

Not safe for us yet

The experiences and views of older lesbians, gay men and bisexuals using mental health services in London.

A scoping study.

EXECUTIVE SUMMARY

Sam Wintrip

A project funded by the City Bridge Trust



Executive Summary

1) Introduction and Background

- i) Previous community work undertaken by Polari involving consultation of older lesbian, gay and bisexual people found access to and negative experiences within mental health services to be an area of concern.
- ii) The mental health professions have been associated with the pathologisation of LGB sexuality since the beginning of the 20th century. Aggressive treatments aimed at changing sexual orientation peaked during the 60s and early 70s, a time when many of today's older LGB population would have been entering adulthood. The effect of this may be an increased suspicion and lack of access of services and increased stigma attached to their use.
- iii) Previous research commissioned by the voluntary sector and within academia has shown that often professionals within statutory services have continued to pathologise and discriminate against LGB service users up until recent times, again contributing to the sense that mental health services do not provide a 'safe' support for LGB people who need them.
- iv) Older LGB people may be at increased risk of mental distress due to increased historical exposure to stigma and life stressors as well as reduced access to LGB social networks (which can act as an ameliorating factor).

2. Developments in Mental Health Services

- i) The National Service Framework for mental health, published by the Department of Health in 1999, sets out the agenda for improvement in the provision of mental health services for working age adults (18-65) only. Subsequent funding was directed at implementing such improvements. The mental health care of older people was covered as part of the generic National Service Framework for older adults in 2001. However, no further funding was attached to this. The Mental Health in Later Life Inquiry carried out by Age Concern presents substantial evidence to suggest that the current mental health system is failing those over 65. (Age Concern, 2007)
- ii) There is a current drive within the NHS to utilise a 'stepped care' model of treatment and prevention of mental health conditions, part of which is provision of brief and intensive psychological therapies at the point of presentation within primary care. Such an approach has been deemed to be cost effective in terms of keeping people in work. Older people often have limited access to such services, possibly because their perceived value to the economy is less.

- iii) The NHS is increasingly aiming to move towards incorporation of a user-derived model or process of recovery. However, concerns about safety within the community have prevented older LGB people from becoming engaged in user groups. Service user involvement initiatives have been seen as valuable, but have sometimes ceased due to lack of ongoing funding.
- iv) Increased social inclusion for those living with mental health conditions is listed as a target by the NSF, leading to the development of a National Social Inclusion Implementation Team co-ordinated by the National Institute of Mental Health in England. Many of the issues raised by this team are particularly pertinent to older LGBs: reduced access to social communities or events due to stigma or feared persecution; negative attitudes around mental health within the community; lack of safety within housing and difficulties securing and sustaining employment which respects LGB identity.
- v) The Mental Capacity Act (2005) has made it possible for individuals to wield more choice in who cares for and makes decisions for them should they become unable to do so themselves. Theoretically this allows for greater recognition of LGB partners and carers, although it is felt by one user in this study that the Act needs further explicit contextualisation.

3. Method

- i) An advisory group made up of older LGB service users and mental health professionals was convened in order to inform the design and implementation of the project.
- ii) 49 older LGB service users completed a questionnaire on their experiences of mental health services within the last five years in Greater London. Of these, 10 took part in further in-depth qualitative interviews. Additionally two carers of LGB mental health service users were interviewed. A small focus group was also held.
- iii) Additionally, several LGB mental health support groups were visited. A small survey of 36 mental health day services for adults across London was conducted as part of this scoping research. Managers were contacted by telephone and asked a short series of questions. Some contact with staff working in older peoples' mental health, adult mental health and voluntary sector older peoples' and LGB-specific services took place also.
- iv) Participants were recruited via existing links in the community, LGB websites, community events, community and social venues, voluntary sector organisations and some NHS and local authority services. Snowball sampling technique was utilised.

4. Quantitative Findings

- i) The sample was fairly balanced in terms of gender and disability, although bisexuals, people with black or minority ethnicity and those over 60 (compared to those 50-60) were under-represented. A majority of participants were single home-owners but people on low income and in social housing were also included.
- ii) Just over a third of gay men and lesbians weren't 'out' to anybody. 38% of gay men and 41% of lesbians were 'out' to health professionals; similar numbers were 'out' to most of their family.
- iii) We compared some findings with statistics available at the time of the study: 22% of men were found to be drinking at levels over the recommended weekly allowance, of which 8% reported consuming amounts considered to be hazardous to health. This was lower than the national average for adult men (Office of National Statistics). The percentage of gay male smokers was almost exactly the same as that reported in previous research, and rates of drug use were lower than previously recorded in a similar sample*.
- iv) The majority of respondents were current users of statutory mental health services. Those who were not had either used them in the past, or were currently using voluntary / private services.
- v) Most individuals who were aware of having a current diagnosis were using statutory mental health services, though a small minority were only accessing voluntary services and a slightly larger minority were using both. More respondents were currently using and had previously used voluntary sector counselling than statutory sector.
- vi) Amongst those participants who had wanted to access statutory services but couldn't / decided against it, the most commonly cited reason was difficulty with disabled access. This was followed by long waiting times, concern about being given unwanted treatment and concern about being told they had a disorder.
- vii) Views of mental health services within this sample were found to be diverse. As a general trend, more current- and ex-service users had negative views of statutory services (for example that professionals would pathologise their sexual orientation or make negative assumptions about them) than those who had never used them. However, few expected overt discrimination or mistreatment.
- viii) Most respondents (current and non-users) said they would be more likely to access mental health services and/or talk about their issues if the professional

* Since this time Stonewall's 'Prescription for Health' (2008) has provided statistics on lesbians and bisexual women.

they were seeing was openly gay or gay-friendly. However, similar agreement was found with respect to professionals who had received training on working with LGB people. Both those who have never used and those who previously used services believe that, if LGB people were represented more prominently in publicity, they would be more inclined to access services.

- ix) 92% of respondents were able to be 'out' within the context of services, and almost half reported that they were pleased with the way in which professionals treated them when they had been open about their sexual orientation. 41 % believed that if there was greater LGB visibility in publicity material they would feel more comfortable to be open about their sexual orientation to all staff. However, over a third of respondents felt that the behaviour of mental health professionals towards them on account of their sexual orientation had made their problems worse. In addition 41% reported being subjected to homophobic remarks from professionals and discriminatory behaviour, with a slightly smaller percentage noting mockery and verbal abuse and disclosure of sexual orientation without permission. Although there was consensus from respondents that they would not keep quiet in such instances, only 38% would know how to make a complaint and 50% do not believe it would be taken seriously even if they were to.
- x) There was some consensus between all groups that there are some mental health services that they don't use because of anxiety about experiencing homophobia from other service users there, and user groups are not excluded from this. Even amongst those who felt comfortable in most instances being open about their sexual orientation to mental health professionals (n=17), just over half (n=9) felt as comfortable when it came to other service users.
- xi) About two thirds of respondents worry that openness would result in service users revealing their sexual orientation to others without their permission, and about half would be concerned for their safety in the area in which they live. 60% had witnessed other service users talking negatively about LGB people in general, and 45% had witnessed discriminatory or negative behaviour towards another. 77% reported experiencing discriminatory behaviour, 66% verbal abuse and 44% violence from other service users on account of their sexual orientation. There was no clear consensus on whether mental health professionals had taken clear steps to prevent or stop such instances.
- xii) There was strong consensus that being in an LGB-specific environment would make it easier to be open about sexual orientation. Once again, there was little consensus on whether complaints would be taken seriously.
- xiii) In summary there was no evidence to suggest that older LGBs had worse experiences of mental health services than younger peers. Nonetheless there had been little evident change in attitudes and experiences since previous research had been carried out five years previously, although sample size in

our study was much smaller. Results seemed to suggest that negative expectations about services with regards to their treatment of LGB people do not represent the primary barrier to engagement for those who have never used them. However, it is possible that expectation of poor practice constituted more of a barrier to continued engagement amongst those who had previously used statutory services; such a group may have more reason to expect bad practice, having previously experienced it themselves

5. Qualitative Findings

- i) Many of the participants discussed (unprompted) topics which highlighted the many ways in which issues surrounding their sexual orientations and indeed their age had been integral to or had affected their mental health, in particular the impact of dealing with homophobia. Some support was lent for the view that LGB people may be at particular risk of developing mental health issues as a result of the effect on self-esteem of being frequently presented with a negative characterisation of LGB identity. Individuals appeared to demonstrate a need to receive support that is non-judgmental and (for them) safe, given their experiences of hostility and stigmatisation in the wider world.
- ii) Unfortunately, despite this need the majority of participants could count mental health professionals amongst their persecutors at some time in their lives. There was some belief that services had generally changed for the better over time. However, most service user participants reported some recent instances of perceived homophobic or discriminatory behaviour from staff within a service context, leading to anger and frustration and other adverse effects. Most commonly, participants described the vulnerability they felt when confronted with staff in a hospital setting who openly discussed their religious beliefs. Others described feeling that they were being subjected to indirect discrimination through professionals' lack of recognition of the validity of their sexual identities.
- iii) Perhaps unsurprisingly, experiences such as the above tended to result in participants becoming very cynical about the ability of statutory professionals to provide a suitable service for them and indeed a general lack of trust. In some instances, this cynicism about the ability of services to provide suitable provision was reinforced by NHS staff themselves who we talked to. Subsequently for some this has meant avoiding statutory services altogether, although the need to access them was there.
- iv) Experiences of reactions from other service users were mixed. A couple of individuals with more limited experience within the mental health system reported generally positive responses. For the majority of others, discrimination and attack from other service users was of at least equal or sometimes greater concern than the negative behaviour of staff. Despite the above, not one individual reported an instance in which members of staff had tackled homophobic behaviour on the part of service users. Most individuals had not seen making a complaint as a viable option.

- v) Participants in most instances were keen to discuss their concern, frustration and in some cases alarm at what was perceived to be poor standards of care currently offered by the NHS. The general picture painted of the hospital environment in many instances was often one of inadequately trained, unmotivated staff making mistakes with regards to practice which (in one instance) had especially serious consequences. Several participants complained of being unable to access services that were supposedly present, despite efforts to the contrary – particularly counselling, despite current initiatives to increase access to talking therapies. This feeling – of being left isolated and without support outside of hospital – was often repeated in some form, and ‘outreach’ was generally criticised as offering inadequate care.
- vi) Related to the final points above, several participants felt very strongly about the current programme of day centre closure, and there was considerable discussion of this issue at the focus group. Contrary to the suggestions of the Department of Health paper mentioned in section 3, they felt that closures had been a) detrimental to user empowerment since users had campaigned fruitlessly to keep their centres open where they had in fact been consulted at all and b) detrimental to the social inclusion of individuals with chronic mental health needs since the majority of these had (subsequent to closures) ended up back in hospital, or simply wandering the streets. The combination of lack of consultation in service closures and perceived doublespeak in terms of user empowerment resulted in the general perception that saving money was considered to be of greater importance than the wellbeing of service users.
- vii) Experiences of staff within the NHS were not universally negative. Nearly every participant spoke positively of at least some individuals, most frequently (though not exclusively) CPNs. However, it was felt by one individual that good staff in the NHS are burnt out or marginalised. A non-judgmental and respectful attitude seemed to be the key trait of staff who were judged to have been helpful. Awareness of LGB resources was also seen as being of benefit, but contact with actual LGB members of staff was not deemed strictly necessary for good service. Several participants spoke highly of attempts to develop service-user involvement initiatives within services, although in one instance funding for this had ceased.
- viii) The two carers interviewed (and included in the focus group) had particular issues to raise about their own experiences of participating in the care of friends or partners experiencing mental distress. Lack of support from both the voluntary and statutory sectors was mentioned as a problem and corroborated by service users talking about their own carers. A wider issue discussed was general lack of recognition and exclusion from the care of LGB loved ones. This issue was raised by those who were concerned about the care of LGB friends and also by a disabled carer whose perception was that disabled

people (seen as 'needing care') were seldom recognised in their roles as carers.

- ix) Several of the participants were one-time or current users of voluntary sector services, and tended to speak highly of them. Speaking to members of an LGB mental health support group tended to confirm the increased sense of safety experienced by users in this environment, and the consequent benefits for their mental wellbeing. Several participants had themselves initiated or volunteered for support organisations, and had found this to be a positive experience. Nonetheless for several people there were various concerns about access, given the relatively small number of LGB-specific services available, and also recognition that as such they tended to be overstretched. Some women (and indeed men) recognised that existing groups had difficulty attracting enough lesbians regularly, which in turn made it intimidating for new women to join. There were also concerns about changes to services occurring as a result of funding cuts, especially around the provision of HIV support and prevention. Finally, one user (who had been refused a statutory assessment and who could not afford to seek out private services) expressed concern about the fact that voluntary organisations often can only really afford to employ trainees in therapeutic roles.

- x) In addition to feeling isolated from society at large, most of the participants felt to some degree discriminated against within or excluded from the LGB community due to stigma attached to and lack of consideration for age, mental health issues or disability. Concerns about the future and hopelessness concerning the possibility of finding meaningful relationships seemed to contribute significantly to several people's distress.

- xi) The issue of sexual orientation monitoring was raised in particular to investigate whether fears that asking about this as part of wider service user monitoring would be perceived as offensive or an invasion of privacy. The consensus tended to be that the question was useful, but that it had to be asked sensitively. It must be noted that here participants were, in the main, 'out' to services, which may have affected their responses.

- xii) As suggested by the recovery model, suitable housing was seen as being integral to mental wellbeing by several service users who felt that such concerns played a large part in the story of their mental health difficulties. The high cost of housing and other financial concerns had in one instance prevented a service user's partner from being able to offer the level of care that she wished to. In every instance, individuals felt disempowered and without representation when confronted by these situations.

- xiii) Ideas for improving accessibility and practice within statutory services were offered freely. Adequate, mandatory diversity training for staff on sexual orientation issues was mentioned most frequently. A related issue is that individuals experiencing crisis or mental health issues need to feel safe in the environment in which they access services, and the guarantee of protection against homophobia (or even acknowledgement that LGB people exist) can be an important way of ensuring this. Others have described a need for LGB-specific services, and indeed a less symptom-based and more holistic approach to the treatment of mental health needs.

- xiv) Some participants who were registered disabled also called for greater physical accessibility of services. In terms of wider support and (potentially) voluntary sector initiatives, almost everyone felt that a peer support network of some form would be massively beneficial.

6. Findings from Staff

- i) The overall perception of older LGB people amongst staff (particularly those not offering an LGB-specific service) was that they tended to be very isolated from their peers and the rest of the community. Voluntary sector staff (especially those providing LGB-specific services) tended to report instances of non-engagement with statutory services amongst users.

- ii) Only two of the mental health resource centres surveyed provided LGB-specific groups. Perceived need for such groups amongst staff was slightly higher at 14%. A commonly reported reason for lack of specific groups was difficulty in generating sustained interest. A few were open to the idea of developing LGB-specific services, but had concerns about doing so. Others described being constrained by the priorities identified by their service level agreements. A substantial proportion of managers felt that LGB issues were more appropriately tackled in one-to-one work. Amongst CMHTs there was some consensus that a peer support network of some kind would prove useful for isolated clients, and wished that the researcher could develop such a service since they were not in a position to be able to do so.

- iii) Polari recognises that many services may not attract sufficient numbers of LGB people to justify running a separate group, or may not have the resources or confidence to attempt to do so. However displaying publicity and signposting to LGB specific services at least caters for those who may not feel able to be open about their sexual orientation to their keyworker and fulfils the commissioning framework's inclusivity requirement. Nonetheless under 20% of centres surveyed actually had any publicity and only a further 28% said they would consider having any.

- iv) Only 56% of services surveyed allowed users to continue to use the service once they reached 65 and only 28% received new referrals for individuals who had reached this age. When asked why this was, no single service mentioned any particular difficulty anticipated (in terms of levels of support or staff required) in catering for or including older people; rather, referral criteria were said to be determined by NHS or local authority policy. Nonetheless, this age cut-off was not universally observed, and many service providers described a level of flexibility in their policy for accepting new referrals.
- v) Many of the NHS staff reported a climate of homophobia within the organisation, often taking place as part of a general expression of religious attitudes within the workplace. Some reported recognising these problems, but experiencing a sense of powerlessness to change anything. However there was also some recognition of a gradual process of change within the organisation, although current training on equalities was seen in some instances as inadequate.
- vi) The issue of monitoring for sexual orientation on the Count Me in Census was raised with older peoples' CMHTs and NHS day service staff contacted. The primary issue expressed was that people felt uncomfortable asking what they perceived to be a very personal question of users.

7. Problems and Limitations

- i) Significant delays to the project were incurred through difficulties in negotiating local protocols around research governance. The small sample size in this study was seen as a problem with regards to the representativeness of the findings. Tightness of inclusion criteria and flaws in the recruitment strategy were supposed to have contributed to this.
Recommendation: Future work would benefit from taking place within statutory services and from being more widely publicised.
- ii) Difficulty in reaching LGB mental health service users over 60 was encountered. The sample was under-representative of bisexuals, people from poorer socioeconomic backgrounds and people from BME communities.
Recommendation: Future work should perhaps aim to focus on qualitative accounts garnered through long term outreach work with particular voluntary or statutory mental health support projects, perhaps undertaken by older LGBs themselves.
- iii) The use of a quantitative tool in this research was not deemed to have been particularly successful: it produced data that was too broad to make any specific recommendations, contributed to biasing the sample towards certain

populations and was generally not received well by participants. Demand characteristics and the fairly directive nature of the questionnaire may also have had a role in shaping responses.

Recommendation: Future research would be better served by concentrating on gathering good quality qualitative material from a wider, more representative base (again possibly through work within statutory services).

- iv) The exploratory design of the study prevented any reliable claims being made about the measured need of older LGB people for mental health services, or relative need compared to other groups.

Recommendation: Future research would benefit from the incorporation of a more objective measure of mental wellbeing (for example tools such as CIS-R, GHQ 12). A possible protocol would be to compare use of mental health services by older heterosexual and older LGB people as well as providing a comparative correlation between mental wellbeing and use of services.

8. Current initiatives aimed at improving services for older LGBs

- i) A range of voluntary sector services (related to mental health or older LGB people in some way) are presented in appendix C of the full report.
- ii) The Department of Health paper 'Core training standards for sexual orientation: Making National Health Services inclusive for LGB People' states categorically that training is needed for all NHS staff to make services inclusive for LGB people. Current training is perceived by some staff as being insufficient in content with regards to sexual orientation.
- iii) Several of the organisational bodies which inform and design policy within health services now have LGBT advisory groups of some form. At the Department of Health the Sexual Orientation and Gender Identity Advisory Group (including members from both the voluntary sector and the NHS) has been currently assisting with the development and delivery of a programme of work with the aim of improving service accessibility for LGBT users. In terms of staff representation, many borough councils, PCTs, and mental health trusts and professional bodies across London host LGBT staff forums which can be contacted through equality and diversity officers.
- iv) Monitoring for sexual orientation is currently taking place across mental health trusts as part of the annual Count Me In census of psychiatric inpatients. This is an important move since monitoring can provide information about health inequalities between minorities, identify potential barriers to services and

identify areas where discriminatory practices might be occurring and subsequently address these problems. Nonetheless, 144 out of 238 providers in 2006 and 127 out of 257 in 2007 refused to collect information around sexual orientation; many of these were in the London area. In a 2006 report 'Monitoring sexual orientation in the health sector.' LGB rights group Stonewall concluded that, despite clear benefits associated with doing so, the NHS will not be ready to monitor for sexual orientation until it takes significant steps to demonstrate inclusion and indicates that it is supportive of LGB people.

- v) The Equality Act (Sexual Orientation) Regulations came into force in April 2007. This legislation makes it *illegal* to discriminate in the provision of goods, facilities, services, education and public functions on the basis of sexual orientation. The law now provides a new powerful protection but individuals are not always in a position to contest their rights and resources to assist them to do so are limited or inaccessible.

- vi) With regards to health service provision, the Department of Health is working with 18 NHS Trusts to develop single equality schemes. The learning derived will be used to provide case studies and tools to assist other NHS Trusts to incorporate practices which will enable them better to respond to the needs of their local communities.

9. Recommendations

i) Training

Training was considered as most important both by questionnaire respondents and during discussion in the focus group. The Department of Health document 'Core training standards for sexual orientation' recommends training on this strand of equalities should a) not be subsumed into a hierarchy of equalities where it is dealt as a sub-issue and should b) be mandatory for NHS and social care staff at all levels (within the first three years of appointment) and tied to the key skills framework. This training should also incorporate the views and experiences of older gay men, lesbians and bisexuals, and ideally (in the spirit of social inclusion) should be delivered by or in conjunction with LGB service users and/or 'survivors.' The training package developed by the Royal College of Psychiatrists is inclusive of older LGB issues, and further work should aim to promote and/or incorporate this into plans to deliver training in the future.

ii) Implementation of existing policies

It is also proposed that the NHS needs to go to greater lengths to promote itself as taking a hard line against homophobic attitudes. Upon appointment of

staff, there needs to be (as part of induction) training on all equalities strands, accompanied by a clear statement that discriminatory behaviour of any form towards any minority (and specifically mentioning sexual orientation) will result in a defined disciplinary procedure. This should then be actively followed through as standard in instances where complaints are made or issues arise.

iii) Information about LGB Services

Information about LGB services should be provided as standard within venues providing mental health services, which if possible should allow service users from all minorities to signpost themselves to relevant resources if they desire to do so. Doing so empowers service users by maximising choice. It partly fulfils the requirement of the service to consider the specific needs of minority users (where the service is unable to cater for them itself). It also helps the organisation to develop a reputation for taking minority issues seriously (with the subsequent benefits for staff and service users described elsewhere in this report).

iv) Information and support to make complaints

This was highlighted as a need. Provision of information about advocacy services and/or referral to these services where necessary must be standard practice, especially within inpatient settings. Service-user-run patient counsellor or outreach posts as well as user-led audits have been popular. Making such projects common practice across every MHT would provide a useful check of good practice and service effectiveness. Given the findings of this study, it would be useful for audits such as these to take into account LGB issues and for LGB service user volunteers to be actively recruited.

v) LGB-specialist counsellors and/or therapists

These currently exist in both voluntary and private sectors. Nonetheless, in the case of private provision, participants reported being deterred from accessing these due to prohibitive cost. With regards to the voluntary sector, respondents worried about long waiting times for sessions with insufficiently experienced trainees.

Given funding restrictions and high demand, voluntary sector organisations currently often rely on trainees or volunteers due to an inability to meet the costs of employing fully trained counsellors. Hopefully demand will ease as primary care counselling continues to develop in the future. Possibly an equally useful way of utilising volunteers (as suggested during the focus group conducted as part of this research) would be to assign advocacy- or counselling-trained LGB 'liaison' officers to psychiatric wards on a part-time and/or rotating basis in order to provide a visible point of contact for LGB

patients who feel under threat in that environment. Considerable thought would have to be given as to how such contact could take place in a confidential fashion.

vi) LGB Service Users' Forum

The possibility of setting up a LGB Service Users' Forum was a key topic of discussion of the focus group, with users keen to see something develop because current similar services were either inaccessible to lesbians, or too geographically dispersed to be feasibly reachable. It was felt that such a group would provide much needed peer support during times of crisis or following discharge from hospital, and indeed that peer support was particularly valuable due to the benefits wrought by shared experiences and insight as service users. It was also felt that it could serve as a non-judgmental, accepting social outlet for older LGB people who feel isolated. The issue of geographical dispersion and access would have to be considered. Polari is also aware that Transgender and Transsexual people have very specific issues with mental health services: the reason they were not included in this scoping study which focused on sexual orientation. However we would recommend consideration and consultation as to whether an LGBT Services Users forum is needed, including support for trans people using the same mental health services.

vii) LGB volunteering and awareness raising

This may help to counteract the perceived non-inclusiveness of the LGB community in general to those with mental health needs, those who are disabled and to older people. A drive to improve disabled access in LGB community venues would be beneficial.

Cross-generational contact has been identified here as potentially beneficial for both older and younger LGB people. A befriending scheme which maximises recruitment from younger age groups could have an impact on the quality of LGB lives. Increasing awareness of opportunities to volunteer as well as emphasising the benefits of doing so to young people (for example, skill sharing, training and experience) would be important in attempting to make such an approach a success. LGB community events (for example Pride, the London LGBT film festival, LGBT history month) could be more inclusive of marginalised groups by giving space to or hosting mental health service user projects and presentations or mental health charities. Funding arts projects for these groups could give them a means of making their experiences known within such forums.

Some participants reported feeling that their sexuality had been marginalised or ignored. A campaign that aims to raise awareness of the potential that

positive sexual identity and indeed activity has for improving mental wellbeing both across statutory and voluntary sectors could help to reverse this situation.

viii) Access for older people to primary care mental health support

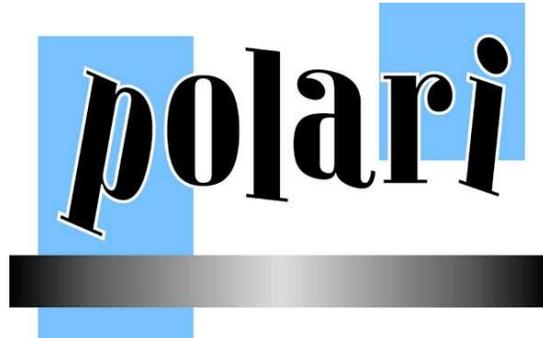
This could be improved; trial periods of inclusiveness (to Advice and Brief Intervention teams) could be implemented and treatment outcomes / cost effectiveness audited in order to assess whether (as the literature suggests) early treatment may shorten subsequent periods of intensive care and improve quality of life for this population.

ix) Inclusive Review of Mental Capacity legislation review

Any review of the current Mental Capacity legislation should aim to incorporate consultation with LGB service users with regards to the success of the Act in providing clear and acceptable guidance and protocol for individual cases where LGB carers or partners have been involved.

x) Monitoring for sexual orientation

In the context of this study, users have felt that it was more important to monitor for sexual orientation than not, despite recognition of the fact that some may find such a process offensive or intrusive. It may be the case that (as Stonewall's 2006 report suggested) the NHS must still make efforts to represent itself successfully as an organisation which values diversity before such monitoring can successfully be carried out. Nonetheless, whilst Count Me In continues to take place annually, it is important to remember to give sufficient information in a manner that is clearly comprehensible concerning the use and storage of data given and the potential usefulness of such data in terms of service commissioning. Participants should be given the means of submitting their responses anonymously, even though this may present some challenges for those with some kinds of impairments.



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The author and Polari's ex-Director can be contacted c/o

Age of Diversity
c/o Consortium of LGBT Voluntary and Community Organisations
J111 Tower Bridge Road Business Complex
100 Clements Road
Southwark
London SE16 4DG

ageofdiversity@googlemail.com