 1%, n. 3) (p = .007).

11.4. Feelings of comfort when using services

Those who have thought about and attempted suicide, who have had serious thoughts of suicide but have not attempted it, are almost twice as likely to say they feel uncomfortable and/or excluded using mainstream public services compared to other LGBT people. When looking at specific types of mental health difficulties, those who experience significant emotional distress; depression; anxiety; stress; fears and phobias; problem eating/eating distress; panic attacks; self harm are more likely to say that they feel excluded or uncomfortable using mainstream services than other LGBT people.

11.4.1. Suicide risk

Table 11.4a: Do you ever feel excluded / uncomfortable using mainstream (public but not LGBT specific) services?

		No mental health difficulties in last 5 years	Thought about and attempted suicide	Thought about but not attempted suicide	Mental health difficulties, but no thoughts of suicide	Total
Yes, but not because of my sexuality / gender identity	No.	14	14	25	62	115
	%	10.4	26.4	19.5	14.5	15.5
Yes, because of my sexuality / gender identity	No.	12	15	32	69	128
	%	9.0	28.3	25.0	16.1	17.2
No	No.	92	15	46	232	385
	%	68.7	28.3	35.9	54.2	51.8
I don't know	No.	16	9	25	65	115
	%	11.9	17.0	19.5	15.2	15.5
Total	No.	134	53	128	428	743
	%	18.0	7.1	17.2	57.6	100
	%	100	100	100	100	100

28% (n. 15) of those who have thought about and attempted suicide in the last five years say that they have felt excluded or uncomfortable using mainstream (public, but not LGBT specific) services because of their sexual and/or gender identity (see table 11.4a). A quarter (25%, n. 32) of those who have had serious thoughts of suicide but who have not attempted it have

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also felt excluded or uncomfortable using mainstream services because of their sexual and/or gender identity. These two rates are significantly higher than for those who have experienced mental health difficulties but have had no serious thoughts of suicide (16%, n. 69) and those who have not experienced any mental health difficulties over the past five years (9%, n. 12).

11.5. Mental health

11.5.1. Significant emotional distress

Those who have experienced difficulties with significant emotional distress in the past five years are significantly more likely (24%, n. 63) to say that they have felt excluded or uncomfortable using mainstream services because of their sexual or gender identity than those who have not experienced significant emotional distress (14%, n. 70) ($p < .0001$).

11.5.2. Depression

Respondents who have experienced depression in the past five years are significantly more likely (23%, n. 79) to say that they have felt excluded or uncomfortable using mainstream services because of their sexual or gender identity than those who have not experienced depression (13%, n. 54) ($p < .0001$).

11.5.3. Anxiety

Respondents who have experienced difficulties with anxiety in the past five years are significantly more likely (20%, n. 70) to say that they have felt excluded or uncomfortable using mainstream services but *not* because of their sexual or gender identity than those who have not experienced difficulties with anxiety (12%, n. 51). They are also slightly more likely (18%, n. 63) to say that they have felt excluded or uncomfortable using mainstream services because of their sexual or gender identity than those who have not experienced difficulties with anxiety (16%, n. 70) ($p = .003$).

11.5.4. Stress

Respondents who have experienced difficulties with stress in the past five years are significantly more likely (20%, n. 96) to say that they have felt excluded or uncomfortable using mainstream services because of their sexual or gender identity than those who have not experienced difficulties with stress (13%, n. 37) ($p = .001$).

11.5.5. Fears and phobias

Those who have experienced difficulties with fears and phobias are significantly more likely (30%, n. 32) to say that they have felt excluded or uncomfortable using mainstream services because of their sexual or gender identity than those who have not experienced difficulties with fears and phobias (15%, n. 101) ($p < .0001$).

11.5.6. Problem eating/eating distress

Those who have experienced problem eating or eating distress in the past five years are significantly more likely (23%, n. 27) to say that they have felt excluded or uncomfortable using mainstream services because of their sexual or gender identity than those who have not experienced difficulties with problem eating or eating distress (16%, n. 106) ($p = .001$).

11.5.7. Panic attacks

Respondents who have experienced difficulties with panic attacks in the past five years are slightly more likely (20%, n. 29) to say that they have felt excluded or uncomfortable using mainstream services because of their sexual or gender identity than those who have not experienced difficulties with panic attacks (17%, n. 104). They are also significantly more likely (22%, n. 32) than those who have not suffered difficulties from panic attacks (14%, n. 89) to say that they have felt excluded or uncomfortable using mainstream services but *not* because of their sexual or gender identity ($p = .04$).

11.5.8. Self harm

Respondents who have experienced difficulties with self harming in the past five years are more likely (24%, n. 17) to say that they have felt excluded or uncomfortable using mainstream services because of their sexual or gender identity than those who have not experienced difficulties with self harming (17%, n. 116). They are also more likely (24%, n. 17) than those who have not suffered difficulties from self harming (15%, n. 104) to say that they have felt excluded or uncomfortable using mainstream services but *not* because of their sexual or gender identity ($p < .0001$).

There are no significant relationships between either anger management or addictions/dependencies and the likelihood of feelings of exclusion and discomfort in using mainstream services.

11.6. LGBT specific services

There were no significant differences between the desire to use LGBT services and mental health difficulties or suicidal risk (see Browne, 2007 for a full breakdown of these categories for the overall sample). Moreover, except for fears and phobias, there is no significant relationship between any of the specific types of mental health difficulty (significant emotional distress; depression; anxiety; stress; anger management; problem eating/eating distress; panic attacks; self harm; addictions/dependencies) and preference for types of services.

11.6.1. Fears and phobias

Those who experience difficulties with fears and phobias are less likely (24%, n. 26) to say that their sexuality or gender identity is unimportant to their use of services than those who do not experience difficulties with fears and phobias (34%, n. 227). They are also more likely to express a preference for LGBT specific services (run for LGBT people) than those do not experience difficulties with fears and phobias (21%, n. 22, compared to 11%, n. 72) (p = .03).

11.7. Monitoring

Perhaps unsurprisingly, given the results regarding the friendliness of mainstream services and the levels of comfort LGBT people who have mental health difficulties have in mainstream services, LGBT people with mental health difficulties are more likely to say that their willingness to provide monitoring data depended on the LGBT friendliness of the service in question. They are also more likely to say that they will never give this information.

Table 11.7a shows that there are significant differences between those who experience mental health difficulties and those who do not in terms of their willingness to provide information to services for monitoring purposes (p = .01). For this question, mental health difficulties are defined as including:

- Significant emotional distress
- Depression
- Anxiety
- Anger management
- Fears/phobias
- Problem eating/eating distress
- Panic attacks
- Self harm
- Addictions/dependencies
- Suicidal thoughts

The difficulties 'isolation', 'confidence/self esteem', 'stress', 'insomnia', as well as the category 'none of the above' are not included in the definition for this particular analysis.

Those who experience mental health difficulties are more likely (27%, n. 145) than those who do not experience difficulties with their mental health (22%, n. 54) to say that their willingness to provide monitoring information depended on how LGBT friendly they thought the service in question was. 7% (n. 38) of those who experience mental health difficulties said they would be willing to provide monitoring information 'sometimes', compared to 14% (n. 35) of those who do not experience mental health difficulties. There is little difference, however, in the percentages of each group willing to provide monitoring information 'always' or 'if the information was anonymous and confidential'. However those with mental health difficulties (6%) are also more likely to say that they will never give information regarding their sexual/gender identities for monitoring purposes.

Table 11.7a: Willingness to provide information regarding sexual/ gender identities to services for monitoring purposes by mental health difficulties

		No mental health difficulties	Mental health difficulties	Total
Yes, always	No.	100	207	307
	%	40.7	38.8	39.4
Yes, if the information was anonymous and confidential	No.	48	109	157
	%	19.5	20.5	20.2
It would depend on how LGBT friendly I thought the service was	No.	54	145	199
	%	22	27.2	25.5
Sometimes	No.	35	38	73
	%	14.2	7.1	9.4
Never, don't know or other	No.	9	34	43
	%	3.7	6.4	5.5
Total		246	533	779
		100	100	100

11.8. Conclusion

There were no differences in LGBT people's opinions on the basis of the friendliness of voluntary sector services according to their experience of mental health issues. When looking at public services, those who have thought about and attempted suicide in the last five years are the most likely (47%, n. 24) to find council and other public services unfriendly towards LGBT people. Those who have experienced significant emotional distress, depression, stress, anger management, fears and phobias, problem eating/eating distress and panic attacks are less likely to find the council and other public services friendly than LGBT people who have not experienced these difficulties. Moreover, those who have thought about and attempted suicide, who have had serious thoughts of suicide but have not attempted it, are more likely to say they feel uncomfortable and/or excluded using mainstream public services compared to other LGBT people. Those who experience significant emotional distress; depression; anxiety; stress; fears and phobias; problem eating/eating distress; panic attacks; self harm are more likely to say that they feel excluded or uncomfortable using mainstream services than other LGBT people.

This could indicate a disengagement from these services; it could also point to a dissatisfaction with the services received. This area needs to be further addressed to establish how LGBT people with mental health difficulties and at risk of suicide engage with services and the experiences they have had. This of course needs to be undertaken sensitively in LGBT friendly environments as this research found (perhaps unsurprisingly), that LGBT people with mental health difficulties are more likely to say that their willingness to provide monitoring data depended on the LGBT friendliness of the research.

12. Conclusions

This report has shown that mental health continues to be an important issue for LGBT people, and has links to prejudice and discriminations. In this chapter the key points from all the chapters will be drawn together. Areas of vulnerability will be discussed and specific vulnerabilities addressed on the basis of particular identities and experiences.

12.1. Key points from the report

Understandings of mental health have historically pathologised LGBT people associating gender and sexual identities with psychological dysfunctions. This continues to this day and has implications not only for service provision but can also result in mental health difficulties and vulnerabilities. Being an LGBT person with mental health difficulties can result in multiple issues of marginalisation which includes discrimination, prejudice and isolation from LGBT people, networks and spaces.

The majority of LGBT people in this sample experienced some form of mental health difficulty in the past 5 years. This varied from 60% of LGBT people experiencing stress to 9% saying that they had difficulties with self harm. Most LGBT people who experience mental health difficulties experience more than one area of difficulty.

Not all LGBT people experience mental health difficulties and some groups are more vulnerable than others. Bisexuals, queer and those who identified as 'other' in terms of sexualities, trans people, BME people, those with a low income and those who feel isolated are more likely than other LGBT people to have experienced difficulties with their mental health in the past five years.

This research found that 23% of LGBT people have suicidal thoughts with 7% attempting suicide in the past 5 years. Risks of suicide and suicidal vulnerabilities vary within the LGBT collective. Bisexual, queer and those who identified as 'other' in terms of sexuality, trans people, young people, those who feel isolated, those on a low income and those who are disabled and/or long term health impaired are more likely to have experienced suicidal thoughts and often to have attempted suicide also. Predictors of suicidal thoughts are depression, self-harm and isolation. Self harm is also a predictor of suicidal attempts.

This research found that those who have experienced domestic violence are more likely to have experienced difficulties with their mental health in the past five years. They are also more likely to have thought of and attempted suicide. Just under half (48%) of those who answered the question said that they had experienced child abuse. It found clear links

between mental health difficulties and experiences of child abuse from a family member or someone close to you. When a person has experienced child abuse, the odds of experiencing depression, anxiety, self-harm and suicidal thoughts at the least double. This research therefore points to the significant risk factors of domestic violence and abuse and child abuse in mental health difficulties. Although a causal relationships cannot be ascertained for domestic violence and abuse and mental health difficulties (such that those who experience mental health difficulties may be more vulnerable to domestic violence and abuse and vice-versa), it is possible to contend that child abuse can predict risk in experiences of depression, anxiety, self-harm and suicidal thoughts.

Isolation is a key issue for some LGBT people. There is evidence in this research that suggests that there is a link between multiple marginalisations and feelings of isolation. Those who are who identified as 'other' in terms of sexuality in terms of sexuality, who are trans, BME identified people and traveller and other ethnic groups deaf LGBT people, those on a low income and those who are disabled or long term health impaired are more likely to feel isolated. Following from this, those who feel isolated are less likely to enjoy using the LGBT scene and more likely to say that they don't use the scene that those who do not feel isolated in Brighton & Hove. Respondents suggested one way of overcoming the isolation felt by some LGBT people, would be to focus away from the scene for LGBT activities, including the formation of sexual and other relationships.

The use of mental health services by LGBT people may be problematic. Yet, most of the respondents who had experienced some form of mental health difficulty said that they had felt the need for support around their mental health difficulties in the last five years. This was particularly pertinent for those who were re-categorised into the 'mental health difficulties' category for this research. Almost a third (32%, n. 109) of those who felt the need for support said that they were unable to find it. In addition to this only 24% (n. 154) of respondents who had experienced mental health difficulties have used NHS mental health services in the last five years. Experiences of depression, fear/phobias, panic attacks, self-harm or suicidal thoughts significantly increased the likelihood of having visited the NHS mental health services in the last 5 years. There was a mixed response to the use of NHS mental health services. Although 42% (n. 64) rated NHS mental health services poor or very poor, 37% (n. 56) rated NHS mental health services as good or very good. Those who have serious thoughts of suicide are more likely to have used NHS services over the past five years, but are somewhat more likely than those who have not had serious thoughts of suicide to rate NHS mental health services as poor or very poor.

Formal and informal support mechanisms were important to LGBT people in to managing their mental health difficulties. However, lack of understanding, waiting times, and stigma affected LGBT people in unhelpful ways.

Throughout the focus groups Mind Out was mentioned as a service that LGBT people relied on. There is a clear need to address those who do not use mental health services, including those who may feel that they 'don't need them', because they find them unsafe. In addition, there should be requirement to consider the effectiveness of NHS mental health services

experienced by those who have seriously considered suicide, particularly as this group is more likely to engage with these services.

Those who have experienced some form of mental health difficulty are more likely to smoke, be concerned with their alcohol use and want greater control over their drug use than those who have not experienced mental health difficulties. Those who experience mental health difficulties are also more likely (82%, n. 435) than those who do not experience mental health difficulties (73%, n. 184) to express a desire to be more physically active. This indicates that health initiatives should work with mental health services in order to provide a range of services for LGBT people who have mental health difficulties and also to ensure that regardless of the point of contact LGBT people can find the correct range of services that meets their needs. It may also indicate areas of working and future initiatives that could be undertaken across services. Almost half of those with mental health difficulties (48%, n. 261) would like to use a GP clinic/service that specifically caters for LGBT people and almost all want an LGBT healthy living centre (see chapter 7). Mental health is indicated by the highest proportion of respondents as being the top priority to improve health and wellbeing in Brighton & Hove in the next five years. 33% of those who do not experience mental health difficulties said that this was a top priority for the improvement of LGBT health and wellbeing.

This research clearly illustrates the link between mental health difficulties and housing. Those with mental health difficulties are also more likely to have problems getting accommodation, are more likely to be dissatisfied with their place of residence and are more likely to experience homelessness. Not only does this point to experiences of multiple marginalisation, it highlights the need for effective inter-agency working. Furthermore, those who are homeless are more likely to be a risk of suicide. There is some evidence that LGBT people with mental health difficulties may be unable to access services that they need in order to deal with their housing issues.

This research shows that those with mental health difficulties may also experience increased levels of hate crime. It suggests that hate crime can lead to increased suicidal risks and feelings of isolation. Moreover, it supports the assertions that mental health difficulties can result from hate crime experiences. Yet it should not be forgotten that mental health difficulties can result in the targeting of individuals and increase vulnerabilities to abuse, violence and discrimination. Fear of crime can result in a reduced quality of life. Fear of crime can both result in and be a result of mental health difficulties and isolation. This research has found that LGBT people who feel isolated are more likely to fear crime and use avoidance strategies than other LGBT people. In addressing LGBT safety these issues are important considerations. LGBT people with mental health difficulties and those who feel isolated are more likely to think that there is prejudice within the police against LGBT people. This clearly has ramifications for the reporting of hate crime and how LGBT people who feel isolated and with mental health difficulties engage with the police.

Although there was no differences found between LGBT people on the basis of the friendliness of voluntary sector services, when looking at public services, those who have thought about and attempted suicide in the last five years and those who have experienced significant emotional distress, depression, stress, anger management, fears and phobias,

problem eating/eating distress and panic attacks are less likely to find the council and other public services friendly than other LGBT people. Moreover, those who have thought about and attempted suicide, who have had serious thoughts of suicide but have not attempted it, are more likely to say they feel uncomfortable and/or excluded using mainstream public services compared to other LGBT people. Those who experience significant emotional distress; depression; anxiety; stress; fears and phobias; problem eating/eating distress; panic attacks; self harm are more likely to say that they feel excluded or uncomfortable using mainstream services than other LGBT people. This could indicate a disengagement from these services, it could also point to a dissatisfaction with the services received. This area needs to be further addressed to establish how LGBT people with mental health difficulties and at risk of suicide engage with services and the experiences they have had. This of course needs to be undertaken sensitively in LGBT friendly environments as this research found (perhaps unsurprisingly), that LGBT people with mental health difficulties are more likely to say that their willingness to provide monitoring data depended on the LGBT friendliness of the research.

12.2. Details of specific marginalised groups

12.2.1. Sexuality

Lesbians / gay women (65%) and gay men (64%) were far more likely to describe their emotional and mental wellbeing as good / very good in the last 12 months compared to those identifying as bisexual (57%) and queer (48%).

Lesbians are more likely (35%, n. 95) than gay men (29%, n. 122) to have experienced significant emotional distress, but are similar in the other measures of mental health difficulties. Although bisexuals and queers are more likely than lesbians and gay men to have experienced those significant emotional distress, depression, anxiety, isolation, confidence/self-esteem, anger management, insomnia, fears/phobias, panic attacks, self-harm, addictions/dependencies, and suicidal thoughts, those who are identify as 'other' in terms of sexuality are more likely than all these groups to have experienced these difficulties. Although at times proportions of queer and bisexual people are close to those of who identified as 'other' in terms of sexuality in experiences of mental health difficulties, problem eating disorders is the only mental health difficulty in which they are the group most likely to experience this.

Bisexual, queer and those who identified as 'other' in terms of sexuality are more likely to have serious thoughts of suicide and attempted suicide in the past 5 years and in the past 12 months. This suggests that these groups are more vulnerable and at risk of suicide than lesbians and gay men.

Those who are who identified as 'other' in terms of sexuality in terms of sexuality are the most likely to feel isolated in Brighton & Hove (61%). This is over twice the proportion of lesbians (30%) and gay men (34%, p. = .002). Bisexual (41%) and queer (46%) people are also more likely to feel isolated in Brighton & Hove than lesbians and gay men.

Within those who feel isolated, bisexuals and those of a sexuality other than lesbian, gay or bisexual were more likely to cite discrimination and exclusion as a reason for their experiences of isolation.

12.2.2. Trans identities

Trans people considered themselves to have significantly poorer emotional and mental wellbeing in the last 12 months than those who were not trans. Trans people were significantly ($p < 0.05$) more likely to have had difficulties in the last five years with all the categories of mental health difficulties except confidence / self-esteem, problem eating / eating distress, self harm. Only 2 trans people (5%) had not experienced any of the difficulties listed. Trans people (56%) were almost twice as likely to have considered suicide in the last five years than non trans (28%) respondents who had mental health difficulties in the past five years. They were more than three times as likely to have attempted suicide in the past five years and over five times as likely to have attempted suicide in the past twelve months as non-trans people. Trans respondents were around four and a half times as likely to state they felt isolated in Brighton & Hove, than other respondents: $p<0.0001$. The qualitative data suggested that trans people, although connected to psychiatrists throughout their transition, may not have their specific needs met.

Trans respondents were around four and a half times as likely to state that they felt isolated compared to other LGBT people. 60% of those who are trans said that they felt isolated, compared to 32% of those who are not trans. Within those who feel isolated- trans people were more likely to cite discrimination and exclusion as a reason for their experiences of isolation than other LGBT people. Trans people in the qualitative research pointed to the failing of services as an aspect of their mental health difficulties as well as a barrier in helping them to manage these issues.

12.2.3. Ethnicity

All of those who identified as BME experienced some form of mental health difficulty in the past five years. The category other / traveller also experienced higher levels of problem eating and self harm in the last five years. Black and Minority Ethnic (BME) respondents and respondents who identify as Travellers or of an 'other' ethnic group are more likely than white respondents to have experienced significant emotional distress and isolation. BME respondents are more likely than all other groups to experience difficulties with anger management. Travellers and those of another ethnicity are more likely than all other groups to experience difficulties with problem eating disorders and self harm. Those who identified as BME or a sexuality other than white or BME are more likely to feel isolated in Brighton & Hove.

12.2.4. Age

Older people's emotional and mental wellbeing in the past 12 months was poorer than the sample as a whole. Those aged over 55 were the most likely (29%, n. 22) to have experienced *none* of the mental health difficulties questioned about. Although older people (those over 55) are the group who are next to young people in having serious thoughts of suicide they are the

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age group that is the least likely to attempt suicide. Those aged between 36 and 45 are the most likely age group to have thought about and attempted suicide in the last 12 months.

Young people's emotional and mental wellbeing in the last 5 years was similar to the average score with no young people defining their mental health and wellbeing as very poor in the past twelve months. Yet, 13% of young people said they had experienced none of the mental health difficulties identified compared to 20% for the sample as whole. Those who are younger are more likely to have experienced difficulties with confidence/self-esteem, stress, problem eating disorders and addictions and dependencies. Young people (46%) were also more likely to have had serious thoughts of suicide than any other age category, although the figure is also higher for older people (35%).

12.2.5. Income

Levels of emotional and mental wellbeing over the past 12 months varied markedly according to income. Where income was less than £10,000, only 41% of respondents claimed good or very good emotional and mental wellbeing, compared to 73% of those with incomes more than £40,000. Similarly, the proportion with poor or very poor emotional and mental wellbeing ranged from 37% in the lowest income bracket to 5% in the highest. The data on experiences of mental health difficulties also varied by income, with those earning over £20,000 being more likely than lower income groups not to have experienced mental health difficulties. Experiences of specific mental health difficulties also varied by income. Those earning over £20,000 were more likely not to have experienced mental health difficulties. Those earning under £10,000 were much more likely to have experienced mental health difficulties, in some cases more than twice as likely as those earning over £20,000 (for isolation (in the past five years), fears/phobias, problem eating disorders, panic attacks, self harm, addictions/dependencies, suicidal thoughts). However, those in the highest income brackets and the lower income brackets experienced similar levels of stress and anxiety. There is no significant relationship between income and the likelihood of experiencing difficulties with either anger management or insomnia. Those on a low income (49%) are twice as likely as those on a higher income (17%) to have serious thoughts of suicide. There was an association between income and higher rates of feelings of isolation. Those who earn under £10,000 are more likely to feel isolated (47%) than those who earn over £40,000 (27%). Within those who are in the lowest and highest income categories being more likely to cite discrimination and exclusion as a reason for their experiences of isolation.

12.2.6. Living with HIV

Those who are living with HIV are more likely to say that their emotional and mental wellbeing in the past 12 months is poor/very poor. This is not reflected in statistically significant differences in the mental health difficulties in the past five years. Those who have tested HIV positive are more likely (49%, n. 27) to experience difficulties with insomnia than those who have tested HIV negative or who have had no HIV test result (34%, n. 127) ($p = .042$).

12.2.7. Tenure and area of residence

Housing tenure and area of residence show highly significant associations with mental health difficulties. Those who live in areas of potential deprivation are the most likely to have mental health difficulties (25%). 39% of those in social housing have had difficulties with their mental health, compared to 12% of those who own their own homes and 22% of those who rent privately.

12.2.8. Physical disability and long term health impairment

The categories of physical disability and long term health impairment are difficult to differentiate from that of mental health, due to the way the questions were asked. Consequently, these results should be taken as indicative and further research undertaken to explore the links between physical disability and mental disabilities and their relationships to long term health impairments.

Those who identified as disabled and/or long term health impaired are more likely to have experienced all forms of mental health difficulties except stress and addiction or dependencies. Respondents who identify as disabled are more likely (8%, n. 9) than respondents who do not identify as disabled (20%, n. 131) to have experienced none of the mental health difficulties questioned about. Those who identified as having a disability (54%) were over twice as likely as those without a disability (25%) to have had serious thoughts of suicide.

Those who are physically disabled or have a long term health impairment are more likely to feel isolated in Brighton & Hove than other LGBT people. People living with a physical disability or are long term health impaired were more likely to cite discrimination and exclusion as a reason for their experiences of isolation.

12.3. Conclusion

This research has shown that mental health difficulties, suicide distress and isolation are key issues for LGBT people. It has highlighted the particular vulnerabilities between those who are classed as LGBT and identified areas of need, as well as indicated future research that is required. The research has pointed to directions for services to follow, in order to engage with and improve LGBT people's mental health and wellbeing. This report is of course locally focused on Brighton & Hove, but it has national and international implications.

13. Recommendations

13.1. Supporting LGBT specific services and LGBT communities

It is recommended that:

- More secure funding arrangements are put in place for LGBT specific services run by and for LGBT communities which support people with mental health difficulties (including Mind Out, Switchboard and Allsorts). Recurrent local funding to ensure the consistency of service provision and increase confidence in the longevity of the service is necessary. Sources of funding need to be identified by the PCT, with a tendering process developed in conjunction with LGBT communities.
- Anti stigma and mental health promotion campaigns are undertaken which target LGBT communities.
- Community based facilities are created and developed to support social networks and to meet key LGBT support needs, including mental health needs, reducing isolation and suicidal prevention.
- Initiatives are developed to strengthen and promote LGBT communities and social networking in ways that increase LGBT community capacity to support each other.
- There is a development of, and support for, LGBT activities that provide alternatives to the commercial scene.
- Mental health services are developed to specifically cater for bisexual and trans issues, and that these recognise the commonalities and differences between lesbian, gay, bisexual and trans people.
- Existing interventions which aim to improve self confidence of LGBT people and reduce isolation are supported and developed, and further initiatives are developed including mental health events, therapeutic services, help lines, out of hours services, and service user led initiatives.

13.2. Statutory Mental Health Service provision

It is recommended that:

- Mental health services address the needs of LGBT people by:
    - Making their services welcoming to LGBT clients
    - Acting to develop all aspects of LGBT affirmative service provision
    - Ensuring the safety of LGBT service users once engaged with a service
    - Providing LGBT awareness training for all staff including service managers
    - Monitoring the use of service by LGBT people
    - Developing evaluation tools and targets to support achievement of the above.
- Mental health services develop awareness of issues of child abuse, and domestic violence and abuse, and work with domestic violence and abuse services, and survivor and children's services, to support LGBT people in appropriate ways

13.3. Suicide Prevention

(These recommendations should be read in association with Johnson et al., 2007)

It is recommended that:

- Prompt and effective responses to expressions of suicidal distress is taken by all those who deal with LGBT people.
- A flexible referral system is created for LGBT people who are experiencing suicidal distress. This should offer a range of LGBT specific and LGBT sensitive support services.
- LGBT community connections are developed to support isolated LGBT people.
- Positive representations of LGBT lives are located within mainstream services, to support those that may be unsure of their sexual/gender identity, or of the welcome they will receive because of their gender/sexuality.
- An in-depth review of the 'crisis support' currently offered to LGBT individuals experiencing suicidal distress is undertaken. This should include establishing a stronger knowledge base by:

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- monitoring the number of LGBT people who are referred from GP practices for suicide related behaviours
- monitoring the number of LGBT people who access A&E services after suicide related behaviours
- clarifying the types of interventions that existing services offer LGBT people who are in suicidal distress.
- 'Crisis support' for LGBT individuals is improved by:
- establishing clear guidelines on referral practice for LGBT individuals
- providing appropriate out-of-hours support to cover weekends and evenings
- incorporating peer support and promoting the development of on-line communities
- establishing and developing links between non-specific LGBT friendly services and LGBT specific services that support suicidal individuals
- providing clear guidelines for LGBT individuals on the type of support that existing services offer, and widely publicising and maintaining up-to-date contact information on how they might access support for suicidal distress and other mental health issues.

13.4. General Service provision

(see also Browne, 2007b; Browne and Lim, 2008 and Browne and Davis, 2008)

It is recommended that:

- All mainstream service providers seek training from LGBT organisations on how to create LGBT friendly services and send out welcoming and inclusive messages for all LGBT people.
- Accurate monitoring procedures and statistics are developed within services, recognising that most LGBT people will not come out to service providers unless services are perceived to be LGBT friendly.
- LGBT training is compulsory for all mental health and health professionals, including GP's and other first contact/referral services.
- Initiatives (such as Mind Out's new work with LGBT communities) are supported and developed to promote the positive of effects of physical fitness in improving mental health.

- Safe and secure housing is found for vulnerable LGBT people across the city and services recognise the support needs of those with mental health difficulties

- Perpetrators of hate crime are dealt with in ways that do not lead to the further victimisation of LGBT people. A common system of monitoring hate crime and reporting is introduced across services

- Training and initiatives are put in place to ensure that those who deal with LGBT people (in specific and mainstream services) are aware of issues of child abuse and Domestic Violence and abuse, without stigmatising LGBT people and/or survivors of sexual abuse and/or violence.

13.5. Research

It is recommended that:

- Further research is undertaken into the causes and effects of isolation, and interventions and initiatives developed to address this issue.

- Research is undertaken to explore and explain the high levels of reported mental health difficulties amongst LGBT people.

- The relationships between multiple marginalisation and experiences of mental health difficulties are explored.

- The links between mental health and domestic violence and abuse are investigated, including an exploration of the complexities, links and overlaps between LGBT experiences of adult domestic violence and abuse by a partner, and experiences of abuse during childhood.

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We welcome any comments and suggestions.

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Downloadable copies of this and other resources are available from the Count Me In Too website including a directory of local LGBT support organisations and groups.