NHS TALKING THERAPIES FOR ANXIETY AND DEPRESSION: LGBTQ+ BITE-SIZED POSITIVE PRACTICE GUIDE (2024)

*Lesbian, Gay, Bisexual, Trans, Queer +

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CONTEXT AND CONSIDERATIONS

In 2018, the Government Equalities Office issued their 'National LGBT Survey: Research Report' to explore the experience of LGBTQ+ people in the UK.

The survey found that 24% of respondents accessed mental health services in the 12 months preceding the survey.

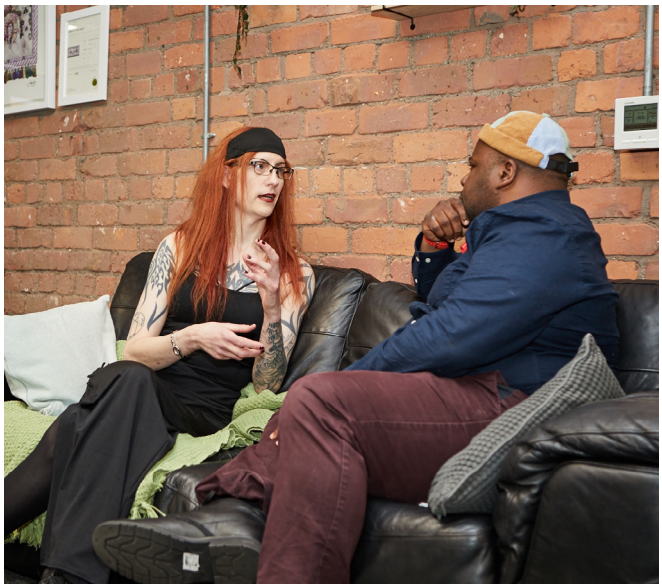
However, 28% of respondents who had accessed or tried to access mental health services in the 12 months preceding the survey said it had not been easy, largely due to waiting lists.

This is a significant issue as previous studies (e.g., Cocks et al., 2019) have found higher rates of mental health conditions including anxiety and depression in LGBTQ+ people compared to heterosexual and cisgender individuals.

To explain these differences, Meyer (2003) suggests that higher incidence of mental health in the LGBTQ+ community is due to cultural, societal, and historical discrimination that LGBTQ+ people are victim to. Adding to this, Laville (2022) highlighted that repeated incidences of homophobia, biphobia, and transphobia can result in the development of mental health conditions and elevated risk rates for self-harm and suicide.

LGBTQ+ individuals are often sceptical of mental health services and are concerned that practitioners will not be aware and understanding of LGBTQ+ considerations (Cocks et al., 2019). A central focus must be to improve practitioners' confidence and competence when working with the LGBTQ+ community. Services need to instil confidence in prospective patients that the psychological therapy will be inclusive and affirming.

Therefore, to support practitioner competence and confidence in working with the LGBTQ+ community and to improve visible LGBTQ+ inclusion at a service level, the following two sections detail practical recommendations to improve access and clinical practice.



REDUCING BARRIERS TO ACCESS

RECOMMENDATIONS	HAS THE RECOMMENDATION BEEN MET?
Self-referral forms need to ask for the patient's gender, pronouns, name, and sexual orientation. It should allow for the patient to self-identify if they select 'other'. This data must be securely stored on the service's electronic patient record. The name provided must be recorded as their first name and not as a preferred name.	☐
There must be visibility of LGBTQ+ inclusivity which could include rainbow lanyards, LGBTQ+ posters, attending events such as Pride, having gender neutral toilets, and staff displaying their own pronouns in their email signature.	☐
Ensure each patient understands what treatment they are waiting for and how long they can expect to be waiting until their first session. This is particularly important for trans individuals who are often on other waiting lists and are therefore, already experiencing significant periods of uncertainty whilst waiting to access a range of healthcare provisions. All modes of treatment (e.g. telephone, face to face, and video calls) should have the same wait time to make it equitable.	☐
Clinicians should be considering potential intersectional barriers, such as neurodiversity, ethnicity, and long term conditions. A discussion with the patient should take place, to consider and make adaptations where required, to increase their ability to access and engage with therapy.	☐
Consider the environment that therapy occurs within, whether this is in person or remote. Routinely discuss if it is a private and confidential safe space to talk openly without people overhearing and potentially being 'outed' and put at risk. Practitioners should be aware of the potential need to switch therapy from remote to in person if circumstances at home change for the patient.	☐

CONSIDERATIONS AND ADAPTATIONS TO CLINICAL PRACTICE

RECOMMENDATIONS	HAS THE RECOMMENDATION BEEN MET?
If the patient has not self-referred, practitioners should ensure that patient information on gender and sexual identity (including 'prefer not to say') is completed at their initial assessment. Then, if relevant, and by utilising the 'appropriate' awareness framework (Kell and Laville, 2021), identity considerations should be discussed at the start of the treatment process.	☐
Formulation and subsequent psychoeducation should utilise a model which accounts for the social influences and minority stresses which are unique to the LGBTQ+ population (e.g., Minority Stress Model; **Meyer (2003)**).	☐
The COM-B system (**Michie et al., 2011**) can be utilised in the initial assessment to identify if the therapy is likely to result in a positive behaviour change.	☐
Aim to have only one practitioner, at each level of care, throughout the treatment process to aid rapport and reduce the need to re-explain identity considerations, which can be exhausting for patients.	☐
Utilise supervision to share experiences of working with LGBTQ+ individuals and to broaden knowledge of current LGBTQ+ topics. This should include supervisors supporting practitioners to discuss their own biases and assumptions.	☐

TRAINING AND RESOURCES

All staff members, regardless of their job role, should complete LGBTQ+ specific training.

The British Association for Behavioural and Cognitive Psychotherapy (BABCP) periodically provide LGBTQ+ training.

They have a LGBTQ+ Special Interest Group (SIG) that members can join which provides updates on training and opportunities.

There are more links to resources within the full version of the LGBTQ+ Positive Practice Guide.

Staff who are LGBTQ+ champions would be encouraged to register with the national NHS Talking Therapies LGBTQ+ Champions Network by contacting: **iownt.lgbtq-network@nhs.net**

To view the NHS Talking Therapies for anxiety and depression: LGBTQ+ Positive Practice Guide 2024, please click **here.**

References;

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