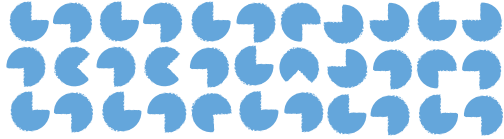


SAMARITANS

**Alcohol
and suicide:
insights from
LGBTQ+
communities'
experiences**

April 2023





➤ Definitions

LGBTQ+

LGBTQ+ stands for lesbian, gay, bi, trans, queer and/or questioning with the '+' representing minoritised sexual and gender identities not included in the initials. LGBTQ+ communities are not a homogenous group. For this work, we have used LGBTQ+ people as an umbrella term that incorporates several identities.

It includes sexual orientations such as gay, lesbian, bisexual, pansexual, queer, asexual, aromantic, or any sexuality that is outside of the heterosexual norm. It also includes bi+, which is an umbrella term for any person who feels attraction to multiple genders. The term LGBTQ+ includes trans and nonbinary people, or any other gender identity that is not cisgender. LGBTQ+ also includes intersex people and can be adapted as a term to refer to different communities such as LGB+ to refer only to lesbian, gay, bi and '+'.

LGBTQ+ incorporates any sexuality and gender that is not cis-heteronormative. Throughout this briefing we will be as specific as possible about the identities we are referring to and have opted to be led by the people who were involved in this work to lead the language around their identities.

Cisgender

Cisgender is a term to describe someone's gender identity being aligned with the sex they were assigned at birth.

Cis-heteronormativity

Cis-heteronormativity is a term that is used to describe cultures and societies where being cisgender and heterosexual is incorrectly regarded as the norm or superior and other genders and sexualities are marginalised and othered.

LGBTQ+ phobia

LGBTQ+ phobia is a term that describes prejudice towards people that identify within the LGBTQ+ communities. This includes transphobia, bi+ phobia and homophobia.

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Introduction

As explored in our 2022 research, Insights from experience: alcohol and suicide, evidence shows that there is a relationship between alcohol use and increased suicide risk, associated with the impact of long-term alcohol use and the immediate effects of drinking¹. This relationship is complex, and may vary depending on a range of factors, including the specific ways in which people drink alcohol². One of the findings from our earlier work reflected a need for further exploration of people's experiences of alcohol and suicide, including examining the intersections with particular identities and life experiences.

In early 2023, we carried out a series of interviews to explore alcohol and suicide with LGBTQ+ people. Through these interviews we heard powerful experiences that have started to help us understand the complex and interconnected factors involved and where changes are needed in healthcare services to better support LGBTQ+ communities and prevent suicide.

We know that risk of self-harm and suicide is higher for people in LGB+ communities than people who aren't³, and higher for trans people than cisgender people⁴. LGBTQ+ people are also more likely to experience alcohol-related harms⁵. This is not because being LGBTQ+ in itself increases risk of suicide or alcohol related harms, but because many LGBTQ+ people may experience additional stressors including but not limited to discrimination, victimisation, isolation and barriers to general help-seeking behaviours, which can increase their suicide risk^{6 7 8}.

The Suicide Prevention Consortium continues to be concerned about the relationship between alcohol and suicide. Samaritans provided emotional support over 176,000 times to people who mentioned alcohol or drugs as a concern during 2022.

With You worked with 75,027 adults in England and Scotland to overcome issues with drugs and alcohol in 2021-22. Although

the connection between alcohol and suicide is well-established, there is limited exploration of how this intersects with the experience of LGBTQ+ communities, especially in their own words. This briefing provides an overview of our findings.

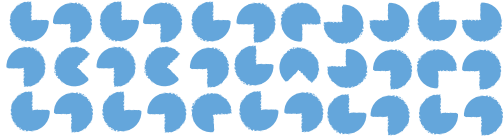
Thank you to all the participants for sharing your experiences and insights with us, this project would not have been possible without you.



What is the Suicide Prevention Consortium?

The Suicide Prevention Consortium is made up of four organisations: Samaritans (lead), National Suicide Prevention Alliance, Support After Suicide Partnership and With You. As part of the VCSE Health and Wellbeing Alliance, it aims to bring the expertise of its member organisations and the voice of those with lived experience directly to policymakers, to improve suicide prevention in England.





What did we do?

We explored three research questions through a series of one-to-one interviews with people with lived experience.

1. What is the relationship between alcohol and suicide/self-harm for LGBTQ+ people?
2. What experiences of support have LGBTQ+ people had for self-harm, suicidal feelings, and/or following a suicide attempt?
 - a. How has alcohol use impacted this support?
3. What should effective support for LGBTQ+ people affected by self-harm and/or suicide who also drink (or previously drank) alcohol look like?

To be eligible to take part in an interview, participants had to be aged 18 years or older, currently live in England, identify as LGBTQ+, self-identify with experiences of drinking alcohol, and having experience of suicidal ideation, attempting suicide or self-harming. 13 people were recruited to participate in interviews.

Interviews were conducted remotely via Zoom and telephone from January to February 2023. Interviews were designed to allow participants to discuss experiences they felt were most significant to them in relation to the themes of the research.

Themes were developed from the content of these interviews, relating to the complexity of identity and personal circumstance, the influence of cis-heteronormativity and LGBTQ+ phobia, and the importance of connection and community. In each of these themes, our research questions are addressed in turn.

This briefing summarises people's insights from their own experience. It is not intended to be representative of LGBTQ+ communities as a whole but to amplify the voices of those with lived experience and extend the current evidence base. We hope that the insights within this briefing will be used by the government, NHS England and other service providers to improve support.

Who did we interview?

The participants we interviewed identified with a diverse range of gender and sexualities, including five different genders, and eight different sexualities.⁹

Gender

- 5 identified as a woman
- 3 identified as a man
- 3 identified as non-binary/gender fluid
- 2 identified with other minoritised genders
- These identities are inclusive of participants that identified as trans

Sexuality¹⁰

- 5 identified as bisexual
- 3 identified as gay
- 6 identified with other minoritised sexualities

Age

- 6 were aged 25-34
- 4 were aged 35-44
- 3 were aged 45+

Ethnicity

- 11 identified as White
- 2 identified with minoritised ethnicities





➤ What did we find?

Finding 1: on personal identity

Identity and circumstance is complex, nuanced and highly personal. This is reflected in people's lived experience of drinking alcohol and suicidality or self-harm and is a vital factor to be considered in effective support.

Participants' experiences of drinking alcohol and suicidality or self-harm, in relation to their identities and personal circumstances.

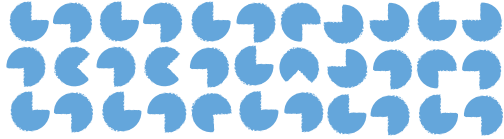
Gender and sexuality is only one part of someone's identity. Although gender and sexuality is one lens through which the LGBTQ+ people we heard from experience their lives, there were also many intersections to their identities and life experiences that weren't connected to their identity as being LGBTQ+. In the same vein, motivations for and experiences of drinking alcohol for participants existed at least in part outside of the lens of LGBTQ+ identity.

“ I'm not really sure if they're interlinked, as such, I'm not sure, like, my sexuality and alcohol. ”

For many participants, drinking alcohol was reflected as a norm in social spaces that included for example family gatherings, work or university socials. For some, this norm meant that drinking alcohol was simply a socially acceptable behaviour, and for others it was felt as an expectation or a social pressure. With this understanding, drinking alcohol was one mechanism through which they could adhere to social norms and gain or retain social acceptance, regardless of LGBTQ+ identities.

“ If I was the only family member that didn't have an alcoholic drink, it was kind of expected that I would. ”





■ Finding 1: on personal identity

Similarly, drinking alcohol for some participants increased confidence and reduced self-perceived barriers to social connection such as social anxiety, low self-esteem or neurodiversity.

“Going to the pub and having a drink that was kind of you know, necessary to start talking to people. I was feeling less self-confident to approach others, I thought that it was my ticket, to join others, to join a community, to feel that I could be part of company.”

Some participants reflected that they have drunk alcohol with the intention of overcoming negative thinking and emotions, that were at times related to particular life stressors. Drinking in this context was described as numbing or calming to varying extents, for some it enabled an escape from rumination, for others the calming effects of drinking alcohol led to boredom to then be eased by other risk behaviours.

“If I’m in a dark place and, like, ruminating and spiralling into, like, a thought process which isn’t helpful for me, then I have, like, on the odd occasion, sort of, got drunk just because I don’t want to think about those thoughts, basically. And it’s helped me escape that sort of realm of thoughts.”

For some participants drinking alcohol was regarded in this context as a coping mechanism that helped interrupt transitions from suicidal ideation to attempting suicide.

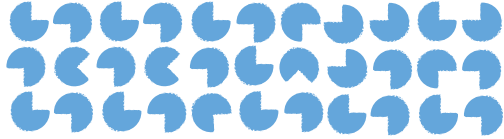
“During that dark period you just, like, would like to drink enough to stop the anguish of being alive but without, like...it stops, you know, you killing yourself then sometimes.”

Relief or ‘numbing’ from drinking alcohol was usually temporary, and afterwards many participants described feeling depressed amongst the re-emergence of negative feelings, thoughts and physical health effects of drinking alcohol.

Some participants also felt shame about their use of alcohol and its impact on their daily lives, contributing to a negative sense of self. When participants reflected drinking alcohol as having a negative long-term effect on their mental wellbeing, pressures to conform to social norms around drinking alcohol for some made it harder to change their behaviour.

“I’ve only had one, and I’m like, ‘Why, why did I do that? I didn’t really want it.’ I know it makes me feel rubbish and I can feel it affecting my mood. I did that for a long time actually before I cut down to where I am now. I kept just having it because I think social conformity.”





■ Finding 1: on personal identity

Self-harm and suicide is rarely caused by one thing. It is usually the intersection of many different individual, interpersonal, community and societal factors that increase risk. While many participants self-attributed certain experiences related to being LGBTQ+ as contextual factors to their suicidality and self-harming, they also discussed many other contextual factors or stressors that were highly varied and individual to their personal life circumstances.

Work pressures, family tensions and bereavement were most commonly discussed by participants in relation to their suicidality and self-harming. Participants also discussed familiarity with suicide and self-harm through bereavement or engaging with the media (for example, harmful suicide/self harm content online) as a related factor that increased their risk of suicide and self-harm.

“ I knew that I would almost certainly have to leave a town where I loved the people I was with, and I loved my job and the people I worked with. So the whole bottom fell out of my world, there was no firm foundations and I hated it, absolutely hated my life. ”

“ With regards to the self-harming, I think there had been some kind of family argument and then that kind of snowballed. In terms of the suicide attempt that was similar circumstances, family arguments, family disagreements. ”

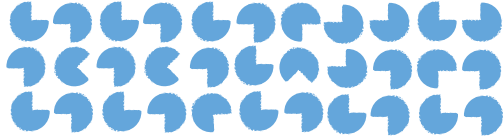
“ When something's in your sphere of understanding, it kind of becomes, like, an option, almost. ”

During more acute episodes of suicidality or low mood, drinking alcohol at times was felt to intensify participants' ideation, aggravate feelings of being out of control, and reduce internal barriers to self-harming or attempting suicide. In these contexts, some participants said they found it difficult to know when they were drinking alcohol as a coping mechanism and when it increased risk, while for others drinking alcohol felt at times to be more intentionally self-destructive.

“ I don't think I was honest with myself for a long time about why I was drinking alcohol. I think I probably thought it was helpful [or] neutral at the time and then only, you know, through years of looking and reflecting on my behaviour have I been able to recognise that actually it was quite problematic ... largely because it often would then evolve into a crisis so either self-harming or making a suicide attempt .. it took me a long time to make that connection. ”

“ On some occasions I had deliberately drunk alcohol because I knew it would lower my inhibitions. It would make me more likely to do something to harm myself. ”





■ Finding 1: on personal identity

Participants' experiences of support and how their healthcare professionals did and did not consider the complexities of their personhood.

Just as experiences of drinking alcohol, suicidality and self-harm were related to many intersecting factors of identity and personal circumstance for participants, so too were their experiences of support. Often, participants felt they weren't being seen in their totality during interactions with healthcare professionals. This was in part due to their perceptions that support was overly process focused. This mirrors our first finding from our 2022 research, [Insights from experience: alcohol and suicide](#).

“It was terrible. Like, it was so by the rote. She was taking me through a textbook. I could see the textbook on the screen. There was no human-to-human interaction, really. It was just point-to-point. Um, it was just bad. There was no sense of self in it.”

“With the multiple identities I couldn't speak to the doctor, it was this and that. Um, and I'd, you know, taken much time to fill out some forms. My answer couldn't fit into the box.”

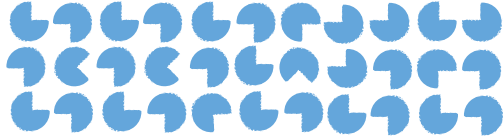
Seeming reliance on process by healthcare professionals meant that for many participants, they felt dismissed through these interactions and were not afforded the time or sincerity through which they could be seen as a whole person and feel heard.

“For a newcomer to the country, or an immigrant, or someone having English as a second language, or someone neurodivergent, on the autistic spectrum, that gets agitated with all this hustle...the system expects you to be a model patient, a model service user.”

“We had the, sort of, one-off conversation, and they were really doubtful almost of what I was saying. They, sort of, made points that I was really well groomed so I couldn't have been feeling low.”

Additionally, siloed provision of mental health and alcohol support services were not felt by participants to reflect the interconnectedness of their experiences. For instance, one participant reflected that in order to receive support around their experiences with drinking alcohol, they would be required to self-refer in complete separation to mental health support:





■ Finding 1: on personal identity

“ They don’t deal with that as a whole either. That’s separated out, you know. You see this person for your mental health, you see this person for dealing with alcohol and actually the problems, it’s all entangled. I’ve never had any professional help. I stopped drinking on my own. But I think I could’ve done with it.

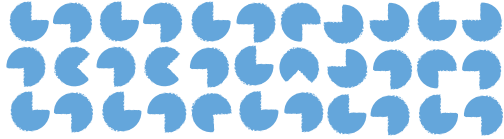
I was offered it but it was a separate service that I had to access myself. I didn’t really want to admit that I had an issue. So I didn’t access that. It kind of felt a bit like, ‘Well, we’re gonna help you with your mental health and those behaviours, if you wanna deal with them, you deal with them.’”

Many participants felt unable to discuss with support professionals the many contextual factors that were felt to be linked to their suicidality, self-harming and wellbeing more broadly. For example, when mental health support professionals asked some participants about their relationship with alcohol, this was often felt to be tokenistic without the intention of exploring their experiences of drinking alcohol in relation to other parts of their identity and circumstance.

“ That [drinking alcohol] has been something that I’ve been asked about but it seems to be more of an assessment question rather than, ‘Let’s see how we can actually support you with this’. I guess things like my physical health, my finances, living situation, all of those other factors that make me me, I don’t think are necessarily considered.”

“ There isn’t much room for like, getting down to the [detail] of it, I think, with a lot of that it’s about structure, not about meandering and going off course.”





■ Finding 1: on personal identity

The importance of holistic support, where people are considered in their totality including the varied contextual factors related to their suicidality, self-harm, and experiences of drinking alcohol.

With their experiences in mind, participants discussed a number of areas for improvement in support centred around a holistic and person-centred approach. Specifically, participants stated that effective support should consider the complexities and nuance of people's identities and personal circumstances. Participants suggested that healthcare professionals should take the time to exercise non-judgemental curiosity. They also expressed the need for healthcare professionals to believe people when they seek support: both around the seriousness of their thoughts and feelings and the factors that they discuss including their suicidality, self-harming and relationship with drinking alcohol.

“ Taking into account that we're all multi-dimensional, dynamic human beings. And harnessing our different facets and validating our different facets in a positive way. I think it would reignite people's inner warmth and belief in themselves and make them more confident with connecting with others. ”

“ People don't drink a lot for no reason. There's usually an underlying cause. I think actually turning it on its head, if we think about how much somebody drinks, if that raises a red flag, why are they? Is there anything you can do to support them? Are they at a risk of suicide? ”

To facilitate holistic support, participants expressed that greater joint working is needed between mental health services, alcohol support services and specialist LGBTQ+ services. However, with current funding constraints in the health sector, the degree to which this could be realised was questioned.

“ I think we need a whole sector approach in health and social care and in the VCSE [Voluntary, Community and Social Enterprise] sector. It needs to be joined up. We need to meet people where they're at and actually get to know them as a person. But we don't have the money and capacity for that. So, it's all in an ideal world, what would it be like? In reality, I don't know if we can change anything. ”





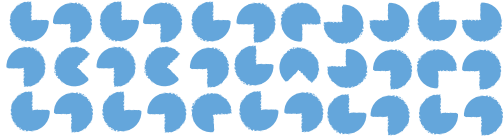
■ Finding 1: on personal identity

Recommendations

People's identities and experiences are nuanced and can play a role in how people experience suicidal thoughts and behaviours and self-harming, as well as in why and how they drink alcohol. When looking to provide suicide prevention support for LGBTQ+ people a variety of health support needs must be met in a holistic and integrated manner. This principle is important not just for those within LGBTQ+ communities: our 2022 report on alcohol and suicide strongly identified the need to move away from siloed support.

1. All mental health services need to take a person-centred approach to care which acknowledges that people will present with multi-dimensional identities and experiences. The pathway of care should be joined up to allow for these many possible factors in order to provide appropriate care alongside other health needs. For example, mental health services joined up with alcohol support services.
2. There should be no barriers or exclusion for people seeking support with suicidality wherever they present, in line with national commitments to a 'no wrong door' approach to care for people with co-occurring conditions. This must include believing the experiences people share as being relevant to their care with consideration of LGBTQ+ identities, experiences with alcohol, suicide and self-harm.
3. As integrated care strategies are forming across England, it is a unique opportunity for the health and social care system to support and facilitate integrated commissioning and provision of mental health, alcohol treatment services and relevant LGBTQ+ support, to ensure joined up care.





Finding 2: on society's expectations

Cis-heteronormativity and LGBTQ+ phobia were pervasive and significant for some participants in their experiences of drinking alcohol, suicidality or self-harming, and seeking support.

The influence of cis-heteronormativity and LGBTQ+ phobia on participants' experience of drinking alcohol, suicidality and self-harm.

For a minority of participants, experiences related to their LGBTQ+ identity were not felt to be linked to their experiences of suicidality or self-harm. For many participants, pervasive experiences of cis-heteronormative othering and LGBTQ+ phobia did worsen their mental wellbeing.

LGBTQ+ phobic discourse was experienced by participants at a structural level through popular media and policy. Participants expressed that public dialogue has both failed to provide a narrative where identifying as LGBTQ+ is legitimate and also perpetuated narratives that frame LGBTQ+ people as inferior. Additionally, media reports of LGBTQ+ phobic violence were felt to stoke an underlying sense of threat.

“No-one tells you that being transgender is a thing...I just did not understand those feelings because no-one had told me it was a thing. I knew about, do you remember that trans man that got pregnant? That, that was the end of my experiences of transgender.”

“All of that, kind of, homophobia in the 1980s that gay people were dangerous. You know, they either had AIDS or they were predatory paedophiles and actually growing up with people holding those kind of views even if it's in the media, they're not directly to you, is horrific, you know? ...I think today it's probably very hard for people to understand just how intense that was.”





■ Finding 2: on society's expectations

Living within these discourses for some participants contributed to a sense of **hopelessness**¹¹, or led to feelings of negativity and shame around their LGBTQ+ identity.

“ I think what I really struggled with is seeing a route forward. What exactly does it look like to continue and to be happy in that space? What does it mean to be LGBTQ+ and, like, live a long life? ”

“ I was realising more and more that it was not okay to be gay, and that I also happened to probably be gay in some form or another, so there was definitely an expression of anger directed at the self. ”

“ Yes, there was the, the element of threat, but then there was also the element of internalising a sense of being defective and wishing that it would be another way. ”

At a community level, some participants experienced a lack of support around their identity as LGBTQ+, that manifested differently for participants, some experienced rejection, and others victimisation. Participants discussed feeling rejected from the communities in which they lived due to their LGBTQ+ identity, with one participant also discussing bi+phobia within the LGBTQ+ community.

“ If anybody asked me, 'Where were you?' 'I was at a gay bar.' ...it was a big mistake to do that. It was a big mistake to make that public knowledge, and that fuelled more feelings of rejection, and from a bigger community of people. ”

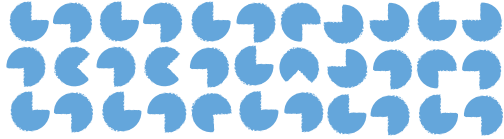
“ If I was more defined as absolutely a lesbian or absolutely a gay man, I think you're slightly more accepted...they just don't think I'm one of them. ”

More viscerally, lack of support at a community level for some participants led to fear of and actual experiences of violence and intimidation.

“ We were the only gay people in the street. And I suppose just constantly not knowing what reaction you're going to get. I think people often now think, 'Oh, it's alright to be gay now' and obviously it's more complex than that. ”

LGBTQ+ phobia at a community level for some participants formed one barrier to social connection and thus contributed to feelings of **isolation**¹² and a negative sense of self. Additionally, the pervasiveness of LGBTQ+ phobia at this level for some participants contributed to feelings of **entrapment**¹³.





■ Finding 2: on society's expectations

“ I think it was one of the things, and I think possibly all my little factors are interlinked in some way, that made it harder for me to find friends or know how to find friends. Yep. So, that lack of connection. ”

“ The trapped nature of feeling like this, like, there's no way out of this situation. ”

Participants experienced cis-heteronormativity and LGBTQ+ phobia from family, friends and peers. Across interviews, LGBTQ+ phobia at this level seemed to be most directly linked by participants to their suicidality and self-harming, where isolation and rejection were experienced most intensely.

“ I was living in a really uncomfortable, unwelcome household with my parents. They were really uncomfortable with my LGBT identity, and I was quite shut off from them because of that. So, I think I started to feel quite isolated, my access to friends was limited at the time by my parents, so, that only increased my feelings of isolation. So, I did start to feel quite suicidal, low, and did start self-harming at that time. ”

In another example, one participant shared how the first time they searched for information about suicide methods was after hearing a family member describe them as no longer wanting to be a woman.

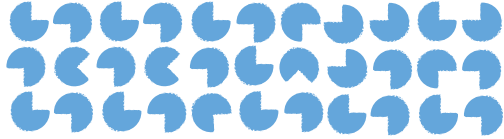
As discussed in section one of this briefing, drinking alcohol amongst these feelings of hopelessness, rejection, isolation, shame and at times ultimately suicidality was for some participants a coping mechanism to address negative thinking and emotions. Other times drinking alcohol intensified these thoughts and feelings thereby increasing participants' risk to engage in self-harming or suicidal behaviour.

“ I was confused about my own identity, sexual identity. They knew that I was gay, before even me myself. It was something on the borderline of teasing and bullied. So alcohol became a tool of giving me some confidence and reassurance while I was alone. It was something that was giving me joy. ”

“ I felt really isolated and marginalised and I'd been hating myself because of that, I've used alcohol to connect me with feelings of a better self. ”

For some participants LGBTQ+ phobia or a lack of inclusive practice was a significant dynamic to the support they engaged with. Cis-heteronormative assumptions were made by support professionals about the gender and sexuality of participants without inclusive curiosity with regards to their LGBTQ+ identity.





■ Finding 2: on society's expectations

“ No one ever asked about my gender or my pronouns or my sexuality. And I think they didn't ask because I was dating a man, so, people just assume you're straight. ”

More actively, LGBTQ+ phobic practice manifested as intrusive curiosity with regards to participants' LGBTQ+ identity, where participants felt concerned about professionals' motivations.

“ I think he was very interested in my trans identity, I thought I was there to talk about mental well-being, but he kept asking me what I thought were very invasive questions about my gender. ”

“ I asked him what the relevance was of my marriage to a psychiatric appointment and my suicide, he really got hostile with me, and that was when the whole meeting ended up being quite traumatic. ”

“ Why am I finding myself asking why I'm being questioned about this? Is he going to make assumptions about me? ”

Similarly, participants also reflected experiences of where this hyperfocus was felt to conflate LGBTQ+ identity with their experiences of suicidality or self-harm.

“ I think the psychologist was almost hyper-focused on my LGBTQ identity, when actually that wasn't what I was primarily seeking help for. I think that can be a problem with medical professionals [...] [they made] it sound like I'm being diagnosed homosexual. ”

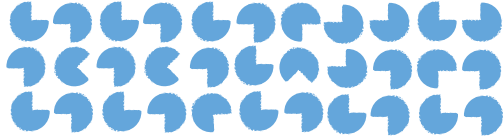
Most explicitly, LGBTQ+ phobia manifested in the last 20 years for one participant as a support professional health professional suggested suppressing their LGBTQ+ identity. In response to these experiences, some participants came to doubt the competence of support professionals or avoid seeking support in the future for self-protection.

“ If things like that happen when you're already feeling vulnerable, it makes you think, what insight might this person have to be able to listen or to help? ”

“ I completely just disengaged from the whole thing out of fear pretty much. I was very hesitant to go for support again. And I didn't until years later. I pretty much had to look after myself. ”

Some participants described instances of engaging in support that they found inclusive and equipped towards their LGBTQ+ identities. When support was experienced as positive in this regard, professionals displayed an understanding of some common experiences for people identifying as LGBTQ+ and surrounding contextual factors to suicidality and drinking alcohol, whilst not making assumptions.





■ Finding 2: on society's expectations

“ [They were] non-judgemental because they knew all of the stuff that was happening in the LGBT community. They knew the sex that we had. The ways that we were doing stuff. Like, there was a, sort of, sense of understanding, non-judgemental space, but also I felt they really were appreciative of what I was saying. ”

Participants' recommendations for embedding LGBTQ+ inclusivity across healthcare and social support.

With these experiences in mind, participants discussed several ideas for improvement concerning LGBTQ+ inclusivity. One participant spoke about how mental health support services should be outwardly presented as actively including all people, particularly those identifying as LGBTQ+.

“ It would be good if they perhaps showed LGBT people or more representation to say that those services are there for everybody. Which I know that I know they are but I don't know if everybody else knows that. ”

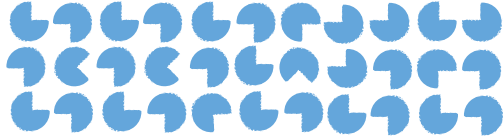
In another way, many participants also suggested a need for healthcare professionals to better understand LGBTQ+ identities, and common contextual factors to suicidality and drinking alcohol that people identifying as LGBTQ+ may experience, while at the same time treating people as individuals and not assuming any universality of experience.

“ NHS professionals especially need to know about LGBT+ experiences and identities. It's not an optional maybe thing, they need to understand our community and understand what we need. We're a large community, it's within their remit to understand how to better our care and how to support us. ”

“ I think more open access for people and recognising that just because you're LGBT doesn't mean that your experiences are the same as the next person's. ”

“ It's one part of my life, it's not everything, but it's important for [healthcare professionals] to know that because that's a lens through which you can see some of my experiences. ”





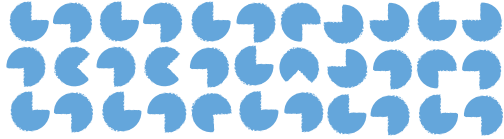
■ Finding 2: on society's expectations

Recommendations

LGBTQ+ people shared experiences where cis-heteronormativity and LGBTQ+ phobia have had a direct impact on their quality of care from healthcare professionals. These experiences are not limited to suicide prevention or alcohol services but have been encountered across all healthcare settings. This needs to be tackled to reduce suicide risk. LGBTQ+ people should not be made to justify their gender or sexuality and should instead be met with inclusive and non-judgmental understanding of their experiences of suicidality, self-harm and drinking alcohol.

4. NHS England and all healthcare providers should ensure that staff in all healthcare settings have comprehensive training on LGBTQ+ inclusivity and person-centred care. This should empower the workforce to be able to approach people from a place of understanding, avoiding assumptions and to be able to ask appropriate questions and explain the relevance of questions to the care being provided, in order to improve wellbeing and help-seeking behaviour within LGBTQ+ communities.





Finding 3: on the role of community

Community and connection was important for many participants' sense of belonging and was one central mechanism influencing their experiences with drinking alcohol.

The role of LGBTQ+ spaces as a contextual factor surrounding participants' experiences of drinking alcohol and how this relates to experiences of suicidality and self-harming.

LGBTQ+ spaces (formal or informal social spaces that are orientated towards LGBTQ+ communities, for example, bars, book clubs, community centres) were regarded as uniquely valuable to participants as a means to **experience a sense of belonging**¹⁴ and express their gender and sexuality in a safe and accepting place.

“ That was the first safe place where Section 28¹⁵ had not long gone. It was, like, early 2000s, I was in university and was nowhere near ready to come out. I just knew that I couldn't exist all those years and then I went to uni and I was like, 'What the holy head is this magic?' And, a gay bar. ”

“ When you do know that you do have sexual desires, you can't always have that same space that other people do to just, like, you can't kiss somebody in the street. So, that space with alcohol allowed you to explore that in a safe space that you couldn't do in a regular pub. ”

Drinking alcohol in these contexts also contributed to confidence and disinhibition to engage with these spaces.

“ I think it gave me access to different worlds and perhaps it gave me a little bit more courage and a bit more of a push to explore the gay world. ”





■ Finding 3: on the role of community

“ I think I wouldn't have been quite so lustful without the alcohol. It's not about general inhibitions but I wouldn't just show myself to be a sexualised fool on the dance floor without it, do you know what I mean? ”

LGBTQ+ spaces in particular are predominantly oriented around alcohol. Without engaging in these spaces, some participants felt they could become isolated from LGBTQ+ communities. Because of this, many participants accepted the norm of drinking alcohol in LGBTQ+ spaces or felt an expectation to drink alcohol, despite understanding the negative effects drinking alcohol may have on their mental wellbeing.

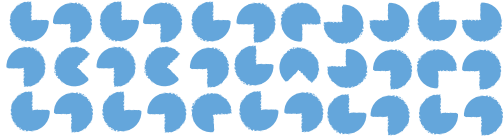
“ I guess it's like the want of belonging, you want to belong, you want to feel in some way comforted by a space. But the spaces that we have as LGBT people, and I would say wider society, we generally link up in is places where there is a lot of alcohol involved. ”

“ I think you risk being, like, a little bit isolated from the community if you don't drink or don't like to be around drinking. ”

Isolation due to a lack of social support was reflected by some participants as a key risk factor in their suicidality or self-harming. This isolation was not always related to their LGBTQ+ identity but for some participants, seeming absence of LGBTQ+ communities did contribute to a lack of belonging.

“ There wasn't other trans people that I could look to or befriend or [be] in a community with. So I did feel like this was a sole thing that I was going through. And I think that that did create a sense of self-loathing or self-hatred for me and that's the link with the suicidality. ”





■ Finding 3: on the role of community

How participants regarded the significance of LGBTQ+ community and connection in support experiences.

Negative experiences of seeking support for participants in this context included when they were unable to connect with other LGBTQ+ people and thus could not find connection through engaging with people who have shared experiences.

“ Nobody even considered that I might relate to somebody better who isn't just, like, a cis het¹⁶ white man...the NHS has all these networks, they've got LGBT+ networks in the NHS. They're not connecting these people up, and identifying that, if somebody is from that community, 'Hey, do you want to speak to our-, one of our-, like, do you know what I mean? ”

“ I wanted to [engage in peer support] and I knew it would have been helpful. But I also, being, like, bisexual and non-binary, it's very much like, 'Pick a side, you're not really gay, you're not really trans.' Which I know isn't true, but also that's the message that you get from a lot of people in a lot of contexts, and I didn't really want to deal with that. ”

In a similar regard, some participants discussed experiences where mental health

support professionals did not recognise the value of informal LGBTQ+ spaces in improving their wellbeing, meaning they were not supported to engage in these spaces.

In contrast, participants evaluated the support they engaged within LGBTQ+ spaces as positive. This was often when they could **experience social support**¹⁷ and establish universality of experience with others, whether that be through formalised peer support, LGBTQ+ friendships, or connecting with LGBTQ+ support professionals.

“ I think that's [LGBTQ+ drug and alcohol group therapy] probably the place where I've, over time, brought so many different things and taken in so many other different things from people. [They] relate to my experiences with drinking alcohol, and with drugs, and with suicide and self-harm, and with my sexuality and also, I guess stitching all of that together, relational life, getting on with other people, and realising that in all this kind of darkness there sometimes comes actually some really valuable knowledge that we can give to each other. ”

“ I sought out an LGBT+ therapist, I specifically picked them because they're LGBT+ and have a lot of experience working in the community and that was really important to me. They're really great. ”





■ Finding 3: on the role of community

Participants' recommendations around increasing the availability of LGBTQ+ community and connection when engaging in support.

With these experiences in mind, participants stressed the importance of creating or illuminating pathways through which LGBTQ+ people seeking support for suicidality and self-harm can connect and find community outside of spaces dominated by alcohol.

“ You could say, ‘hey, do you know we’ve got our LGBT [staff] network, if you wanted to speak to somebody,’ just a casual chat, to know that you’re not alone. ”

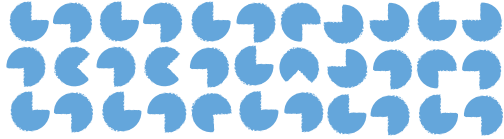
“ I think a lot of great work can be done online. Having some form of alcohol-focused, LGBTQ+ focused group could be really, really great. It could also be really, really great in person. But I do think community is really really important for LGBTQ+ people anyway, especially those who rely on alcohol. ”

“ It can be so much more reassuring to be connected. It’s belonging, isn’t it? And belonging I would say is probably one of the best antidotes to suicide. ”

To achieve this, one participant suggested a need for support professionals to work in partnership with organisations creating or hosting these spaces in order to provide people seeking support with information on how they could be accessed.

“ I think if my GP had any knowledge of what was available, that could have been really useful information for me to know. So, I think something like a peer support group or a club or a well-being group or something would have been really useful. ”





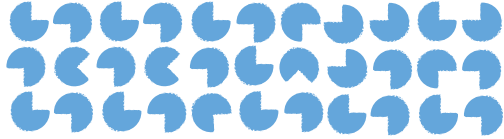
■ Finding 3: on the role of community

Recommendations

Both formal LGBTQ+ specific services and informal spaces and support within LGBTQ+ communities have an important role to play in ensuring that LGBTQ+ people have effective support regarding suicide, self-harm and alcohol use.

5. Integrated care strategies need to acknowledge the role that LGBTQ+ peer support, community spaces and specific LGBTQ+ services have in suicide prevention. They should also enable them to complement the healthcare pathways and experiences of care within NHS services through adequate funding and resource. This could include the dedicated suicide prevention funding provided by central government to local areas.
6. Relevant stakeholders across health and social care should work with people with lived experience of alcohol use, suicide and self-harm to develop these models of support to complement the care within healthcare settings.





Further support


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If you need someone
to talk to, we listen.
We won't judge or tell
you what to do.**

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get in touch.

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Samaritan will face it with you.**

Need to talk? We are With You.

Get free, confidential support with
alcohol, drugs or mental health
from one of our local services or
online at [wearewithyou.org.uk](https://www.wearewithyou.org.uk)

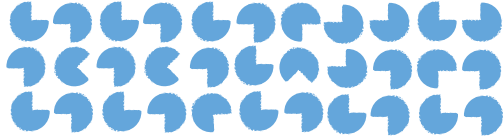


You can contact the **LGBT+
foundation** helpline by calling
0345 3 30 30 30 (open Weekdays
- 9am until 9pm, Saturday & Sunday -
10am until 5.30pm)

For emotional and mental health
support for people identifying as trans
or non-binary, contact **MindLine
Trans+** on **0300 330 5468** (open
Friday's 8-11pm)

For help finding mental health support
in your local area, go to **Hub of Hope**
and enter your postcode.

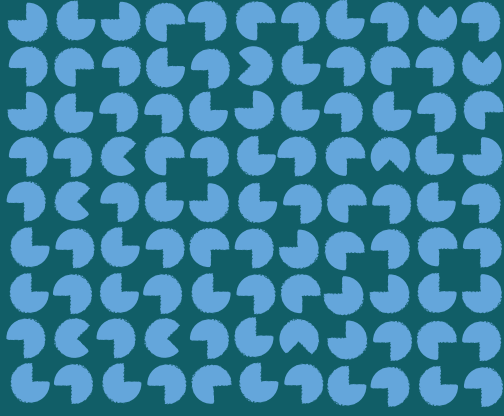




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- 8 Rivers, I. et al. (2018). '[LGBT People and Suicidality in Youth: A Qualitative Study of Perceptions of Risk and Protective Circumstances](#)', *Social Science & Medicine*, 212, 1–8.
- 9 Please note that to protect the identity of those who took part in an interview, demographic information that relates to less than three participants has been grouped.
- 10 One participant identified with more than one sexuality.
- 11 Known risk factor for suicidal ideation as illustrated in the Integrated Motivational-Volitional (IMV) Model of Suicidal Behaviour. O'Connor, R. C., & Kirtley, O. J. (2018). The integrated motivational–volitional model of suicidal behaviour. *Philosophical Transactions of the Royal Society B: Biological Sciences*, 373(1754). DOI: 10.1098/rstb.2017.0268
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- 14 Sense of belongingness is a known protective factor against suicide as discussed in Joiner's interpersonal theory of suicide (Van Orden, K. A., Witte, T. K., Cukrowicz, K. C., Braithwaite, S. R., Selby, E. A., & Joiner Jr, T. E. (2010). The interpersonal theory of suicide. *Psychological review*, 117(2), 575. DOI: 10.1037/a0018697
- 15 Section 28 was legislation that prohibited the 'promotion of homosexuality' by local authorities in the UK, including through teaching or publishing materials. It was in effect from 1988 until 2003.
- 16 'Cisnet' is an abbreviated term to describe someone's gender and sexuality as cisgender and heterosexual.
- 17 Social support has been recognised as a protective factor against suicide in UK nationally representative samples (Kleiman, E. M., & Liu, R. T. (2013). Social support as a protective factor in suicide: Findings from two nationally representative samples. *Journal of affective disorders*, 150(2), 540-545. DOI: 10.1016/j.jad.2013.01.033)





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