Improving the mental health outcomes of Nottingham's LGBT populations

Quantitative analysis of existing national and regional statistics concerning the mental health needs and healthcare experiences of LGBT people

Authors: Tammy Ayres, Rebecca Barnes, Clare Gunby and Katherine Johnson

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This research has been commissioned by NHS Nottingham City Clinical Commissioning Group

University of Brighton
Centre for Transforming Sexuality and Gender

UNIVERSITY OF LEICESTER

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Glossary of Terms

Asexual	A person who does not experience a sexual/romantic attraction to others
Bisexual	Umbrella term used to describe a sexual orientation/attraction towards more than one gender/sex (bi, pan and queer may also be used)
Cisgender	Having a gender identity that aligns with the sex they were assigned at birth (non-trans may also be used)
Gay	A person who has a sexual orientation/attraction to someone of the same sex/gender e.g., a man who has a sexual orientation/attraction to men and a woman who has a sexual orientation/attraction to women
Heterosexual	A person who has a sexual orientation/attraction to someone of the opposite sex/gender (straight may also be used)
Homo/Bi/Transphobic	The fear/dislike of someone, based on prejudice or negative attitudes, beliefs and/or views about lesbian, gay, bi or trans people
Intersex	A person who may have the biological attributes of both sexes or whose biological attributes do not fit with those typically associated with male or female (hormones, chromosomes, external/internal reproductive organs). Intersex people may identify as male, female or non-binary
Lesbian	A woman who has a sexual orientation/attraction towards women
LGBT	An acronym for Lesbian, Gay, Bisexual and Transgender people
Non-Binary	Umbrella term for people whose gender identity does not sit comfortably with man or woman and includes people that reject binary identities entirely (genderqueer, agender or gender fluid is also used)
Pansexual	A person who has a sexual orientation/attraction to others regardless of their sex or gender
Queer	Although sometimes seen as a slur, the term has been reclaimed and is used by people who identify with a minority sexual orientation or gender identity and/or to reject labels of sexual orientation and/or gender identity and/or the perceived norms of the LGBT community
Questioning	In the process of exploring your sexual orientation and/or gender identity
Trans/Transgender	Umbrella term used to describe people whose gender is not the same as the sex they were assigned at birth (gender-queer, gender-fluid, non-binary, gender-variant, transsexual, third sex, genderless, agender, non-gender, trans-man, trans-woman, androgynous, transvestite, cross-dresser and neutrois may also be used)

(see GEO, 2017 and Stonewall's Glossary of Terms: https://www.stonewall.org.uk/help-advice/glossary-terms#a)

Executive Summary

This analysis has been conducted as part of the 'Improving Mental Health Outcomes of Nottingham's LGBT Populations' research that is being led by researchers from the University of Leicester and University of Brighton and is commissioned by NHS Nottingham City Clinical Commissioning Group (CCG).

Existing national survey data and, where available, regional and/or Nottingham-specific data, has been reviewed in this report in order to establish what is already known about the mental health needs of lesbian, gay, bisexual and transgender (LGBT) people and their experiences of mental healthcare services. The findings of this analysis have been used to inform priority areas for consideration in the subsequent qualitative phase of the research.

The data sources used include official statistics from national, representative government surveys such as the Annual Population Survey and findings from the landmark government National LGBT Survey which was conducted for the first time in 2017. Non-government surveys are also included, where appropriate, including local data collected by Nottingham and Nottinghamshire Healthwatch and at Nottinghamshire Pride.

The analysis covers the following core topics:

- LGBT population estimates
- The characteristics of LGBT populations
- Discrimination and victimisation related to sexual orientation and/or gender identity
- LGBT people's health and wellbeing
- LGBT people's experiences of accessing healthcare
- Trans people's experiences of accessing gender identity health services
- LGBT people's experiences of accessing mental health services

Whilst there are some encouraging findings regarding overall satisfaction with healthcare services, both nationally and specifically in Nottingham City, this analysis has highlighted multiple aspects of disadvantage for LGBT people in relation to both their mental health and their healthcare experiences.

What is apparent, and particularly concerning, is that **services which should be supporting individuals at some of the most difficult times of their lives may either exacerbate the difficulties which they are facing, or may be avoided for fear of unhelpful, inappropriate or inequitable responses.**

The key findings are as follows:

- Young LGBT people are more likely to identify as non-binary, bisexual or gay/lesbian, compared to older individuals, and older people are less likely to disclose their sexual identity in both national and local surveys.

- Experiences of hate victimisation, discriminatory or marginalising experiences at school and sexual victimisation are especially high for LGBT people. These experiences of structural and interpersonal oppression need to be a central consideration when exploring factors affecting LGBT people's mental health and their feelings about accessing healthcare services and disclosing their sexual orientation and/or gender identity. This raises the question of how healthcare services are signalling that they are LGBT-inclusive and facilitating opportunities for disclosure.

- LGBT people have higher rates of poor mental and physical health, and higher rates of smoking, drinking alcohol, drug use, self-harm, suicidal ideation and victimisation both inside and outside the home than heterosexual, cisgender people. This is even higher for the younger LGBT population. These findings are replicated in both national and Nottinghamshire specific datasets.

- It is important to pay attention to differences within LGBT populations. A recurring theme to arise from the analysis of both the national and local data is that those identifying as bisexual have poorer physical and mental health. Intersections with other aspects of LGBT identities need to be considered, but the small numbers of LGBT people in many surveys inhibits conducting any sufficiently robust intersectional re-analysis.

- Encouragingly, the majority of LGBT people rated their healthcare experiences positively both nationally and in Nottingham City. However, this was not the case for trans people accessing specialist gender identity services either nationally or locally, with long waiting times being a particular issue.

- Despite generally positive healthcare experiences, it is the case that, nationally and locally, LGBT people are more likely to report a negative experience when accessing healthcare services than those identifying as heterosexual. Again, negative healthcare experiences were not evenly distributed amongst LGBT populations: those identifying as bisexual, transgender and queer were more likely to report negative experiences such as not feeling listened to, feeling that their needs were ignored and/or feeling worried and anxious about accessing healthcare services, particularly GPs.

- Some of the most negative experiences of healthcare for LGBT people related to GPs, who not only failed to understand their needs or know which services to refer LGBT individuals to, but were also unsupportive and in some instances, discriminatory and hostile to their patients. Although these experiences are found in both national and local datasets, the rates of poor GP experiences were markedly higher for LGB people

in Nottingham City CCG than across all CCGs nationally, although small numbers of LGB respondents mean that this finding is not conclusive.

- Men, regardless of their sexual orientation, were reluctant to access both general healthcare services and mental health services compared to women of any sexual orientation. Trans men were more likely to avoid seeking treatment due to fear of having negative experiences.

Overall, this review illustrates that **LGBT people have greater healthcare needs across the board than heterosexual, cisgender people, and yet they experience barriers to accessing treatment and hostility in some instances when they do**. This situation intensifies the health inequalities that are experienced by LGBT populations. Priorities for future research, including the next phases of this research project, are:

- To gain a greater insight into how intersectionality impacts on mental healthcare needs and experiences among LGBT populations, and to particularly understand the issues facing bisexual people.

- To explore healthcare practitioners' confidence in providing services to less well-understood groups such as those identifying as queer, pansexual, non-binary or trans men , as well as the extent to which existing training prepares them to work with the whole spectrum of LGBT populations.

- To identify how primary care and community mental health services can embody a commitment to inclusive and non-discriminatory practice from the perspectives of LGBT people and healthcare providers.

- To elicit LGBT people's and healthcare practitioners' views about sexual orientation and gender identity disclosure and monitoring, respectively. This is particularly pertinent to the survey data finding the greatest vulnerabilities in the 'prefer not to say' category for sexual identity, and this is timely given that the NHS Sexual Orientation Monitoring Standard is being implemented currently or imminently.

For any further information about this research, and/or to stay updated with its findings, please contact the Principal Investigator, Dr Rebecca Barnes, rb358@leicester.ac.uk

1) Introduction

The aim of this review is to examine the already existing data on LGBT people's mental (ill)health and experiences of healthcare provision, rather than generating new survey data as part of the research. This is to avoid re-asking participants questions that have already been answered (LGBT Foundation, 2017) and to avoid research fatigue for a group which is in some respects over-researched (Barker et al., 2012). Therefore, what follows provides an overview of what is already known about the mental health needs of LGBT people and their experience of services.

After clarifying our use of terminology in relation to sexual orientation and gender identity, we will first review national, and where available, regional (East Midlands) or local (Nottingham City) data, on the following topics:

- LGBT population estimates
- The characteristics of LGBT populations
- Discrimination and victimisation related to sexual orientation and/or gender identity
- LGBT people's health and wellbeing
- LGBT people's experiences of accessing healthcare
- Trans people's experiences of accessing gender identity health services
- LGBT people's experiences of accessing mental health services

We conclude by identifying some of the key messages that derive from analysis of the existing quantitative data and highlighting priority areas to explore further within the qualitative component of this research.

a) Data sources

The main data sources that are discussed in this report are official statistics (statistics that are collected by, or on behalf of, central government agencies), such as the Annual Population Survey and the Health Survey for England. The benefits of official statistics are that they are based on large, representative samples and they are repeated at regular intervals, thus enabling changes to be compared over time. As will become evident though, many official statistics do not collect data on sexual orientation or gender identity or have only started to do so recently, thus limiting opportunities for longitudinal analyses.

One recent official data source that we draw on is the first ever National LGBT Survey, conducted by the Government Equalities Office in 2017 and reporting on the largest ever sample of LGBT people in the UK to date; over 100,000. This survey does not meet the same rigorous methodological standards of official government surveys because it is based on a self-selected convenience sample and can therefore not guarantee representativeness, and because it is self-administered rather than many government surveys which are

interviewer-administered. Nonetheless, it is a landmark survey which provides vital baseline data about LGBT people's experiences in many areas of life, not least regarding their health and healthcare experiences.

In addition, relevant statistics will be used including the GP Patient Survey, which provides local data, and the Youth Chances national survey of 16-25 year olds (Metro, 2016). Data obtained from Nottingham City Clinical Commissioning Group (CCG) will also be integrated, although sexual orientation and gender identity are not yet being systematically recorded and monitored across all commissioned services. No data sources are without their limitations, especially given the challenges of collecting robust data from LGBT populations. Therefore, caveats and cautions will be flagged where necessary.

b) A note on terminology

For the purposes of this report, when citing statistics from existing research, the terminology used by the original researchers to describe sexual orientation and/or gender identity will be adopted to ensure validity in the types of claims that are being made (e.g. not ascribing findings to transgender people if they are not indicated within the research findings). For the overarching narrative of this report the acronym LGBT will be used, whilst recognising that individuals who identify with this acronym might have more wide-ranging gender and sexual identities. For easy reference, we have included a glossary of terms at the opening of this report. Below, we discuss issues of terminology in further detail.

LGBT is an acronym that describes the lesbian, gay, bisexual and transgender population(s). There are multiple variations of this acronym which extend it to include other identities such as *LGBTQ*, where Q stands for queer, and *LGBT+*, where + indicates the inclusion of other diverse gender and sexual identities such as pansexual, which refers to being attracted to people of all genders, rather than restricting sexual attraction to binary male/female gender identities. Some studies also include people who identify as asexual, which refers to not experiencing sexual attraction to others. Q is sometimes also used to denote questioning, especially in studies of young people.

The term *LGB* refers to lesbian, gay or bisexual-identifying individuals and is used in studies that focus on sexual identity or sexual orientation, rather than gender identity. However, the intersection with gender remains important to distinguish between gay men and gay women, bisexual men and bisexual women. Importantly, research about LGB identities may also include trans-identified people as some LGB people will identify as trans. LGB people also identify as cisgender or cis, which refers to having a gender identity that aligns with the sex assigned to them at birth.

Transgender, often referred to as trans, is a broad term for a diverse range of gender identities. These might include transsexual, genderqueer, non-binary, gender-variant,

third sex, androgynous, drag king/queen, transvestite, cross-dresser, and/or people who are undergoing, or have undergone, hormone treatment and/or surgery to modify their body to fit with their gender identity (Lenihan et al., 2015). Some studies of trans or gender diverse populations also include people who are intersex, where this may be written as *LGBTI*. Trans people may identify as LGB+ or heterosexual, and their understanding of their sexual orientation may change during or following experiences of transitioning (Auer et al., 2014).

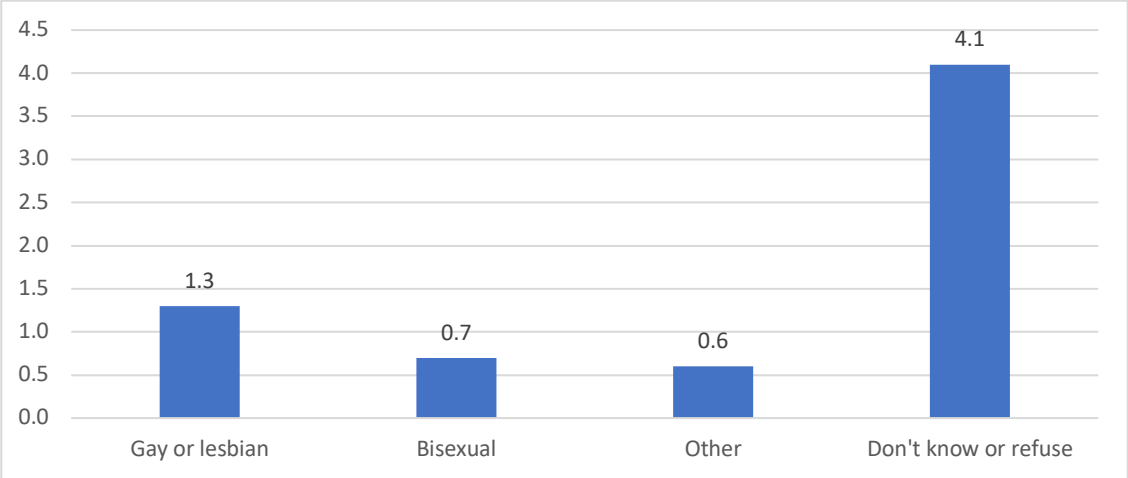
In addition, where data is available, the relationship between sexual orientation, gender identity and other aspects of identity such as age and ethnicity will be examined.

2) Measuring sexual orientation and gender identity: population estimates

Whilst various government surveys have asked questions about sexual orientation, the main data source in England and Wales is the Annual Population Survey (APS), which is a continuous household survey based on a representative sample of 320,000 people. The measure of sexual orientation which the APS used is based on sexual identity; that is, asking people to self-identify their sexual orientation from a range of pre-set options.

According to the APS, 2% of the UK population (an estimated 1.1 million people) identified themselves as LGB in 2017, which was the same as in 2016 but a 2% increase from 2015. This comprised of 1.3% identifying as gay/lesbian and 0.7% as bisexual. A further 0.6% identified as other and 4.1% did not know or refused to disclose (ONS, 2019) (see Figure 1).

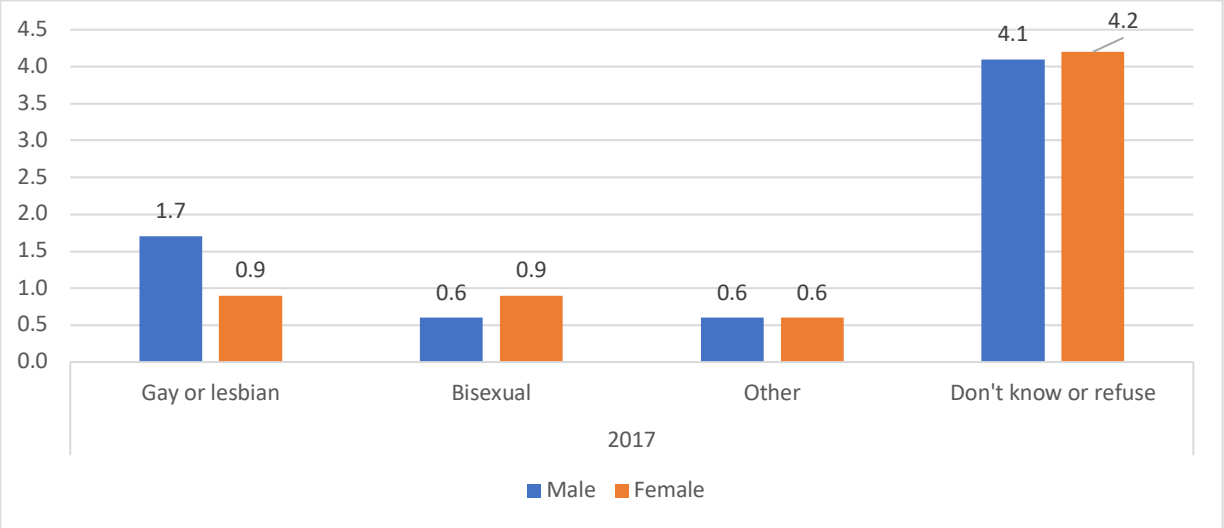
Figure 1: Sexual orientation in the UK in 2017 excluding heterosexuals (%): APS (ONS, 2019)



In terms of gender differences, a larger proportion of men (2.3%, n=444,000) identified as LGB than females (1.8%, n=326,000). Males were more likely to identify as gay (1.7%)

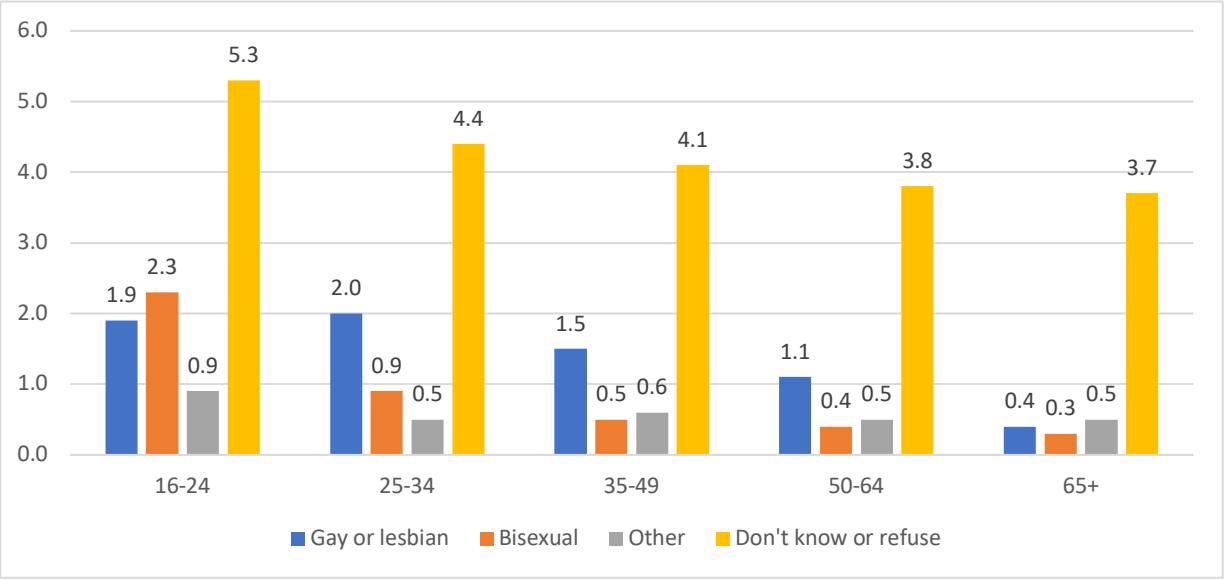
compared to 0.9% of females identifying as gay/lesbian, while females were more likely to identify as bisexual (0.9%) compared to 0.6% of males (ONS, 2019) (see Figure 2).

Figure 2: Sexual identity by sex in 2017 excluding heterosexuals (%): APS (ONS, 2019)



Age also impacted on reporting, with the younger age group (16-24year olds) being more likely to identify as LGB (4.2%, n=298,000), with a larger proportion identifying as bisexual (2.3%, n=163,000) compared with lesbian/gay (1.9%, n=135,000). The likelihood of identifying as LGB decreased with age. The majority of over 65 year olds identified as heterosexual/straight (95.2%), with only 0.7% (n=79,000) identifying as LGB (ONS, 2019) (see Figure 3).

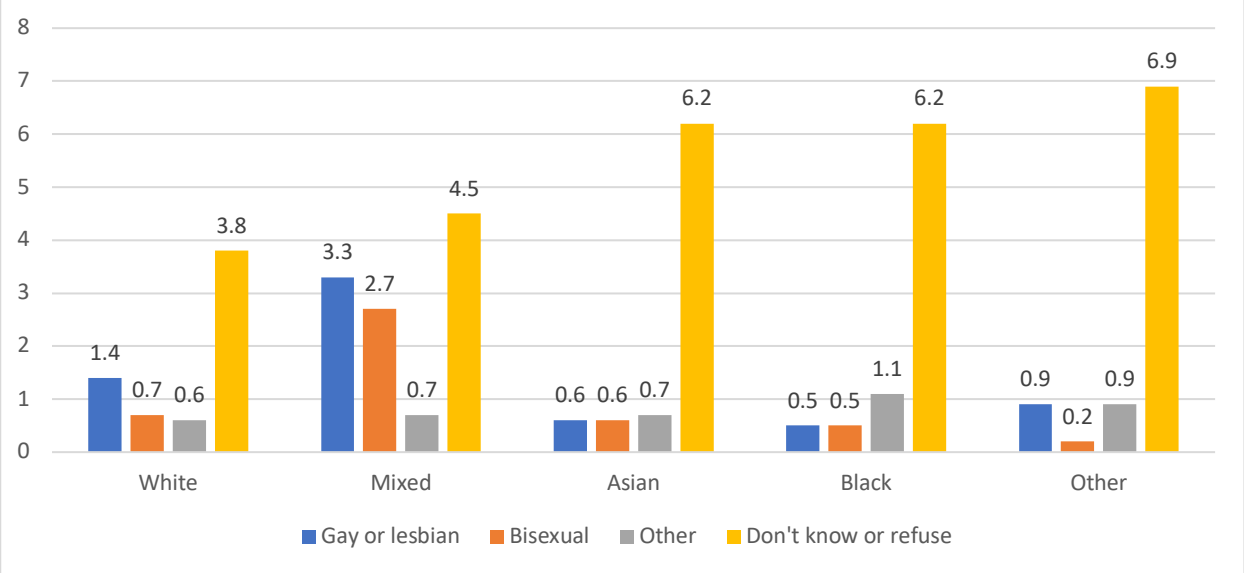
Figure 3: Sexual identity by age group in 2017 excluding heterosexuals (%): APS (ONS, 2019)



In relation to ethnicity, in 2017, 6% (n=31,000) of the population who described their ethnicity as 'mixed or multiple ethnic groups' identified as LGB, compared to 2.1% (986,000) who identified as white, 1.2% (n=37,000) as Asian/Asian-British, 1%

(n=16,000) as Black African Caribbean/Black-British and 1.1% (n=9,000) as other (ONS, 2019) (see Figure 4).

Figure 4: Sexual identity by ethnicity in 2017 excluding heterosexuals (%): APS (ONS, 2019)



In addition, official statistics find that those who identified as LGB were most likely to be single (70.7%) (although they may be in same-sex cohabiting couples). This might merely reflect their younger age, but it is an important finding in terms of the potential risk of social isolation for LGB people (ONS, 2017a).

At a regional level, there are five counties in the East Midlands[1]. Regional estimates of the size of the LGB population in 2017, calculated using APS data, suggest that the vast majority of the East Midlands population identify as heterosexual/straight (93% n=3,533,000), compared to 1.0% (n=37,000) who identify as gay/lesbian, 0.8% (n=32,000) as bisexual and 1.2% (n=45,000) as other, while 4% (n=153,000) did not know or refused to disclose. However, the numbers are very small in the LGB categories which limits the reliability of these data, although they do largely replicate national trends.

LGB population estimates calculated for Nottinghamshire using data from 2013-2015 indicate that 0.8% (n=5,000) identified as gay/lesbian, 0.5% (n=4,000) as bisexual, 0.5% (n=3,000) identified as other and 3% (n=19,000) did not know or refused to disclose. However, the ONS advise that these estimates need to be read with caution because there is insufficient data to have full confidence in their accuracy (ONS, 2017c).

There are serious flaws when trying to measure sexual orientation as there is little consistency in categories and definitions across datasets and surveys, inhibiting meaningful comparisons (Bell 2017; ONS 2017a). As noted, government surveys usually focus on sexual identity, yet other studies have found that when more detailed measures of sexual orientation are used which ask not only about identity, but also about attraction

[1] Nottinghamshire, Northamptonshire, Leicestershire, Derbyshire and Lincolnshire.

and sexual behaviour, the percentages of people whose sexual experiences and attractions are not limited to heterosexuality increases considerably (Geary et al., 2018).

An example is the National Survey of Sexual Attitudes and Lifestyles (Natsal), a non-official survey conducted by researchers from the London School of Hygiene and Tropical Medicine, University College London and NatCen[2]. Whilst the data from the latest survey, Natsal-3 (n=15,162, 16-74 years old), dates back to 2010-2012, a key finding is that of people aged 16-44 years old, 5% of men and 8% of women reported that they had ever had a same-sex sexual experience which included genital contact (Natsal, 2014). Whilst many of these respondents self-identify as heterosexual, this finding shows greater fluidity of sexuality than sexual identity figures alone reveal, whilst also introducing the potential for identity conflicts that could adversely affect mental health.

Given the limitations of any single survey, in 2017 Public Health England attempted to generate a more accurate estimate of the size of the LGB population (PHE, 2017). Through synthesising the results of 15 different government surveys which apply various measures of sexual orientation, PHE calculated that at least 2.5% of the population of England (amounting to 1,358,848 people), but possibly as many as 5.89%, identify as LGB or other. In the East Midlands, PHE estimated that 1.98% of the population are LGB or other (PHE, 2017). In Nottingham City, which had a registered[3] population in April 2018 of 379,277, this equates to 7,510 people. However, since Nottingham City is an urban area with more LGBT social activities and groups than other areas of the East Midlands, this figure may well be an under-estimate. Moreover, it does not take into account heterosexual-identifying trans people.

Indeed, it is a significant limitation that no government surveys (with the exception of the recent National LGBT Survey) ask questions about gender identity. There is also a need to better understand which identities are collapsed into the 'other' category, given that more marginalised and less understood groups may face particular vulnerabilities. Furthermore, existing statistics, including those which the PHE (2017) estimates draw on, are based on sample surveys which are voluntary and suffer from non-response/refusal to participate, as opposed to a full population census. Some of these surveys are also administered by an interviewer visiting respondents in their homes, and this could lead to under-reporting of non-heterosexual sexual identities due to embarrassment, fear of negative reactions or concerns about privacy and confidentiality. There is potential for more robust and comprehensive population-wide data for England and Wales to be collected via the 2021 Census, when questions about sexual orientation and gender identity will be asked for the first time (ONS, 2017b).

[2] NatCen Social Research, which is a non-governmental research organisation.
[3] The number of people registered with a General Practice in Nottingham City Clinical Commissioning Group.

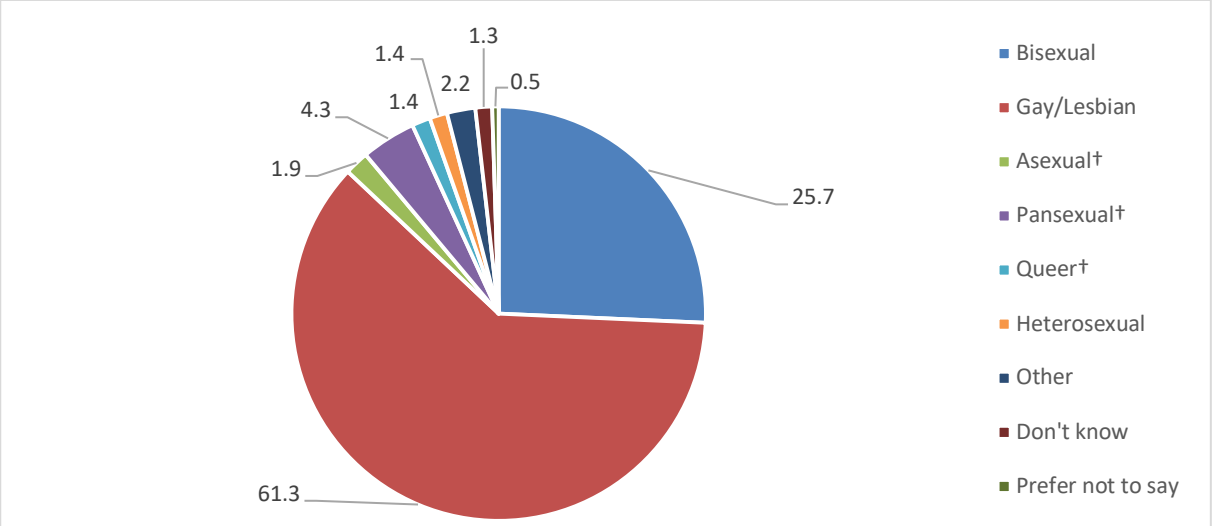
3) The characteristics of LGBT populations

In this section, studies which are based on predominantly or exclusively LGBT samples are considered in order to provide more detailed insights into the characteristics of LGBT populations than most official surveys can currently offer.

To overcome some of the limitations arising from the more general health surveys, and after a review highlighting the poor evidence base underpinning LGBTQ health service provision (see NIESR, 2016), the Government launched the National LGBT survey in 2017. Its aim was to address the dearth of data capturing the experiences of LGBT people in the UK. The data from the National LGBT survey, based on responses from 108,100 LGBT people, replicates some of the findings from the larger, less focused national health surveys, but also provides more nuanced information on the LGBT population aged 16 and over.

In line with findings from the Integrated Household Survey and Annual Population Survey (ONS 2017a), the National LGBT survey found the majority of respondents identified as gay/lesbian (see Figure 5), lived in London and were in the younger age groups who were more likely to identify as bisexual.

Figure 5: Sexual identity in the UK, 2017 (%) (GEO, 2018)



Unlike the APS, the National LGBT survey collected more nuanced data on gender identity. These showed that 13% of respondents identified as transgender: 6.9% identified as non-binary, 2.9% were trans men and 3.5% were trans women. Trans identification was influenced by age (see Table 1), with younger trans respondents being more likely than older respondents to identify as non-binary[4] (GEO, 2018).

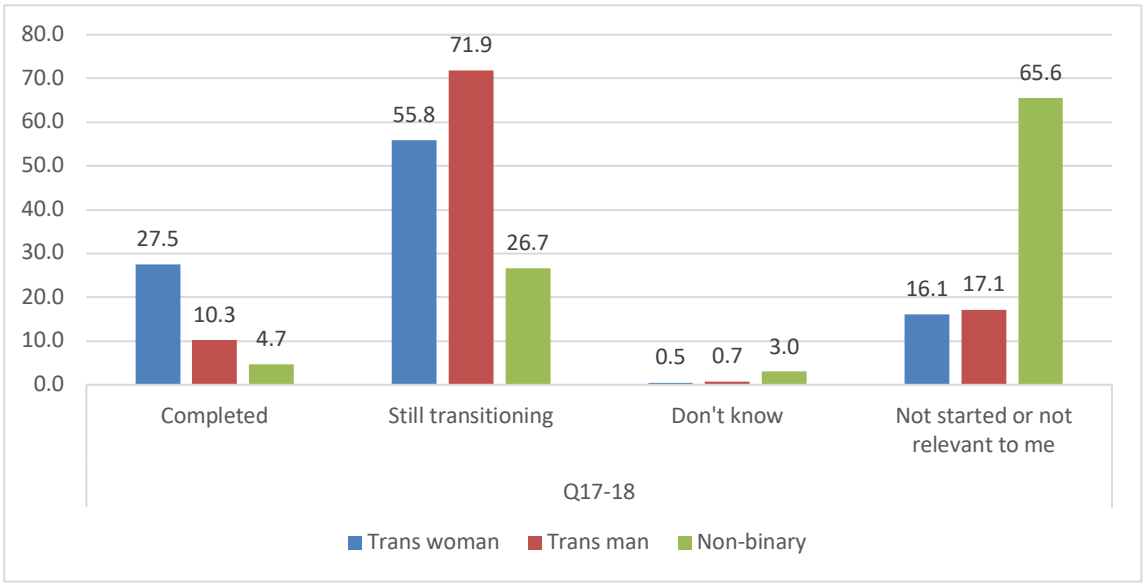
[4] Younger respondents were also more likely than older respondents to identify as bisexual, pansexual, asexual or queer (GEO, 2018).

Table 1: Gender identity by age (GEO, 2018)

		Age (%)								All (%)
		16-17	18-24	25-34	35-44	45-54	55-64	65-74	75+	
Gender identity	Woman	49.3	44.6	35.7	33.7	29.0	26.9	22.3	14.8	38.3
	Man	23.5	36.7	52.5	57.0	59.3	57.6	58.2	39.9	46.3
	Trans woman	2.4	2.7	2.5	3.1	6.2	9.8	14.0	10.3	3.5
	Trans man	8.9	4.2	1.8	1.0	1.0	0.9	0.8	2.7	2.9
	Non-binary	11.6	9.4	6.0	4.0	3.1	3.0	2.2	15.7	6.9
	Other	1.3	0.8	0.8	0.9	1.1	1.2	1.8	10.3	0.9
	Don't know or prefer not to say	3.2	1.7	0.7	0.4	0.3	0.5	0.6	6.3	1.2
Respondents (rounded N)		8950	37120	28150	16700	11220	4560	1180	220	108100

Just under half (44.5%) of trans respondents were transitioning[5] at the time of the survey (see Figure 6) and the majority (88.4%) did not have a gender recognition certificate (GEO, 2018).

Figure 6: Whether respondents had completed, or were still transitioning by gender identity (trans) (%) (GEO, 2018)



[5] Transitioning is described in the National LGBT survey as 'the steps a person may take to live in the gender with which they identify' (GEO, 2018). This could include medical transition such as hormonal therapy or gender reassignment surgery, but also includes social transition such as changing one's preferred pronouns (e.g. from he to she or they) and/or forename, or dressing in clothing which reflects one's gender identity rather than one's assigned sex.

4) Experiences of discrimination and victimisation related to sexual orientation and/or gender identity

Surveys of LGBT people's experiences consistently find high reporting of experiences of homo/bi/transphobic victimisation and discrimination. In the EU LGBT Survey (2013) of 93,097 LGBT individuals across Europe, just under half (44%) of the 6,759 respondents from the UK felt discriminated against or harassed due to sexual orientation (Bell, 2017; FRA, 2013. Research suggests the social hostility, stigma, discrimination, prejudice and intolerance experienced by LGBT people negatively impacts on their quality of life and has been identified as a key factor in explaining their higher rates of mental (ill)health/psychiatric morbidity as these experiences can be internalised[6] (Breslow et al. 2015; McLaughlin, Hatzenbuehler, Xuan and Conron, 2012; Mays and Cochran, 2001; Morrison, 2011; Semlyen et al., 2016).

Similarly, the National LGBT Survey found that the majority of the sample had felt discriminated against or harassed due to their sexual orientation. In fact, 40% had experienced an incident of verbal harassment or physical violence committed by someone they did not live with in the 12 months preceding the survey, which had impacted on their behaviour. For example, more than two thirds (68%) of LGBT respondents said they had avoided holding hands with a same-sex partner for fear of a negative reaction from others and 70% had avoided being open about their sexual orientation for fear of a negative reaction (GEO, 2018).

Just under a third (29%) of LGBT people had experienced a hate incident involving someone they lived with because they were LGBT. Younger LGBT people were more likely to experience hate victimisation than older respondents (GEO, 2018). This finding is mirrored in the Youth Chances survey of 16-25 year old LGBTQ and heterosexual respondents (Metro, 2016), where 74% of LGBTQ young people had experienced name-calling; 45%, harassment or threats and intimidation; and almost a quarter (23%), physical assault.

Just under a third (29%) of young people were also victims of domestic/familial abuse, which was slightly higher than the heterosexual non-trans group (25%). Over a third (36%) of LGBTQ respondents cited their sexuality or gender identity as a contributing factor in the abuse (Metro, 2016).

[6] Minority stress theory proposes that the internalisation of prejudice and discrimination manifests both internally and externally, which leads LGBT people to have poorer mental and physical health and wellbeing, partake in harmful and risky behaviours and have lower levels of life satisfaction and happiness (see Meyer, 2003).

In addition, LGBTQ young people had nearly double the rates of sexual abuse than non-trans heterosexuals, with one in five (18%) having experienced some form of sexual abuse, compared with one in ten (11%) non-trans heterosexuals (Metro, 2016). These experiences of physical, sexual and hate victimisation are all contributing factors to poor mental health. They may be compounded by social isolation and increased vulnerability when victimisation perpetrated by family members means that home is not a place of safety or welcome.

Alongside these high rates of victimisation, what is also striking and concerning are the low rates of reporting of these incidents and/or dissatisfaction with agency responses when incidents are reported. The National LGBT Survey found that the majority of respondents (91%) had not reported the most serious incident to the police, although incidents involving people they did not live with were more likely to be reported than incidents involving people they lived with (93.6% compared to 90.8%). The main reason given in both instances for just over half of respondents (53.2% for those living with them and 56.8% for those not) not reporting an incident was because it was seen as too minor and 'something that happens all the time' (GEO, 2018). This may be indicative of the normalisation and minimisation of victimisation experiences.

Of the incidents that were reported, most were reported to the police (58% of incidents involving people they lived with and 66% of incidents involving people they did not live with) and for the most part there was an even split between rates of satisfaction. Rates of satisfaction were slightly higher for those reporting incidents involving someone they did not live with (43.7% being somewhat to very satisfied) compared to incidents involving someone they did live with (where 41.8% were somewhat to very satisfied) (GEO, 2018). Incidents involving someone they lived with were more likely to be reported to an LGBT organisation (11.1% compared to 10.4%) or a victim support charity (14.2% compared to 5.4%) than if they involved someone they did not live with (GEO, 2018). In the Youth Chances study, 88% of the 16-25 year olds surveyed did not report victimisation to the police, and for the minority who did, only 10% of reports resulted in a conviction (Metro, 2016).

LGBT people's experiences of school and education as captured by the National LGBT survey were also not positive. The majority of respondents (77%) felt like their needs were not being addressed and had no experience of discussing sexual orientation or identity at school. In fact, most respondents (67.9%) said staff were not very or not at all understanding of the issues facing LGBT people, which may explain why the majority of respondents (52.8%) had told none of their teachers/tutors/lecturers about being LGBT.

Importantly, these are not only historic issues but continue to affect young people today. Amongst LGBTQ people aged 16-25, nearly two thirds (65%) thought that their school supported its pupils badly regarding sexuality or gender identity. The majority of young

people (89%) also said they learnt nothing about bisexuality and 94% said they learnt nothing about trans identities at school. In fact, less than one in five LGBTQ young people (18%) report that school provided any useful preparation for happy and healthy sex and relationships, while nearly half (49%) reported that their time at school was affected by discrimination or fear of discrimination (Metro, 2016).

Over a third (36%) of adult trans respondents in the National LGBT survey who were transitioning while at school reported that their school was very or somewhat supportive of their specific needs, while only 13% said their teachers were very or somewhat understanding of the issues facing trans pupils (GEO, 2018). This highlights the lack of knowledge and understanding of LGBT health issues by teachers, potentially inhibiting opportunities for early intervention and diagnosis of mental health needs.

5) LGBT people's health and wellbeing

Research has consistently found that LGBT populations face various risks to their health and wellbeing. Whilst the focus of this section will be on mental health and wellbeing, it is important first to more briefly review data about LGBT people's physical health and engagement in health risk behaviours such as smoking and excessive alcohol consumption.

To examine health risk behaviours and measures of health among the LGB population, the National LGBT Survey (GEO, 2018) provides some of the most comprehensive information to date. National population health surveys like the Health Survey for England and the Adult Psychiatric Morbidity Study routinely only include the binary categories of male and female gender identity (e.g. see ONS, 2016), making them less useful for this analysis.

However, the 2014 Health Survey for England included a question on sexual orientation and revealed that LGB people report higher rates of poor mental health, physical health and are more likely to partake in risky/harmful behaviours like heavy drinking, smoking, drug use, self-harm and suicide (see Table 2). This data is useful for making comparisons with heterosexual-identifying respondents and therefore highlighting health inequalities. The GP Patient Survey (GPPS) is also a useful source of national and local data, enabling data to be broken down to a Clinical Commissioning Group (CCG) level.

Table 2: Health measures from the Health Survey for England 2014 according to sexual orientation (% that said yes) (NHS, 2015)

	Heterosexual* (n=6,718)	Gay/ Lesbian (n=75)	Bisexual (n=46)	Other (n=37)	Prefer not to say (n=167)
Currently smoke cigarettes	33.1	40.5	50	31.2	32.9
Need help with tasks	31.5	40	33.3	54.5	42.4
Drink alcohol nowadays	77.9	85.1	78.3	64.9	60.2
Drink almost everyday	10.3	7.2	4.8	3.4	10.5
Panic attacks**	17.6	24.1	35.3	14.8	18.1
Depression**	27.8	29.7	41.2	18.5	34.3
Post-traumatic stress disorder (PTSD)**	3.4	9.3	2.9	3.7	5.8
Obsessive compulsive disorder (OCD)**	3.3	9.3	8.8	7.4	2.9
Bipolar/Manic Depression**	0.6	1.9	0	3.7	1
Eating Disorder**	2.3	1.9	11.5	0	5.8
Personality Disorder*	0.6	1.9	0	0	1
Schizophrenia/Psychosis**	0.4	3.7	0	0	0
Drug/Alcohol addiction**	2.4	1.9	11.8	0	2
Self-harm only	1.7	0	20.6	11.1	1.9
Attempted suicide	3.4	7.4	11.8	0	4.8
Self-harm and attempted suicide	1.7	1.9	8.8	0	2.9
Admitted to a ward/hospital specialising in mental health	2	2.7	2.2	2.7	5.4
Doctor diagnosed high blood pressure	23.7	20	23.9	29.7	35.3
Wears a hearing aid	6.4	1.8	6.1	7.4	14.7

*The sub-sample numbers (N) correspond to the numbers of respondents of each sexual orientation who participated in the survey. However, the number of respondents that answered each of the items in this table varied, hence the data may be based on smaller numbers of respondents due to non-response.
**Includes those with and without a self-reported diagnosis (NHS, 2015).

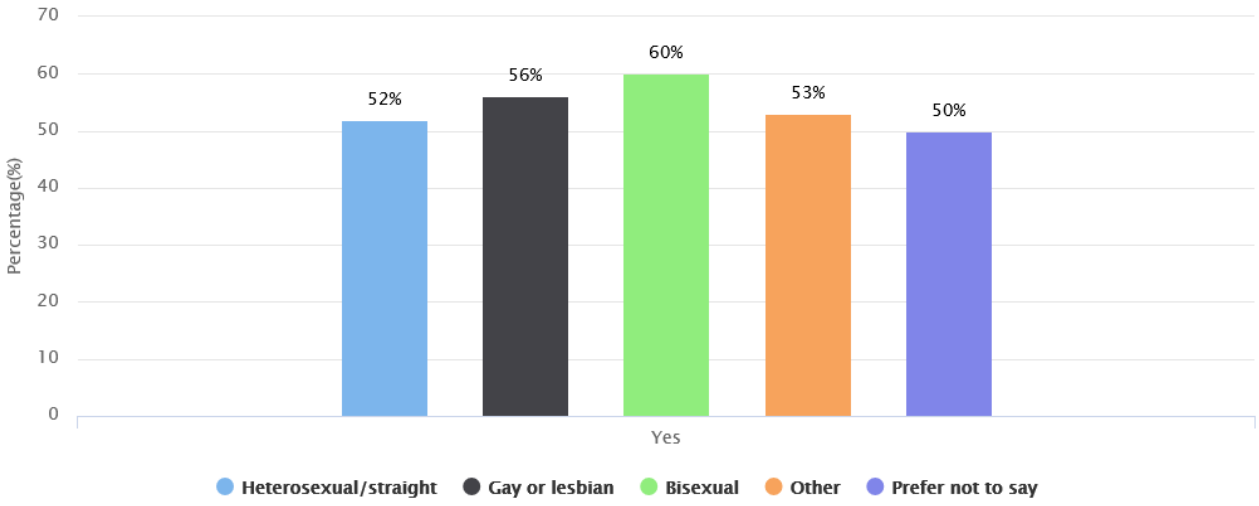
a) Physical health

Data from the latest GPPS results[7] (NHS, 2018b) derives from a national sample of 750,000 respondents, of whom 663,342 identified as heterosexual/straight; 8,515 identified as gay or lesbian; 5,080 identified as bisexual; 5,778 identified as other; and a substantial 40,905 who responded 'prefer not to say'. These data provide some useful and robust findings about self-rated general health, which combines physical and mental health.

[7] Findings which report on the relationship between sexual orientation and either health status or healthcare experiences do not exist in any published GPPS report, but have instead been sourced via the GPPS analysis tool: http://www.gp-patient.co.uk/analysistool

It was more common for bisexual respondents (60%) and gay/lesbian respondents (56%) to report having a long-term physical or mental health condition, disability or illness, compared to heterosexual/straight respondents (see Figure 7). Closer examination of the data indicates that whilst the most commonly reported conditions for heterosexual/straight people were high blood pressure and arthritis or other ongoing back/joint problems, for LGB respondents, mental health conditions were most prominent.

Figure 7: Self-reported long-term physical or mental health conditions, disabilities or illnesses (NHS, 2015b)



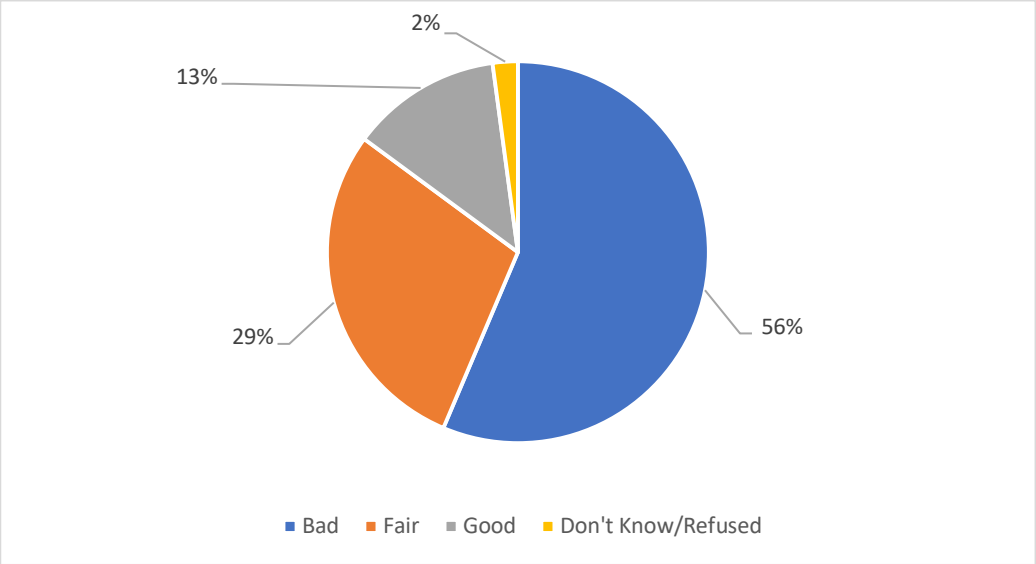
Similarly, data from the Health Survey in England shows that gay/lesbian people were also slightly less likely to report having high blood pressure (20%, compared to 23.7% of heterosexual people and 23.9% of bisexual people). However, gay/lesbian people were more likely (along with those identifying as 'other' or 'prefer not to say') to report needing help with tasks, but it is not known whether this relates to poor physical and/or mental health (see Table 2).

Echoing this, but with a focus on bisexual people, findings from the GPPS which show that when asked about the impact of any ongoing physical or mental health conditions on respondents' day-to-day lives, bisexual people were more likely to say that they were affected a lot (25%) compared to 18% of heterosexual/straight people and 19% of gay or lesbian people. Only a quarter (24%) of bisexual people said that they were not affected at all, compared to 42% of heterosexual/straight people and 40% of gay or lesbian people. As with the Health Survey for England, it is not possible to disaggregate the impact of physical and mental health conditions.

These specific health surveys do not include trans people's experiences. However, one relevant finding from the National LGBT survey is that whilst overall, 16.5% of the 108,100 respondents reported having a disability, almost a third of the 14,320 trans respondents (32.5%) disclosed that they had a disability, although there is no further detail on the types of disabilities that participants had (GEO, 2018).

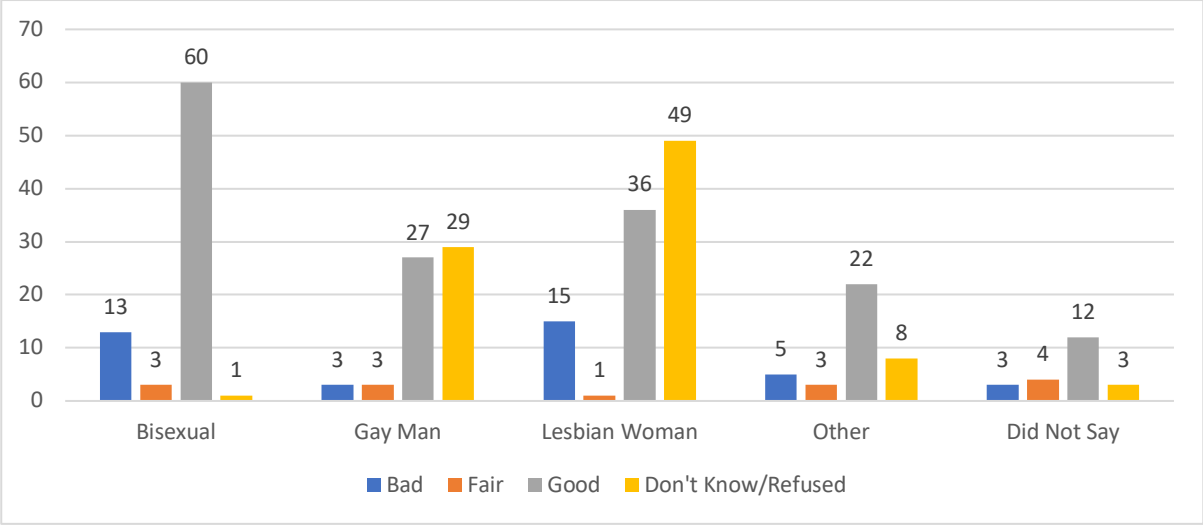
Turning to the local context, data collected at Nottinghamshire Pride in 2017 also found that LBGT+ people had high rates of poor mental and physical health. Over half (56%) of respondents reported poor physical health (see Figure 8).

Figure 8: Physical health of LGBT+ people in Nottinghamshire in 2017 (NHS, 2018a)



Poor health appeared to be concentrated in lesbian women and those identifying as bisexual (see Figure 9).

Figure 9: Physical health of LGBT+ people in Nottinghamshire by sexual orientation in 2017 (%) (NHS, 2018a)



The data collected from a national sample of 750,000 GP patients in the GPPS includes 4,477 respondents in the Nottingham City CCG area. The latest data finds that those identifying as bisexual and other were more likely (two-thirds compared to around half) to report a long-term physical, mental health condition, disability or illness as heterosexual respondents in Nottingham City CCG (NHS, 2018b) (see Table 3).

Table 3: Long-term physical or mental health conditions, disabilities or illnesses of patients in Nottingham City CCG (NHS, 2018b)

	Total		**Heterosexual or straight**		**Gay or lesbian**		**Bisexual**		**Other**		**Prefer not to say**	
Base (N)	4477		3863		102		78		47		387	
	%	N	%	N	%	N	%	N	%	N	%	N
Yes	47%	2113	47%	1800	52%	53	64%	49	67%	31	46%	179
No	49%	2177	50%	1920	45%	46	30%	24	21%	10	46%	178
Don't know/ can't say	2%	95	2%	70	3%	3	1%	1	12%	6	4%	15
I would prefer not to say	2%	92	2%	73	0%	0	5%	4	0%	0	4%	15

Moreover, the data collected at Nottinghamshire Pride showed that people with poor physical health were also three times more likely to have seen mental health services in the last year than those with good physical health (NHS, 2018a). This reinforces the important connections between physical and mental ill-health, associated, for example, with the greater risk of social isolation and the financial burdens of poor physical health.

b) Health risk behaviours

Secondly, there is substantial evidence that LGBT people are more likely to engage in health risk behaviours such as smoking, high alcohol consumption and recreational drug use.

Referring again to Table 2, those identifying as gay/lesbian were more likely to drink alcohol almost every day than those identifying as bisexual, which is interesting since those identifying as bisexual were more likely to admit having an addiction to alcohol/drugs. This is one of the only areas where heterosexual people scored higher, as well as those who 'prefer not to say'. Bisexual people were more likely to report alcohol or drug addiction; in fact, they were more than six times more likely than gay/lesbian people and almost five times more likely than heterosexual people to report having an addiction to drugs or alcohol.

Table 2 also indicates that bisexual and gay/lesbian people were more likely to smoke than heterosexual people, and this was most heightened for bisexual people, with 50% reporting that they smoked, compared to a third (33.1%) of heterosexual people. The Integrated Household Survey also finds that LGB individuals aged 18 and over are more likely to smoke than people identifying as heterosexual/straight (25.3% compared to 18.4%, thus lower in both cases than the Health Survey for England data). These differences may, at least in part, be attributable to the younger age profile of the LGB population (ONS, 2015d).

Replicating national trends, statistics gathered through questionnaires distributed at Nottinghamshire Pride for the 2017 Mental Health Survey Report for LGBT+ people in Nottinghamshire (n=505), indicate that the LGBT+ population in Nottingham were more likely to smoke (20% of respondents) or have taken illegal drugs and sought professional help due to drug or alcohol issues (7% of respondents), when compared to heterosexual respondents (NHS, 2018a). Further, local data on smoking status collected via the GPPS finds that those identifying as LGB were also more likely to smoke than those identifying as heterosexual, although gay/lesbian people were twice as likely to be regular smokers compared to bisexual people (see Table 4).

Table 4: Smoking by sexual orientation in Nottingham City CCG (NHS, 2018b)

	Total		**Heterosexual or straight**		**Gay or lesbian**		**Bisexual**		**Other**		**Prefer not to say**	
Base (N)	4525		3904		102		76		51		393	
	%	N	%	N	%	N	%	N	%	N	%	N
Never smoked	60%	2705	59%	2317	54%	55	54%	41	60%	31	67%	262
Former smoker	21%	965	23%	888	6%	6	17%	13	21%	11	12%	47
Occasional smoker	10%	436	9%	358	6%	6	12%	9	8%	4	15%	58
Regular smoker	9%	418	9%	341	34%	34	17%	13	10%	5	6%	25

However, when it comes to observing differences between different sexual orientation sub-groups within the LGBT population, the very small sub-sample size locally mean that the national data is far more robust.

c) Mental health and wellbeing

Moving next to the main focus on LGBT people's mental health and wellbeing, there is a very clear pattern of LGBT people reporting markedly high rates of poor mental health, including higher rates of self-harm and suicidality.

As noted previously, data from the GPPS indicates that LGB people are more likely to report ongoing mental health conditions than ongoing physical health conditions. To examine these data more closely, 9% of those who self-identified as heterosexual/straight said that they had a mental health condition, compared to 22% of those identifying as gay or lesbian and 31% of those identifying as bisexual. In addition, bisexual people were much more likely to say that they had felt isolated from others in the last 12 months (24%) compared to 16% of gay or lesbian people and a much lower 6% of heterosexual/straight people.

The Health Survey for England provides more specific information about the types of mental health conditions that the LGB population is likely to experience, highlighting some key differences between sub-groups (see Table 2). For example, those identifying as bisexual suffered more from panic attacks (35.3%) and had higher rates of depression than

any other group (41.2%). Bisexual people were also markedly more likely to suffer from an eating disorder (11.5%, compared to 2.3% of heterosexual people and 1.9% of gay/lesbian people).

Table 2 also shows that gay/lesbian people were more likely to report self-harm or attempted suicide compared to heterosexual people (1.9% of gay/lesbian people compared to 1.7% of heterosexual people), but this was markedly higher again for bisexual people (8.8%). Further, gay/lesbian people had the highest rates of more severe but less commonly reported mental health conditions such as bipolar, PTSD, OCD, personality disorders and schizophrenia/psychosis. For example, 3.7% of gay/lesbian people reported having schizophrenia/psychosis compared to 0.4% of heterosexual people and 0% of bisexual people.

Whilst the relatively small numbers of non-heterosexual respondents mean that we have to be cautious about the claims made based on this data, these statistics may explain why gay/lesbian people were slightly more likely (2.7%) than heterosexual (2%) or bisexual (2.2%) people to be admitted to a hospital/ward specialising in mental health problems. However, those who selected 'prefer not to say' were most likely to have experienced a mental health in-patient admission (5.4%), highlighting the likelihood that some of the most marginalised or vulnerable people are to be found in the 'prefer not to say' category (see Table 2).

Similar findings were reported among young LGBTQ people aged 16-25, with 42% of LGBTQ respondents seeking help for depression or anxiety, which was much higher than their heterosexual non-trans counterparts (29%). Over half (52%) of young LGBTQ respondents reported self-harm and just under half (44%) reported suicidal thoughts, which again, was much higher than heterosexual non-trans people (35% and 26% respectively). Further, rates of self-harm and suicidality are much higher amongst young people than their adult counterparts (Metro, 2016).

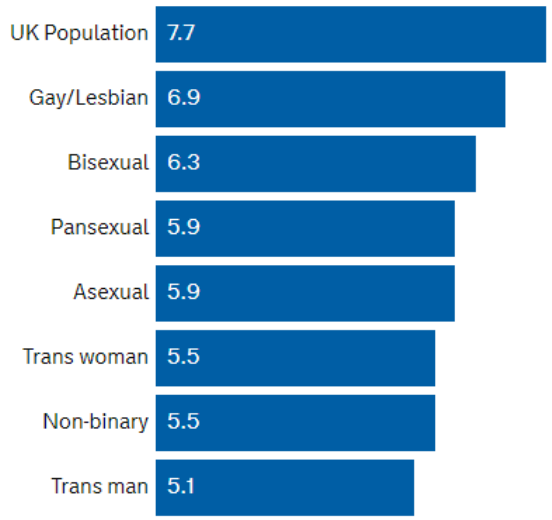
Locally too, striking disparities are also evident. In the GPPS data for Nottingham City CCG, the repeatedly documented disadvantages faced by bisexual people is again evident: those identifying as bisexual (31%, n=23) were three times more likely to report a mental health condition than those identifying as heterosexual (10%, n=343) and gay/lesbian (10%, n=9) (NHS, 2018b).

Further, survey data collected at Nottinghamshire Pride in 2017 found that 39% of gay/lesbian participants had ever self-harmed compared to 15% of heterosexual/straight respondents. However, most pronounced in this survey were the much higher rates of self-harm and suicidality among trans people: 57% of participants identifying as trans admitted to ever self-harming and 48% to ever having attempted suicide, compared to a quarter of gay/lesbian participants (NHS, 2018a).

Whilst there is consistent evidence that LGBT people have higher rates of poor mental health and lower rates of wellbeing than heterosexual cisgender people, it is important to recognise that sexual orientation and gender identity remain sporadically and poorly recorded across national UK datasets on health. The recent introduction of the NHS Sexual Orientation Monitoring Standard (NHS England Equality and Health Inequalities Unit 2017) may lead to improvements in the accuracy of prevalence rates and understanding of associated health needs of LGB people, hopefully promoting increased familiarity and comfort with asking and answering questions about sexual orientation in health settings, although this will depend on how it is administered.

Moreover, in terms of measures of wellbeing and life satisfaction, nationally, LGBT individuals were less satisfied with their life overall (6.5 out of 10) than the general population (7.7 out of 10); this was most pronounced for those who identified with trans and non-binary gender identities (see Figure 10).

Figure 10: LGBT average life satisfaction (out of 10) (GEO, 2018)



Further, in the 2015 APS, bisexual people reported lower levels of life satisfaction and happiness, and higher levels of anxiety (30%) than those who identified as heterosexual/straight (19%) (ONS, 2017d).

Low levels of life satisfaction were also found amongst young LGBT people aged 16-25, with trans young people in particular reporting lower levels of overall satisfaction with their lives when compared to LGBQ and heterosexual non-trans respondents (Metro, 2016). Having lower levels of life satisfaction and happiness combined with higher levels of anxiety has been attributed, as noted, to LGBT people's exposure to discrimination and harassment in relation to all aspects of life, including health service access, employment and education (NIESR, 2016).

More encouragingly, in 2015, a survey of 286 LGBT people in Nottingham was undertaken with 39% of respondents describing themselves as gay, 34% as lesbian, 13% as bisexual, 5% as heterosexual and 4% as pansexual. The majority (62%) stated that Nottingham was an LGBT friendly city, with three-quarters (75%) stating that it was a good place for LGBT+ people to live. For example, 55% of respondents felt that there was an LGBT+ community (55%), and 44% of respondents said that they felt they belonged to this community (Divercity, 2016). This is a very positive finding about the local context. However, because this is a relatively small convenience sample, it is quite possible that the sample over-represents those who are connected to LGBT social scenes and conversely under-represents LGBT people who are not connected to such scenes and those who may feel more isolated. This finding should consequently be interpreted with caution.

Little data about self-care exists, but the survey data collected at Nottinghamshire Pride in 2017 found that the majority of females (73%), males (69%) and those identifying as transgender (67%) kept well physically and mentally by spending time with their friends, family or partner, which was closely followed by keeping active for males (61%) and females (59%). By comparison, 55% of trans people reported talking to people and asking for help (NHS, 2018a). These findings echo the data that the research team collected through their public engagement stall at Nottinghamshire Pride in 2018. Here, practical activities such as exercise and eating healthily, as well as seeking support from people who care and would listen, were identified as ways of practising self-care.

6) LGBT people's experiences of accessing healthcare

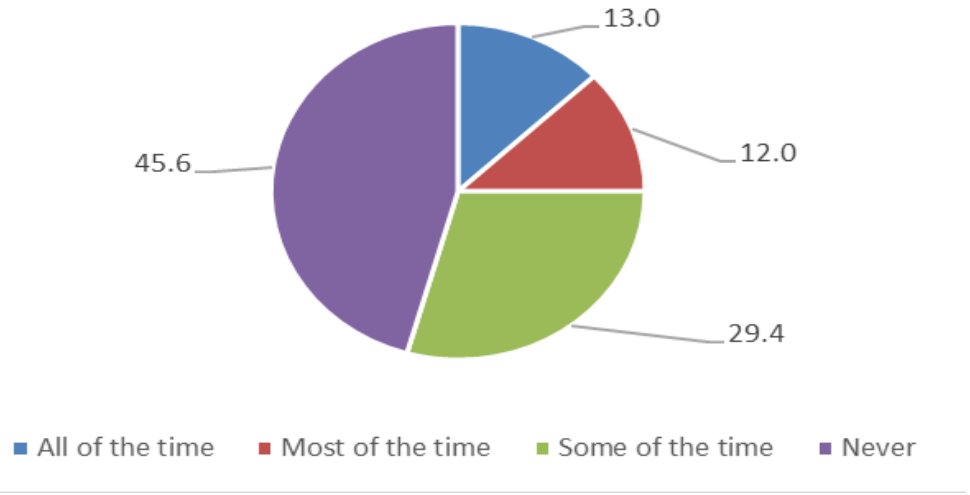
The National LGBT Survey found that LGBT people were more dissatisfied with health services in comparison to those who do not identify as LGBT, although the majority of LGBT respondents reported having no issues when accessing healthcare services because of their sexual orientation (84.3%) or gender identity (62.2%). Those that did have issues reported a lack of knowledge among medical staff about the health needs of LGBT people, specific concerns with mental and sexual health services and, among transgender people, concerns with the gender identity services provided by the NHS (GEO, 2018).

The majority of LGBT people (80%) had accessed public healthcare services in the 12 months prior to completing the National LGBT survey, which was higher among trans women (87.2%) and trans men (89.3%), closely followed by queer women (86.4%) and queer men (85.1%), pansexual women (83.7%), bisexual women (83.7%) and intersex respondents (74.5%) (GEO, 2018). Respondents identifying as asexual (26.8%) were the least likely to have accessed public healthcare services in the 12 months prior to completing the National LGBT survey, followed by those who preferred not to disclose their sexual orientation (35.2%). Although the majority of respondents had accessed healthcare services, the figures varied when gender identity was taken into account, with

males being less likely to access public healthcare services across the board, regardless of their sexual orientation (GEO, 2018). This reflects more established trends regarding (ostensibly heterosexual, cisgender) men being less likely to seek healthcare (see for example Wang et al., 2013).

However, respondents tended not to routinely, or even ever, disclose their sexual orientation to healthcare staff (see Figure 11), mostly because they did not see it as being relevant (83.7%), although some respondents were afraid of a negative reaction (14.4%), had had a bad experience in the past (6%), or were afraid of being outed (4.9%). Non-disclosure was higher among those identifying as asexual, both as asexual men (71.2%) and asexual women (74.8%), followed by bisexual women (69.6%), which were all higher than those identifying as transgender (43.7%) (GEO, 2018).

Figure 11: How often respondents discussed or disclosed their sexual orientation to healthcare staff in the 12 months preceding the survey in % (GEO, 2018)



Where respondents had disclosed their sexual orientation, '73% said it had no effect on their care, 18% said it had a positive effect, and 9% said it had a negative effect' (GEO, 2018: 162), although this varied across the different subgroups. Just over a quarter (25.6%) identifying as asexual said disclosing their sexual orientation had a negative effect, followed by 13.4% of those identifying as queer, 10.5% for pansexual, 8.7% for bisexual and 7.1% for gay/lesbian respondents. Disclosure of sexual orientation negatively impacting on healthcare was also higher for respondents identifying as female, regardless of sexual orientation (GEO, 2018).

The majority had no negative experiences to report (76%) when accessing or trying to access healthcare (see Table 6) but this again varied across groups. Trans people were more likely to have a negative experience when accessing healthcare services because of their sexual orientation, with 16.2% of trans respondents saying they were subject to inappropriate curiosity and questions, while 15.2% said their specific needs were ignored or not taken into account, and 12.7% said they avoided treatment for fear of discrimination

or intolerant reactions. These experiences were higher for trans men across the board, with 21% of respondents saying they were subject to inappropriate curiosity and questions, while 18.6% said their specific needs were ignored or not taken into account, and 15.6% said they avoided treatment for fear of discrimination or intolerant reactions.

Table 6: Experiences respondents had when accessing, or trying to access, healthcare services because of their sexual orientation and gender identity in the 12 months preceding the survey (GEO, 2018)

	All Sexual Orientation (%) (n=83,670)	**All Gender Identity (%) (n=13,000)**
Inappropriate questions or curiosity	7.3	19.9
My specific needs were ignored or not taken into account	6.3	16.9
I avoided treatment or accessing services for fear of discrimination or intolerant reactions	4.8	16.6
Discrimination or intolerant reactions from healthcare staff	3.1	9.3
Unwanted pressure or being forced to undergo any medical or psychological test	1.9	7.8
I was inappropriately referred to specialist services	1.9	7.0
I had to change GP (General Practitioner) due to negative experiences	1.3	6.4
None of the above	84.3	62.2

(Note: The total exceeds 100% as respondents could select all that applied to them)

After trans men, those identifying as queer were more likely to have a negative experience when accessing healthcare services and be subject to inappropriate curiosity and questions (11.9%), have their specific needs ignored or not taken into account (11.9%), and avoid treatment for fear of discrimination or intolerant reactions (6.1%). This again points to the marginalisation within the smaller and less well-understood sub-groups within the wider LGBT population who are less likely to receive a service which meets their needs, or may avoid healthcare services, thus delaying diagnosis and treatment, and potentially leading to the escalation of symptoms of mental ill-health. Relatedly, the Youth Chances survey found that only a minority of areas in England appear to have services that are sensitive to the specific needs of LGBTQ young people, despite this group having high rates of poor mental health (Metro, 2016).

Turning now to the local context, data from the GPPS for the Nottingham City CCG area, where 619 of the 4,507 respondents identified as LGB, other or prefer not to say, indicates that the majority were happy with their experience (see Table 7). However, rates of satisfaction were lower for LGB patients than for heterosexual/straight patients. Most markedly, 75% of bisexual respondents described their GP practice as very or fairly good compared to 83% of heterosexual/straight respondents (NHS, 2018b).

Table 7: Experience of GP practice in Nottingham CCG by sexual orientation (NHS, 2018b)

	Total		Heterosexual or straight		Gay or lesbian		Bisexual		Other		Prefer not to say	
Base (N)	4507		3888		102		77		48		392	
	%	N	%	N	%	N	%	N	%	N	%	N
Very good	43%	1923	44%	1694	39%	40	31%	24	46%	22	37%	143
Fairly good	40%	1794	40%	1541	38%	38	44%	34	37%	18	42%	163
Neither good nor poor	11%	480	11%	422	9%	9	4%	3	11%	5	10%	40
Fairly poor	4%	191	4%	155	6%	7	17%	13	2%	1	4%	16
Very poor	3%	119	2%	76	7%	8	4%	3	5%	2	7%	29

The majority (66%) of the respondents in Nottingham City, regardless of sexual orientation, found it very or fairly easy to get through to someone in their GP practice by phone. Bisexual respondents were slightly more likely (33%, n=26) than heterosexual/straight (25%, n=951) and gay/lesbian (16%, n=17) to have a GP they preferred to see for all appointments, and were more likely (32%, n=11) to always speak to their preferred GP compared to those identifying as heterosexual/straight (29%, n=534) or gay/lesbian (26%, n=9) (NHS, 2018b).

However, when compared with the national statistics taken from the GP Patient Survey, whilst those identifying as heterosexual/straight in Nottingham City report negative experiences during general practice appointments at a comparable rate to the national average, for LGB people the results are markedly different (see Table 8). Those identifying as lesbian or gay in Nottingham City CCG are almost twice as likely to report a negative experience with their GP than the national average and are more than three times as likely to report negative experiences than their heterosexual/straight counterparts (NHS, 2018b).

Table 8: Experience of GP practice in Nottingham CCG and nationally by sexual orientation (NHS, 2018b)

Last time you had a general practice appointment, the healthcare professional was poor/very poor at:	**Heterosexual/Straight**				**Lesbian/Gay**				**Bisexual**			
	Nottingham City		National		**Nottingham City**		National		**Nottingham City**		National	
	N	%	N	%	N	%	N	%	N	%	N	%
Giving you enough time	130	3	21738	3	9	11	726	6	8	11	397	5
Listening to you	150	4	20838	3	9	11	708	6	12	16	461	6
Treating you with care and concern	132	3	22420	3	9	10	740	6	12	18	522	8

As with other findings, this was even more pronounced for bisexual people. For example, bisexual (16%, n=12) and gay/lesbian (11%, n=9) respondents were much more likely to report that the last healthcare professional they saw was poor/very poor at listening to them compared to only 4% (n=150) of those identifying as heterosexual/straight (NHS, 2018b) (see Table 8). Notably, the number of LGB respondents within Nottingham City was extremely small, meaning that percentages are very susceptible to being skewed. Nonetheless, these tentative indications that GPs within Nottingham City CCG are less effective at consistently delivering quality and empathic care to LGB patients cannot be ignored and need to be explored further in the qualitative phase of this research.

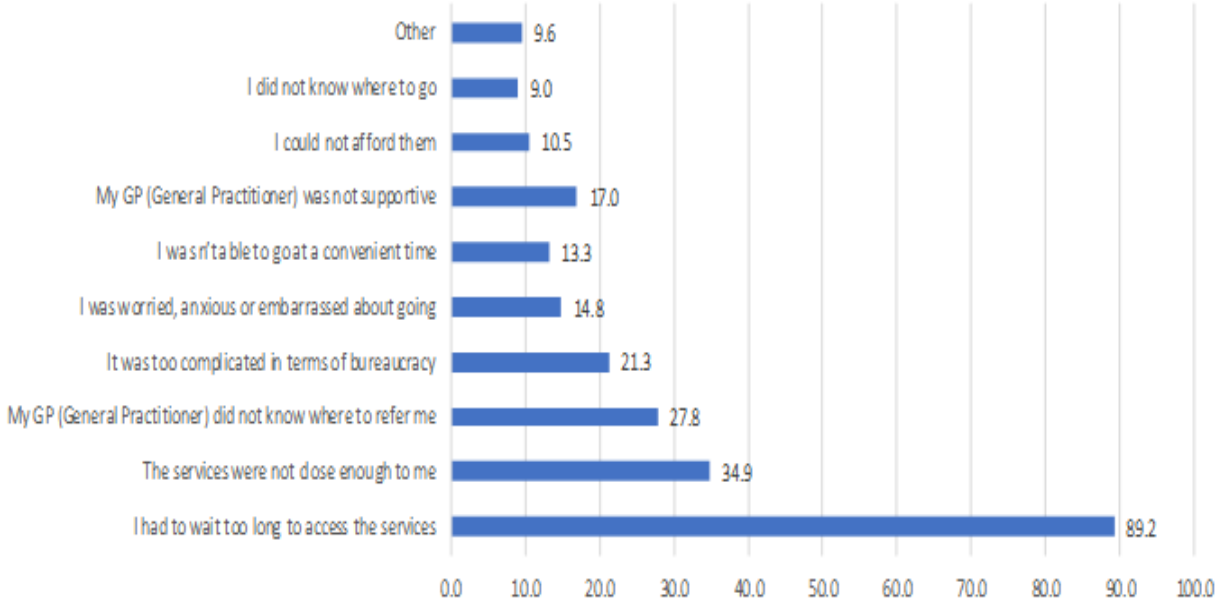
7) Trans people's experiences of accessing gender identity services

Whilst the focus of this research excludes specialist provision such as gender identity services (GIS), consideration of trans people's experiences of gender identity healthcare services helps to contextualise how trans people might feel about engaging with healthcare professionals. It is also important to recognise that delays to, or difficulties accessing, specialist GIS can adversely impact on trans people's mental health.

According to the National LGBT survey (GEO, 2018: 20) 'half (50%) of trans men and 43% of trans women respondents had accessed gender identity services in the past year, while 16% of trans men and 15% of trans women had tried but were unsuccessful'. Not being able to access these services was reported more by 16-24 year olds, 23.2% of whom had tried accessing services unsuccessfully. The majority of trans respondents (80%) said that accessing specialist GIS had not been easy: nearly a quarter (24%) of trans women and a third (32.3%) of trans men felt their specific needs were ignored or not taken into account. Waiting lists were a particular issue, with 68% saying that they were too long (GEO, 2018).

There were regional variations, and in the in the East Midlands, a modest majority (62.8%) of trans people who accessed specialist GIS reported that it had been a positive experience. However, the majority of respondents in the East Midlands who had tried to access GIS had found this difficult, with 89.2% of respondents reporting having to wait too long to access services (see Figure 12). This is echoed in the Healthwatch Nottinghamshire and Healthwatch Nottingham (2017) survey, where 23% of the 76 respondents reported that the Nottingham Centre for Transgender Health had long waiting times ranging from 12-18 months.

Figure 12: Reasons respondents found it difficult to access specialist gender identity services in the East Midlands in the 12 months preceding the survey (GEO, 2018)



(Note: the percentages presented in this graph are based on N=320 respondents. Respondents could select as many reasons as applicable)

Problems with the GP were also reported as a reason for not accessing specialist gender identity services in the East Midlands, with 27.8% of trans respondents reporting that their GP did not know where to refer them and 17% said their GP was unsupportive (GEO, 2018).

8) LGBT people's experiences of accessing mental health services

Focussing next on mental healthcare, LGBT individuals are more likely to report receiving professional help because of their mental health than heterosexual non-trans respondents (NHS, 2018a). Just under a quarter of respondents to the National LGBT Survey (23.5%) had accessed mental health services in the 12 months prior to completing the survey, although this differed across subgroups (see Table 9), particularly when gender identity was taken into consideration. Men across the board were less likely to access mental health services in the 12 months prior to the survey, regardless of sexual orientation. Furthermore, 7% of all respondents had tried to access mental health services but had been unsuccessful (GEO, 2018).

Table 9: Respondents accessing, or trying to access, mental health services in the 12 months preceding the survey by sexual orientation (GEO, 2018)

	Sexual orientation (%)								**All (%)**
	Bisexual	Gay/ Lesbian	Asexual	Pansexual	Queer	Other	Don't know	Prefer not to say	
Yes, I accessed	29.4	17.5	28.1	36.4	32.7	29.8	27.1	13.6	21.4
Tried but was unsuccessful	10.4	5.4	9.3	13.5	11.7	12.1	8.2	5.6	7.1
No	60.2	77.1	62.6	50.2	55.6	58.1	64.7	80.8	71.5
Respondents (rounded N)	22330	61970	1110	2320	770	1230	620	210	90570

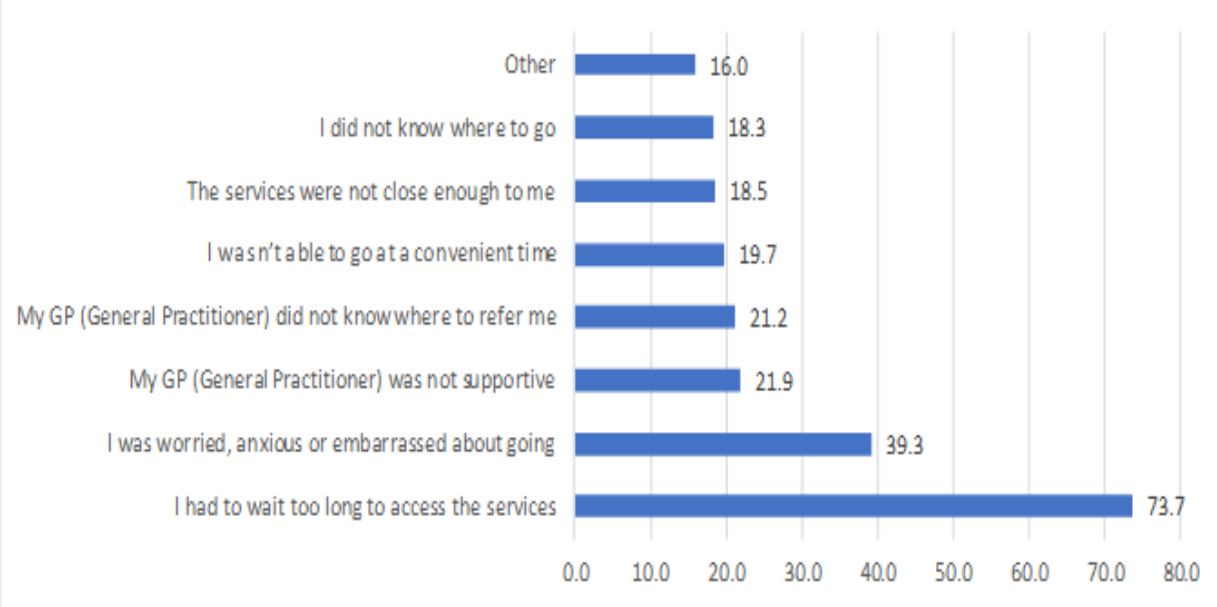
These figures were higher for trans people[8] with over a third (35.8%) of all trans respondents accessing mental health services in the 12 months preceding the survey (comprising 30% of trans women, 40% of trans men and 37% of non-binary people). Further, 13.9% of trans people had tried to access mental health services but had been unsuccessful (comprising 12% of trans women, 15.4% of trans men and 14.2% of non-binary people).

More than a quarter (28.3%) of all respondents to the National LGBT survey who had accessed or tried to access mental health services in the 12 months preceding the survey said it had not been easy at all, while 11.8% found it very easy. Just under a third of trans respondents (32%) found it not at all easy compared to 27% of cisgender respondents. The most frequent reason given for difficulties was long waiting lists (given by 51.5%) or they were worried, anxious and embarrassed about going (26.9%).

[8] The total number of trans respondents for this question was 13,970, which was broken down into 3,640 trans women, 4,000 trans men and 7,230 non-binary (GEO, 2018).

For cisgender respondents, just over a quarter (25.9%) said they were worried, anxious and embarrassed about going compared to 29.5% of trans respondents, while 16.5% of trans and 15.6% of cisgender respondents said their GP was unsupportive (see Figure 13).

Figure 13: Reasons why trans respondents found accessing mental health services difficult in the 12 months preceding the survey (GEO, 2018)



However, when mental health services were accessed, respondents were generally positive or neutral about the support they received (78.4%); around a fifth of respondents (22%) reported that they had a negative experience, although this figure was higher for trans (26.1%) compared to cisgender (20.3%) respondents (GEO, 2018).

In contrast to the National LGBT Survey, studies of the Nottingham context have found a greater preponderance of negative experiences amongst LGBT people who have accessed mental health services. LGB respondents in the 2017 Mental Health Survey Report for LGBT+ people in Nottinghamshire were almost twice as likely than heterosexual/straight respondents to leave negative feedback about mental health services (NHS, 2018a). In fact, just over a third (36%) of the 76 LGBT+ respondents surveyed by Healthwatch felt their experiences had been affected by their sexual orientation and/or gender reassignment and of these, the majority (77%) had been negative (Nottinghamshire Healthwatch and Nottingham Healthwatch, 2017).

Almost a third of those with a negative experience (29%) were referring to GP services and just under a quarter (23%) were referring to community-based services. A third attributed these negative experiences to healthcare staff, with 36% (n=11) saying assumptions were made about their sexual orientation, which in some instances forced the individual to reveal details about their sexual orientation and/or gender reassignment. Also, 16% (n=5) of respondents made reference to the lack of dignity and respect that was shown to them and 7% (n=2) 'made specific reference to healthcare professionals making homophobic

comments or demonstrating a homophobic attitude, or making insensitive comments to them, or within earshot of them' (Nottinghamshire Healthwatch and Nottingham Healthwatch, 2017: 12). The small sample size should be noted here, but for these experiences to have occurred recently is nevertheless of great concern.

The findings from Nottinghamshire replicate some of the trends in the national data, with transgender people also reporting limited knowledge about transgenderism (13%) among healthcare professionals. For example, one trans respondent reported being referred to as the incorrect gender (misgendering). Just under half (44%) felt these negative experiences had a negative impact on them as LGBT+ individuals and just under a third (30%) felt their experience had a negative impact on their mental health and made them experience feelings of anger or despair.

Importantly, there were also positive experiences reported, with 86% of these being attributed to good practice from healthcare staff. This is both encouraging to find and a platform to build upon (Nottinghamshire Healthwatch and Nottingham Healthwatch, 2017).

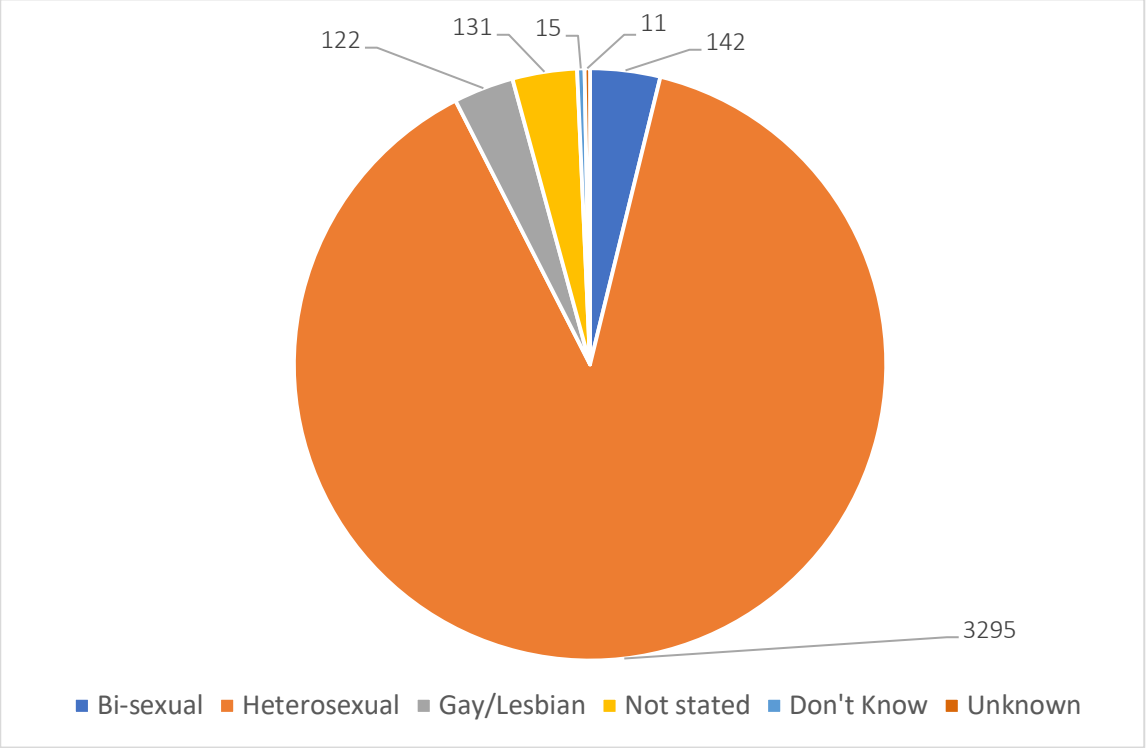
In Nottingham City CCG, data from the GPPS shows that a quarter of all respondents, regardless of sexual orientation, felt the healthcare professional they saw during their last general practice appointment definitely understood their mental health needs, although those identifying as LGB were more likely to report they did not understand them at all compared to those identifying as heterosexual/straight (see Table 10).

Table 10: Whether during their last general practice appointment, they felt that the healthcare professional recognised and/or understood any mental health needs they had (NHS, 2018b)

	Total		**Heterosexual or straight**		**Gay or lesbian**		**Bisexual**		**Other**		**Prefer not to say**	
Base (N)	4167		3620		80		71		44		352	
	%	N	%	N	%	N	%	N	%	N	%	N
Yes, definitely	25%	1040	26%	923	24%	20	29%	20	34%	15	18%	62
Yes, to some extent	16%	651	15%	547	12%	10	28%	20	24%	11	18%	64
No, not at all	7%	283	6%	217	12%	9	14%	10	17%	7	11%	39
I did not have any mental health needs	33%	1365	33%	1184	30%	24	15%	11	15%	7	40%	139
Did not apply to my last appointment	20%	828	21%	749	22%	17	14%	10	10%	4	14%	48

As well as examining self-report survey data, it is also useful to acknowledge that some of NHS Nottingham City CCG's commissioned services collect relevant data. For example, data from the Improving Access to Psychological Therapies (IAPT) services finds that 3% of the patients identified as gay/lesbian (n=131) and 4% as bisexual (n=142). (Figure 14).

Figure 14: Sexual orientation monitoring data for new patients in Nottingham City CCG-commissioned IAPT services, April-October 2017



These figures support national trends that LGB people are over-represented in mental health services, given the earlier cited statistic that 1.3% of the Nottingham population identify as LGB (ONS, 2017a). Such health provider-collected data tends to be patchy, however. A recent Health Equity Audit for IAPT services in Nottingham City found that the comprehensiveness of sexual orientation data varied between providers, with one provider returning data where in 14.1% of cases, patients' sexual orientation was unknown (Johns, 2017).

Johns' (2017) health equity audit also reveals some important disparities in IAPT treatment outcomes in relation to sexual orientation. Two key measures are relevant; 'reliable improvement' and 'reliable recovery': reliable improvement constitutes a significant, measurable improvement between the start and end of treatment, while reliable recovery indicates a significant improvement such that the patient is no longer clinically diagnosed as having the condition for which they were receiving treatment (Clark and Oates, 2014).

Johns' (2017) health equity audit found no significant differences in relation to reliable improvement and sexual orientation, although whilst 75.1% of all treatment completers demonstrated reliable improvement, this figure was only 50% for those who did not know or were not sure what their sexual orientation was. Regarding reliable recovery, bisexual people were overall least likely to reach reliable recovery at the end of treatment, and rates of reliable recovery are generally lower for those who did not know what their sexual

orientation was, or declined to provide this information. Differences between providers mean that these trends are not consistent, and as Figure 14 shows, the numbers of individuals that some of these findings pertain to are extremely small.

Finally, one area of significant concern nationally which recent research has highlighted is the continued practice and endorsement of so-called conversion or 'gay cure' therapies, contrary to a joint statement by leading UK psychotherapeutic and counselling professional bodies in 2014 which renounced such practices (UKCP, 2014). In fact, a survey by Stonewall (2015) found that one in ten health and social care staff across Britain have witnessed colleagues express belief that someone can be 'cured' of being LGB.

The National LGBT survey found that 5% of respondents had been offered conversion therapy to cure them of being LGBT but had not taken it up, while 2% (2,640 people) had undergone conversion therapy, which for some had involved surgical interventions and 'corrective' rape. Such interventions were mostly conducted by faith groups (51%), but in almost a fifth of cases (19%), a healthcare professional was responsible (see Figure 15) (GEO, 2018).

Figure 15: Who conducted the conversion therapy (GEO, 2018)

Evidence has shown that conversion therapy has a detrimental impact on the mental health of the person subjected to it and can lead to depression, anxiety, drug use, homelessness, self-harm and suicide, not to mention its ineffectiveness and breach of human rights (APA, 2009). What is unclear from the National LGBT Survey is how long ago respondents were subjected to so-called conversion therapies, although religious groups that offer sexual orientation 'change' continue to operate in the UK.

9) Conclusion

In summary, whilst there are some encouraging findings which are indicative of good practice both nationally and locally, there are a number of sobering indications in the data analysed that gaps and inconsistencies in healthcare provision are negatively impacting on the mental health and wellbeing of LGBT people, who are already known to be at greater risk of mental ill-health (NIESR, 2016).

What is apparent, and particularly concerning, is that **services which should be supporting individuals at some of the most difficult times of their lives may either exacerbate the difficulties which they are facing, or may be avoided for fear of unhelpful, inappropriate or inequitable responses.**

Some of the key findings from this analysis of relevant national, regional and local data pertaining to the mental health of LGBT people are that:

- Young LGBT people are more likely to identify as non-binary, bisexual or gay/lesbian, compared to older individuals, and older people are less likely to disclose their sexual identity in both national and local surveys.

- Experiences of hate victimisation, discriminatory or marginalising experiences at school and sexual victimisation are especially high for LGBT people. These experiences of structural and interpersonal oppression need to be a central consideration when exploring factors affecting LGBT people's mental health and their feelings about accessing healthcare services and disclosing their sexual orientation and/or gender identity. This raises the question of how healthcare services are signalling that they are LGBT-inclusive and facilitating opportunities for disclosure.

- LGBT people have higher rates of poor mental and physical health, and higher rates of smoking, drinking alcohol, drug use, self-harm, suicidal ideation and victimisation both inside and outside the home than heterosexual, cisgender people. This is even higher for the younger LGBT population. These findings are replicated in both national and Nottinghamshire specific datasets.

- It is important to pay attention to differences within LGBT populations. A recurring theme to arise from the analysis of both the national and local data is that those identifying as bisexual have poorer physical and mental health. Intersections with other aspects of LGBT identities need to be considered, but the small numbers of LGBT people in many surveys inhibits conducting any sufficiently robust intersectional re-analysis.

- Encouragingly, the majority of LGBT people rated their healthcare experiences positively both nationally and in Nottingham City. However, this was not the case for trans people accessing specialist gender identity services either nationally or locally, with long waiting times being a particular issue.

- Despite generally positive healthcare experiences, it is the case that, nationally and locally, LGBT people are more likely to report a negative experience when accessing healthcare services than those identifying as heterosexual. Again, healthcare experiences were not evenly distributed amongst LGBT populations: those identifying as bisexual, transgender and queer were more likely to report negative experiences such as not feeling listened to, feeling that their needs were ignored and/or feeling worried and anxious about accessing healthcare services, particularly GPs.

- Some of the most negative experiences of healthcare for LGBT people related to GPs, who not only failed to understand their needs or know which services to refer LGBT individuals to, but were also unsupportive and in some instances, discriminatory and hostile to their patients. Although these experiences are found in both national and local datasets, the rates of poor GP experiences were markedly higher for LGB people in Nottingham City CCG than across all CCGs nationally, although small numbers of LGB respondents mean that this finding is not conclusive.

- Men, regardless of their sexual orientation, were reluctant to access both general healthcare services and mental health services compared to women of any sexual orientation. Trans men were more likely to avoid seeking treatment due to fear of having negative experiences.

Overall, this review illustrates that **LGBT people have greater healthcare needs across the board than heterosexual, cisgender people, and yet they experience significant barriers to accessing treatment and hostility in some instances when they do**. This situation intensifies the health inequalities that are experienced by LGBT populations. Priorities for future research, including the next phases of this research project, are:

- To gain a greater insight into how intersectionality impacts on mental healthcare needs and experiences among LGBT populations, and to particularly understand the issues facing bisexual people. In light of recurring findings which point to the particular vulnerabilities of LGBT people, it would be useful to have a bisexual-specific focus group as part of the qualitative fieldwork, as well as to purposively sample bisexual people to participate in the in-depth service user interviews.

- To explore healthcare practitioners' confidence in providing services to less well-understood groups such as those identifying as queer, pansexual, non-binary or trans men needs, as well as the extent to which existing training prepares them to work with the whole spectrum of LGBT populations.

- To identify how primary care and community mental health services can embody a commitment to inclusive and non-discriminatory practice from the perspectives of LGBT people and healthcare providers. We shall achieve this firstly by seeking examples of what healthcare services are doing to make visible their commitment

to LGBT equality. Secondly, we will capture the views of local LGBT populations regarding the markers of LGBT inclusivity that are important to them when considering whether to seek mental healthcare or to continue to use NHS primary care and/or community mental health services.

- To elicit LGBT people's and healthcare practitioners' views about sexual orientation and gender identity disclosure and monitoring, respectively. This is particularly pertinent to the survey data finding the greatest vulnerabilities in the 'prefer not to say' category for sexual identity, and this is timely given that the NHS Sexual Orientation Monitoring Standard is being implemented currently or imminently. In order for the implementation of the new monitoring standard to be managed effectively and sensitively, accumulating local knowledge about perceived barriers and concerns for patients and healthcare practitioners, as well as identifying examples of good practice, would be a positive contribution of this research.

References

American Psychological Association (APA) (2009) *Report of the American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation.* Washington: APA.

Auer M.K., Fuss J., Höhne N., Stalla G.K., and Sievers C. (2014) Transgender Transitioning and Change of Self-Reported Sexual Orientation. *PLoS ONE* 9(10): e110016.

Bell, M. (2017) *Data Collection in Relation to LGBTI People*. Brussels: European Commission.

Breslow, A.S., Brewster, M.E., Velez, B.L., Wong, S., Geiger, E. and Soderstrom, B. (2015) Resilience and Collective Action: Exploring buffers against minority stress for Transgender individuals. *Psychology of Sexual Orientation and Gender Diversity*, 2(3): 253-265.

Clark, D. and Oates, M. (2014) *Improving Access to Psychological Therapies: Measuring Improvement and Recovery: Adult Services - Version 2*. London: NHS.

Divercity (2016) *Transnational and comparative research on homo- and transphobia in small and medium cities.* European Union: Divercity.

FRA (2013) *EU LGBT Survey*. Luxembourg: Office of the European Union.

Geary, R.S., Tanton, C., Erens, B., Clifton, S., Prah, P., Wellings, K. Mitchell, K.R., Datta, J., Gravningen, K., Fuller, E., Johnson, A.M., Sonnenberg, P. and Mercer, C.H. (2018) Sexual identity, attraction and behaviour in Britain: The implications of using different dimensions of sexual orientation to estimate the size of sexual minority populations and inform public health interventions. *PLoS One* 13(1): e0189607.

Government Equalities Office (GEO) (2018) *National LGBT Survey, 2017.* London: Government Equalities Office.

Healthwatch Nottinghamshire and Healthwatch Nottingham (2017) *Exploring health care experiences of the LGBT+ community.* Hucknall: Healthwatch Nottinghamshire and Nottingham: Healthwatch Nottingham.

Johns, D. (2017) *Health Equality Audit: Improving Access to Psychological Therapies*. Nottingham: Nottingham City Council.

Lenihan, P., Kainth, T. and Dundas, R. (2015) "Trans sexualities". In C. Richards and M.J. Barker (eds) *The Palgrave Handbook of the Psychology of Sexuality and Gender*. Basingstoke: Palgrave Macmillan, pp.129-146.

McLaughlin, K., Hatzenbuehler, M., Xuan, Z. and Conron, K. (2012) Disproportionate exposure to early-life adversity and sexual orientation disparities in psychiatric morbidity. *Child Abuse and Neglect*, 36(9): 645–655.

Mays, V.M. and Cochran, S.D. (2001) Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health*, 91(11): 1869-1876.

Metro (2016) *Youth Chances: Integrated Report.* London: Metro Charity.

Meyer, I. (2003) Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5): 674–697.

Morrison, M.A. (2011) Psychological Health Correlates of Perceived Discrimination among Canadian Gay Men and Lesbian Women. *Canadian Journal of Community Mental Health*, 30(2): 81-98.

National Institute of Economic and Social Research (NIESR) (2016) *Inequality among LGB&T groups in the UK: a review of evidence.* London: NIESR.

Natsal (2014) *Sexual attitudes and lifestyles in Britain: Highlights from Natsal-3*. Accessed 20 December 2018: http://www.natsal.ac.uk/media/2102/natsal-infographic.pdf

NHS (2018a) *2017 Mental Health Survey Report for LGBT+ People in Nottingham.* Nottingham: NHS.

NHS (2018b) *GP Patient Survey*. London: NHS.

NHS (2015) *Health Survey for England: 2014.* London: NHS.

NHS England Equality and Health Inequalities Unit (2017) *Sexual Orientation Monitoring Standard: Full Specification.* London: NHS England.

ONS (2019) *Sexual Identity, UK.* London: ONS.

ONS (2017a) *Sexual Identity, UK: 2016.* London: ONS.

ONS (2017b) *2021 Census topic research: December 2017*. London: ONS.

ONS (2017c) *Sexual Identity, Subnational.* London: ONS.

ONS (2017d) *Lesbian, gay, and bisexual people say they experience a lower quality of life*. London: ONS.

ONS (2016) *Adult Psychiatric Morbidity Study: Survey of Mental Health and Wellbeing, England, 2014.* London: ONS.

Parliament UK (2018) *LGBT+ Health Inequalities.* Accessed 5 July 2018: https://www.parliament.uk/documents/post/LGBT-Health-Inequalities.pdf

Public Health England (PHE) (2017) *Producing modelled estimates of the size of the lesbian, gay and bisexual (LGB) population of England*. London: PHE.

Semlyen, J., King, M., Varney, J. and Hagger-Johnson, G. (2016) Sexual orientation and symptoms of common mental disorder or low wellbeing: combined meta-analysis of 12 UK population health surveys. *BMC Psychiatry*, 16(67): 1-9.

Stonewall (2015) *Unhealthy Attitudes Survey.* London: Stonewall.

Wang, Y., Hunt, K., Nazareth, I., Freemantle, N. and Petersen, I. (2013) Do men consult less than women? An analysis of routinely collected UK general practice data. *BMJ Open*, 3:e003320.

United Kingdom Council for Psychotherapy (UKCP) (2014) *Conversion Therapy: Consensus Statement*. London: UKCP.