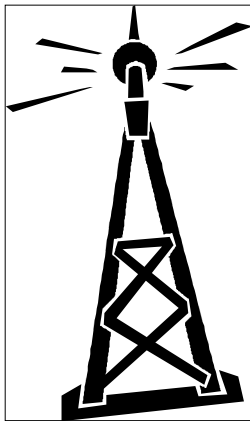




LGBT MENTAL HEALTH NEWSLETTER

time to change

let's end mental health discrimination



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New newsletter; new network

This is the first of a series of occasional newsletters which will be put together by MindOut in Brighton. MindOut is part of the Time To Change consortium where we take the lead on LGBT mental health. This newsletter is part of our strategy to develop a national network (England) of individuals and organisations with an interest in LGBT mental health. This network is to include both service users, service providers and community groups as well as interested individuals. It will be a forum for sharing knowledge, ideas and experience about mental health promotion, service provision and access, research etc.

The aims of this newsletter are:

- To share information and ideas about LGBT mental health
- To stimulate discussion and reflection on key issues.

As this is the first of these newsletters the contents will be entirely from and about MindOut in Brighton – but we hope that the content of subsequent issues will be filled with content provided by other groups/organisations/individuals. This could be:

- descriptions of service provision
- publicity materials, leaflets
- case studies
- issues you would like to give an airing to
- etc etc.

So if you would like to share what your project/group is doing or has done, or have any ideas (controversial or otherwise) that you think would provide interesting stimulus to others please contact me. If you don't have time to write anything you can call me and I will put something together.

Best wishes

Chris Pearcy chris.pearcy@mindcharity.co.uk

on behalf of

MindOut

Data Watch

A couple of useful sources of data



LGB people are 2.5 times more likely to have attempted suicide.....

Mental disorders, suicide, and deliberate self harm in lesbian, gay and bisexual people: A systematic review. King, M. et al. 2008. NIMHE.

Available at www.biomedcentral.com/1471-244X/8/70.

This is a systematic review of peer reviewed research on LGB (but sadly not trans) mental health. Its principal finding is that 'gay, lesbian and bisexual people are at higher risk than heterosexual people of mental disorders, substance misuse and dependence, suicide, suicidal ideation and DSH.'

This document provides useful (and sometimes surprising) comparative data between L, G and B people and between LGB people and heterosexual people. All of which could prove to be useful in applying for specific resources for LGB mental health.

It also addresses, to a limited extent, explanations for the disparity between LGB and heterosexual mental health and what the implications of the findings are for services.

Mental Health Findings. Count Me in Too. Brown, K. and J. Lim. University of Brighton and Spectrum 2008. Available at www.countmeintoo.org.uk

Count Me In Too is a study of the needs of LGBT communities in Brighton and Hove based on the findings of 819 questionnaire respondents and 20 focus groups.

Respondents were questioned on a variety of issues including, experience of mental health services, housing, income, what had proved helpful and unhelpful in managing mental health difficulties. In the Mental Health report some of the data was extrapolated independently for L, G, B and T groups as well as presenting aggregate data. There are a great deal of correlations between, for example between isolation, domestic violence, hate crime and mental health difficulties.

As in King et al (2008 above) the overall finding was that LGBT people on the whole experience poor mental health and that bisexual and trans people experience on the whole poorer mental health than lesbian and gay people.

Although the study is specific to Brighton and Hove I think that many of the findings could prove useful for other parts of the country.

The full academic report and a summary of findings are both downloadable from the above website.

Some data: Suicide and isolation

LGB people are 2.5 times more likely to have attempted suicide within the last year than their heterosexual peers (King et al).

Local research in Brighton suggests that trans people are 3 times more likely than LGB people to have attempted suicide (therefore 7.5 times more likely than their non-trans heterosexual peers).

The Brighton research suggests that certain factors increase suicide risk within LGB&T communities, these include:

- Being on a low income
- Identifying as disabled
- Recent physical attack
- School bullying
- Feeling isolated

People who were on a low income, trans, bisexual, from a BME community or identifying as disabled were more likely to feel isolated which rather neatly matches up (for the most part) with those most at risk of suicide.(Brown and Lim 2008)

Services information: 1 MindOut

MindOut is an LGBT mental health project based in Brighton and Hove and is part of Mind in Brighton and Hove. 2009 is MindOut's 10th birthday year. We provide an advice, information and advocacy service; facilitated peer support groups; the opportunity for activities. We also deliver mental health promotion and training around LGBT mental health. We are also tasked by Time to Change to network those with an interest in LGBT mental health, including service users, volunteers and professionals.

Advocacy service

The advocacy service was first part of the service to be set up. Currently we have two LGBT advocates. Their workload is mostly one-to-one advocacy around a range of issues ranging from gaining access to appropriate mental health services, housing problems to legal and policing issues.

Tuesday groups

The peer support groups at MindOut grew out of the advocacy service. Service users wanted the opportunity to meet up with other LGBT people with mental health issues. Currently we run three facilitated peer support groups each Tuesday evening. There are two closed groups, for which there is usually a waiting list. New people are only allowed to join the group at the beginning of each ten week 'term'. The open group which runs at the same time as the two closed groups is relatively fluid. Anyone who is a member of MindOut may attend as frequently as they wish, the work done within this group is usually less intense than in the closed groups.

Out of the Blue

Out of the blue is a closed suicide prevention group that runs once a week. Like the Tuesday groups it is facilitated by a sessional facilitator. It is for anyone who is or has experienced suicidal distress..

Activities

We offer a range of activities for LGBT people who identify as having mental health difficulties. We offer regular walks ranging from the short walk and talk to more strenuous walks over the downs. We have also offered a couple of series of climbing sessions, an art group and a writing group. MindOut has its own allotment run by service users and a volunteer which has been providing organic vegetables, some of which are distributed to service users attending the Tuesday groups. We have used the allotment for some social events. We also offer individual advice and support for people wanting to increase their physical and social activities.

Mental health promotion

As part of our mental health promotion and anti-stigma work we contribute a regular column to one of the local LGBT monthly magazines. Some of these columns are written by service users and others by MindOut staff.

Recently we have produced a leaflet (*MindOut for each other*) advising LGBT people about what they can do to contribute to making LGB&T communities more mentally healthy. This leaflet is posted on our website: www.lgbtmind.com.

In 2006 we planted a tree in a local park in memory of LGB&T people who have committed suicide and to provide a place of remembrance for friends and family. We hold a vigil at the tree each year to raise awareness of the high suicide risk of LGBT people and allow us to remember those we have lost.

Training/workshops

We offer training in LGBT affirmative practice in mental health for service providers, and training and workshops about most aspects of LGBT mental health for service providers, service users and communities. We are just coming to the end of delivering LGBT Affirmative Practice training for the whole of Brighton and Hove's first tier NHS mental health services. If anyone would like us to deliver any training and/or workshops we would be happy to do this, all that we would require from non-statutory service providers would be a contribution towards our expenses.

Something to think about

Homo/bi/trans/phobia versus stigma

The effects of prejudice, discrimination, abuse and stigma towards LGBT people has such detrimental impact on mental health that it may be worth pausing to consider the concepts we use.

I have a preference for the concept of stigma over homophobia and its cousins. There are various reasons for my dislike of the concept, ranging from the relatively facile to more complex reasons. What I have written here is basically a partisan set of notes about of my problems with 'homophobia' and a brief account of stigma and its usefulness.

Some disadvantages of homophobia:

1. It sounds medical

In fact the concept was created in the 70s with DSM in mind and was intended as a diagnosis: the irrational fear of homosexuality. Of course the problem with this as a diagnosis for an individual (like most psychiatric diagnoses) it has little explanatory power in terms of the social. But I think the worst aspect of this connection with the medical is that 'internalised homophobia' takes on a tone of individual pathology too.

3. It's not a phobia

This may seem a bit nit-picky. The concept has come to mean something other than fear of homosexuality but still resonates with a psychoanalytic assumption; that we denigrate, hate or demean those things that we fear. This of course brings us back to a root in the feelings of individuals.

4. It cannot account for the social

To bring homophobia to the social we have to create concepts like 'institutionalised homophobia' or 'homophobic societies'. These concepts in themselves cannot help us account for discrepancies between social groups or societies.

3. Its too specific

By being so specific it inhibits us from looking at the wider social context, and perhaps stops us from seeing social processes clearly and our ability to learn from the work on other marginalised / excluded groups in society.

Stigma

In order to look at stigma I think it is useful to look first at a system of concepts.

The key text on stigma is Irving Goffman's 1968 book: *Stigma: Notes on the management of spoiled identity*, but I have also included two additional concepts (primary and secondary deviance) which I think can enhance thinking about stigma. (The idea of the addition of deviance comes from another source but unfortunately I can't remember which.)

Stigma is a characteristic of a person or a group of people that is perceived as undesirable. This characteristic 'taints' people, makes them lesser people; abnormal.

When this characteristic is obvious, apparent or known it is usually referred to as **discredited stigma**. A good example is with some physical disabilities eg needing to walk with a walking stick. An out LGB or T person has discredited stigma.



When it is not obvious, apparent or known by others it is usually referred to as **dis-creditable stigma**. Mental health problems and sexual/gender identity both can fall within this category. An LGB or T person who is not out has discreditable stigma.

Enacted stigma consists in the behaviour of others towards those with a stigma and is experienced by people whose stigma is apparent (ie *discredited*) and observed by those whose stigma is discreditable.

Felt stigma is experienced when the individual is aware of their stigma, but others may not necessarily be aware of it (ie *discredited* or *discreditable*) (pace internalised-homo-, bi- trans -phobia)

Primary deviance – behaviour which is perceived as socially abnormal and usually regarded as unacceptable.

Secondary deviance – behaviour which results from the social reaction to the primary deviance.

The advantage of the stigma model is that it is located in the social and has a broad explanatory power. As an example, issues relating to coming out. Most stigmatised people will experience felt stigma from the very fact of living in a particular society, however a bisexual woman, for example, will not directly experience enacted stigma unless she has come out. While she is not out her stigma is discreditable ie she *could be* outed. This certainly can be a source of anxiety: if I'm outed people will treat me differently, I'll be seen as a lesser person ie will experience the enacted stigma of society. Other potential psychological sequelae of enacted stigma (or the content of felt stigma) include taking on the implications of the stigma; in the form of accepting the judgement of society as a whole that you are in some way lesser, and all of the implications that go with this (low self-worth, depression, self-doubt etc); enacting stigma upon yourself (hate, desire to destroy, harm, restrict).

It is generally difference (from the majority) that is stigmatised. So growing up healthily with a stigmatised trait is, in part, a process of learning how to live 'different' from the majority. I suspect that we all have some desire to conform sometimes. We can certainly observe this in children when they go to school. Wearing similar clothes, having the same toys and games, a similar range of icons etc. all become massively important. I believe that there is often a great tension between a desire to conform at some level, to be part of something and a desire to be my own person, an individual. This too can have problematic behavioural and psychological consequences. I also think this difference/conforming can in part explain the ambivalence that LGBT people often have towards the idea of LGB or T community or 'the scene'. We often have stereotyped ideas of what people on 'the scene' are like 'and I'm not like them'.

Although the language of deviance is resonant with negative overtones it has a usefulness in explaining behaviours. Secondary deviance can explain certain behaviours eg being secretive about sexual/gender identity, self-ghettoisation or separatism and also general wariness, difficulty in developing trust etc.

The structural function of stigma has been well researched and can offer non-psychological explanations of its own existence. Enacted stigma is a means of maintaining the status quo; a good example of this is the attitude of the Catholic church to homosexuality and women. Stigma is also used by groups to establish some status, especially those who are already marginalised, stigmatised or under threat in some way themselves: in the prison system the murderer can always look down on the paedophile and say that at least he is not that bad; embattled white working class communities turn to racism (stigmatising people from black and ethnic minority groups) as a means of establishing some sort of status and explaining their own marginalisation/exclusion. We could also look at some of the negative behaviours/attitudes within lesbian and gay communities towards trans and bisexual people from this perspective.

Chris Pearcy

We welcome any comments on this newsletter.

We particularly welcome any contributions for future newsletters—our intention is not to edit, but use the newsletter as a means of open communication between service providers, service users and others with an interest in LGBT mental health. Future newsletters will be distributed once sufficient material has been received for distribution.

We also welcome any views/ideas on how this network should operate.

All communication to go through Chris Pearcy at MindOut: chris.pearcy@mindcharity.co.uk

tel. 01273 722550

MindOut website: www.lgbtmind.com

