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Improving the mental health outcomes of Nottingham's LGBT+ populations:

final report

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This research was commissioned by
NHS Nottingham City Clinical Commissioning Group

RMIT UNIVERSITY Social and Global Studies Centre
Transformative Research for Social Justice

University of Brighton
Centre for Transforming Sexuality and Gender

UNIVERSITY OF LEICESTER

Contents

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/Pan	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)

(adapted from Stonewall's Glossary of Terms: https://www.stonewall.org.uk/help-advice/glossary-terms#a)

1. Introduction

The current research was commissioned in late 2017 by NHS Nottingham City Clinical Commissioning Group (CCG)[1], who wanted a research study to be carried out in Nottingham City to inform decisions about the future commissioning of mental health services to meet lesbian, gay, bisexual and/or transgender (LGBT[2]) people's needs. Improving mental health outcomes and reducing inequalities are strategic priorities for NHS Nottingham City CCG, who in 2016 commissioned engagement work with Nottingham's population[3] to inform their five-year commissioning strategy. This engagement work recommended that the CCG identify how to improve cultural competence amongst healthcare professionals, with a focus on general practitioners, to enable them to better understand, identify and respond to specific communities, including LGBT people.

In May 2017 Healthwatch Nottingham and Nottinghamshire published their report on LGBT+ people's experiences of health services (Healthwatch Nottingham and Nottinghamshire 2017). Key recommendations included services being encouraged to continue to work with LGBT+ people so as to avoid labelling and language errors, as well as ensuring that all staff had knowledge of LGBT+ people's needs, particularly transgender people's needs, including understanding how trans individuals want to be addressed. A number of these considerations were captured in *Nottingham City's Mental Health and Wellbeing Strategy 2019-2023*, where an emphasis on reducing stigma and discrimination and improving the mental health outcomes of LGBT people, including via the current research study, are explicitly articulated.

This Nottinghamshire focus on LGBT+ mental health runs alongside a parallel national picture where in 2017 the Government launched the first National LGBT Survey (Government Equalities Office 2018a). This emerged from the dearth of data capturing LGBT and intersex people's experiences of health, education, personal safety and employment: spheres where LGBT+ individuals face the largest inequalities. As a 'call to action' (p. 1) in response to the findings, the Government developed *the LGBT Action Plan* (Government Equalities Office 2018b), with over 75 commitments from Government that set out how they will improve the lives of LGBT people. Amongst other key actions, appointing a national LGBT health adviser to offer leadership on reducing the health inequalities faced by LGBT populations is included. Thus, it is disappointing that the *NHS (2019) Long Term Plan* mentions LGBT+ people only twice, although it does acknowledge that LGBT+ children and youth are likely to experience additional mental health needs. Indeed, in order to support early intervention, the Plan commits to embedding new Mental Health Support Teams within schools and colleges and, once rolled out, recommends the testing of comparable approaches for outside of educational settings. It also proposes the introduction of national waiting time standards for children and young people needing to access specialist mental health services.

Thus, the aims of this research, as set out in the commissioning brief, were to increase understanding of how to prevent mental ill-health, facilitate early diagnosis and promote self-care amongst

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[1] On the 1st April 2020 NHS Nottingham City CCG merged with 5 other local CCGs to form the new NHS Nottingham and Nottinghamshire CCG.

[2] This research was originally commissioned to focus on LGBT people's experiences. We use the acronym LGBT+ to be inclusive of other sexual and gender identities which have become more visible over the last few years, such as pansexual, non-binary and genderqueer.

[3] Unpublished. Available at: http://communityresearch.co.uk

Nottingham City's LGBT+ population. The services that are in the scope of the research are primary care services – that is, the general practices within Nottingham City[4] – and community mental health services commissioned by NHS Nottingham City CCG[5]. As the related footnotes explicate, the number of GP practices and commissioned mental health services changed over the duration of this research project.

A mixed-methods approach was adopted to undertake the research. The components of this were:

1. A rapid evidence assessment (literature review) was conducted to produce an up-to-date, rigorous review of literature about LGBT+ mental health and healthcare.

2. An analysis of national, regional and local statistics about LGBT+ people's mental health needs and healthcare experiences.

3. A creative, participatory stall at Nottinghamshire Pride 2018 to elicit a wide range of perspectives (on a graffiti wall, decorated drinks mats and comment cards) about self-care and what helps and hinders LGBT+ people's mental health.

4. Focus groups with LGBT+ people about what helps and hinders them in maintaining good mental health, their perceptions of mental healthcare for LGBT+ people and views on good practice in making primary care and community mental health services LGBT+-inclusive.

5. Semi-structured interviews with LGBT+ people who have sought mental healthcare from NHS general practices and community mental health services to explore their experiences of seeking and receiving mental healthcare, to include experiences of good practice and areas for improvement.

6. Semi-structured interviews with commissioners of mental health services, mostly in Nottingham and Nottinghamshire, focusing on how they make commissioning decisions and their awareness of LGBT+ people's mental health needs.

7. Semi-structured interviews with frontline practitioners and service managers in community mental health services to explore experiences of providing healthcare to LGBT+ people, working with other providers such as GPs, perceptions of LGBT+ people's mental health needs and views on providing LGBT+-inclusive services.

8. Semi-structured interviews with General Practitioners and an online survey of general practices which sought to identify how patients with mental health needs are supported,

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[4] Over the study period the number of GP practices reduced from 54 to 50 due to mergers and closures.

[5] These services are - **Children's and Young People's Services:** Base 51 (youth service); Behavioural and Emotional Health Service; KOOTH (online counselling and support for children and young people); Self-Harm Awareness and Resource Project (SHARP); Targeted Child and Adolescent Mental Health Service (CAMHS) and Specialist Community CAMHS. **Adult Services:** Insight Healthcare (Improving Access to Psychological Therapies (IAPT) service; Let's Talk Wellbeing (IAPT service); Trent PTS (IAPT service); Support Towards Empowering People Service (STEPS; for Black, Asian, Minority Ethnic and Asylum Seeker and Refugee communities); Wellness in Mind and City Local Community Mental Health Services. The Primary Health and Wellbeing College, Primary Care Mental Health Service and Turning Point (IAPT service) were commissioned community mental health services at the start of the research and therefore may also have been services experienced by the LGBT+ people who took part in the interviews and focus groups.

perceptions of LGBT people’s mental health needs, their views about the NHS Sexual Orientation Monitoring Standard and how equipped they are to support LGBT patients.

Whilst the number of participants was sometimes small within certain components of the study, the ability to triangulate across them, including with the rapid evidence assessment, offers rigour. Ethical approval for all aspects of the research was received from the University of Leicester Ethics Sub-Committee of Criminology and School of Education, and approval from the Health Research Authority was received for the fieldwork components involving NHS health professionals[6].

The research has been guided by a steering group comprising representatives from NHS Nottingham City CCG and Nottingham City Council. The steering group has offered critical input on key decisions throughout the research process, as well as being an important communication mechanism for sharing updates with the research team about the local context. We would like to take this opportunity to thank our steering group members for their commitment and support, and to thank our two research assistants, Nicola Shelton and Joshua Stuart-Bennett.

Three volunteer LGBT+ community researchers were recruited via an open selection process and provided with training. Community researchers were involved in running the creative participatory stall at Nottinghamshire Pride, analysing the Pride stall data, feeding back on research materials, and supporting the recruitment of focus group participants and the facilitation of the focus groups. Only one of the three community researchers, Kristan Hopkins, has been able to remain involved for the full duration of this study, and we thank her for her tireless efforts to recruit participants and for being a warm and welcoming presence at the focus groups. We thank the two community researchers who supported us in the earlier stages of this project for their valuable contributions.

Finally, we extend our huge thanks to all of the health professionals and commissioners who participated in this research and who helped to facilitate this research. Our greatest thanks go to the members of Nottingham’s LGBT+ population who shared their valuable insights and often very painful experiences with us[7].

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[6] Fieldwork for this research took place between December 2018 and January 2020, ending before the Covid-19 pandemic. Publication of this report has been delayed due to Covid-19.

[7] To contact the research team directly for further information or enquiries, please email Rebecca Barnes at rb358@leicester.ac.uk

2. Rapid evidence assessment: overview

A rapid evidence assessment reviewed available literature on lesbian, gay, bisexual and transgender (LGBT+) mental health in the United Kingdom.[8] An initial search generated 1190 articles and reports, which were subsequently reduced to 40 studies published within the last 10 years. The rapid evidence assessment aimed to gather and synthesise existing evidence to inform the commissioning of primary care and community mental health services to improve the mental health outcomes of LGBT+ people in Nottingham.

The rapid evidence assessment addresses four distinct areas:

1. Rates, predictors of and protective factors for mental health outcomes for LGBT+ people in the UK.
2. Evidence of existing models of health service delivery (primary care, community health) that have shown to be effective in supporting LGBT+ mental health/reducing mental health inequalities (prevention, early diagnosis, self-care).
3. Evidence of effective mental health interventions for LGBT+ people.
4. Evidence of models of 'good practice' for reducing barriers to access, developing cultural competence, improving early diagnosis, supporting self-care.

Research consistently shows that LGBT+ people experience poorer mental health than the rest of the population. The importance of providing services to address these mental health disparities cannot be overstated, but there is a need for greater understanding of how these services can be delivered in a way that is both sensitive to and appropriate for LGBT+ populations. This review identifies examples of good practice in service delivery that offer LGBT+ specific interventions and provide LGBT+ support and advice. Significant gaps in evidence about existing service provision nationally and locally are also identified, along with gaps in knowledge about what quality interventions might be delivered for LGBT+ people in a UK setting. Further research is also needed to understand the specific issues for trans and non-binary people's mental health and the development of culturally appropriate models of care for LGBT+ people in general.

Identity categories and the terminology used in this report

LGBT is an acronym that describes the lesbian, gay, bisexual and transgender population(s). Often this acronym can be written in the variant style LGBTQ with the addition of the letter Q for queer-identified, or LGBT+, where + indicates the inclusion of other diverse gender and sexual identities. Q is sometimes also used to denote questioning, especially in studies of young people. The term LGB refers to lesbian, gay or bisexual identified individuals and is used in studies that focus on sexuality, rather than gender identity, but the intersection with gender remains important to distinguish between gay men and gay women, bisexual men and bisexual women. It is worth noting that research about LGB identities may also include trans-identified people as some LGB people also identify as

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[8] The full rapid evidence assessment is available here:
https://www2.le.ac.uk/departments/criminology/documents/improving-the-mental-health-outcomes

trans. Transgender, now 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, Kainth et al. 2015). Although LGB can be used to refer to lesbians, gay men and bisexual men and women, some LGB people may also identify as cisgender, where cisgender refers to having a gender identity that aligns with the one assigned to them at birth.

For this report, when reporting on research findings from existing studies, the terminology used by the researchers will be adopted to ensure validity in the types of claims that are being made (e.g. not ascribing findings to trans people if they are not indicated within the research findings). For the overarching narrative and report recommendations the acronym LGBT+ will be used, in recognition of the diversity of sexualities and gender identities beyond lesbian, gay, bisexual and transgender.

LGBT+ mental health disparities

This section is divided into LGB and trans mental health, reflecting the nature of the evidence available. However, it is worth noting that studies that include data on LGB mental health may include trans people and studies on trans mental health may include LGB individuals.

Evidence drawn from studies with a comparative group, shows poorer mental health amongst LGB people (McNamee, Lloyd et al. 2008, Chakraborty, McManus et al. 2011, Semlyen, King et al. 2016, Woodhead, Gazard et al. 2016) and higher rates of low well-being (Semlyen, King et al. 2016, Woodhead, Gazard et al. 2016), substance misuse (Hagger-Johnson, Taibjee et al. 2013, Pesola, Shelton et al. 2014, Mercer, Prah et al. 2016, Woodhead, Gazard et al. 2016), eating disorders (Calzo, Austin et al. 2018), anxiety (Jones, Robinson et al. 2017) and self-reported longstanding psychological or emotional problems (Elliott, Kanouse et al. 2015) than heterosexual people. One Scottish longitudinal study using a schools-based sample demonstrated a link between same-sex sexual behaviour and self-harm in young people (Young, Riordan et al. 2011).

There is very little research looking directly at bisexual mental health (Barker 2015), but it is worth considering the mental health disparities for bisexual men and women within LGB populations. From a self-selected sample of lesbian and bisexual women, Colledge, Hickson et al. (2015) found that bisexual women reported poorer mental health than lesbian respondents. A recent representative population study has found that levels of poorer mental health are higher for bisexual men and women (Semlyen, King et al. 2016). Pompili, Lester et al. (2014) conducted a systematic review specifically to examine the risk of suicidal behaviour among bisexual people; they concluded that bisexual people had an increased risk for suicide attempts relative to both heterosexual and gay and lesbian people.

There has been a dearth of data on trans mental health and although there has been a very recent increase of research in this area, no population studies exist, and no nationally representative health surveys collect gender identity beyond binary female/male categories. However, studies found during the evidence review demonstrate high rates of mental health issues in trans and non-binary populations with samples drawn from those attending gender identity services (GIS) (Claes, Bouman et al. 2015, Arcelus, Claes et al. 2016, Jones, Haycraft et al. 2018, Thorne, Witcomb et al. 2018). Other studies have used convenience or opportunity samples (McDermott, Hughes et al. 2017, Rimes, Goodship et al. 2017, Timmins, Rimes et al. 2017).

LGBT+ mental health service use: access and experience

Evidence shows that LGB people seek and/or access mental health services more frequently than heterosexuals (King, Semlyen et al. 2007, Chakraborty, McManus et al. 2011). From the review evidence we know that men who have sex with men reported higher treatment use for depression (Mercer, Prah et al. 2016) and that LGB people have poorer mental health treatment outcomes (Rimes, Broadbent et al. 2018)

The recent UK Government's National LGBT Survey states mental health services were accessed by 24% of the 108,000 respondents (Government Equalities Office 2018a). A further 8% made unsuccessful attempts to access services. Almost three quarters of these found access difficult, with half reporting that they had to wait too long. This survey also showed that treatment for mental health conditions is accessed more frequently by people who identify with sexual orientations that are less common (such as pansexual-identified people) and that pansexual and queer identified people found accessing mental health services more difficult, in particular experiencing a long waiting time. In addition, trans non-heterosexual respondents found accessing mental health services more difficult than trans heterosexual respondents.

Notably, the National LGBT Survey also found some positive ratings of mental health services, once accessed, with 14% of those who accessed mental health services in the previous 12 months rating them as 'completely positive' and a further 43% as 'mainly positive'. However, approximately one in five reported completely or mainly negative experiences, with this proportion increasing for trans people of all sexual orientations and bisexual, pansexual and queer women (Government Equalities Office 2018a). Community samples and qualitative research tell us that LGBT people often are not successful in getting the help they need (Guasp and Taylor 2012, Rivers, Gonzalez et al. 2018). Some report lack of LGB sensitivity in service delivery (McNair and Bush 2016) and for those who do access treatment, many report low satisfaction (Guasp and Taylor 2012). A recent study in Australia suggests that to improve experiences of healthcare, more needs to be done to foster feelings of belonging amongst sexual and gender minorities (Newman, Prakumar et al. 2020).

Barriers to accessing healthcare exacerbate levels of mental health needs (King, Semlyen et al. 2007). LGBT people may delay or avoid seeking help for depression and anxiety or substance misuse, leading to possible increased risk of further and more severe mental health problems (King, Semlyen et al. 2007). Research shows that healthcare professionals have very limited knowledge about LGBT health (Kitts 2010, Obedin-Maliver, Goldsmith et al. 2011, Guasp and Taylor 2012). LGBT people are not often asked about their sexuality or gender identity, resulting in a lack of appropriate treatment and referral (Kitts 2010). Non-disclosure may be because of previous poor experience, or a fear of mistreatment. Evidence shows non-disclosure is higher in Black, Asian and minority ethnic LGBT people (Petroll and Mosack 2011).

In a recent qualitative study that examined equity of access to psychological therapies in Nottingham, some LGBT participants reported that they were fearful about being identified within IAPT services and so did not self-refer (Murphy and Godbehere 2015). Other minority stress mechanisms involving negative experiences of ‘coming out’ and homophobic bullying have been associated with increased odds of suicidal thoughts and attempts (Nodin, Peel et al. 2015). Finally, evidence suggests that for some LGBT+ people, this results in them simply not engaging with mainstream services. For example, a quarter of the respondents in the Queer Futures youth survey had not sought help for their self-harm behaviour/suicidality (McDermott, Hughes et al. 2016). Knowledge of others’ poor experiences and fear of discrimination can act as barriers to help-seeking for LGBT+ people. This is further evidenced by Stonewall's (2014) survey of healthcare experiences, where 18% of LGBT respondents reported anticipating negative experiences in advance of seeking help from mental health services.

Risk and protective factors for mental health amongst LGBT+ people

Evidence for the causal pathways to poorer mental health is lacking but links between mental health and health behaviour (Pesola, Shelton et al. 2014) and evidence of the impact of discrimination on poorer mental health (Chakraborty, McManus et al. 2011, Woodhead, Gazard et al. 2016) indicate that likely links lie with social determinants and structural inequalities, including experiences of discrimination and victimisation. Meyer’s minority stress theory, extended for gender diverse groups (Testa, Habarth et al. 2015), proposes that there is a link between mental health and stress that is linked to minority status (Meyer 2003).

The area with most research on ‘risk’ has focused on suicidality (including suicide ideation or suicide attempts) in LGBT+ people. For example, McDermott et al.’s (2017) mixed-methods study used interviews and online convenience sampling to explore determinants of LGBT suicidality, suggesting a broad range of factors increase risk of suicide for young LGBT respondents. Experience of discrimination and/or not being able to talk about feelings showed a strong association with poor mental health. Evidence indicates that the highest risk time for suicidal ideation and suicide attempts is when LGB individuals “come out” to their families (Igartua, Gill et al. 2009). When parents support LGBT youth this improves self-esteem in young adulthood and is linked to improved overall health (Ryan, Russell et al. 2010).

In terms of protective factors, the importance of strengths-based interventions and the development of resilience are key to LGBT+ mental health promotion (Gahagan and Colpitts 2017, McNeil, Ellis et al. 2017). Social support is also important (Seil, Desai et al. 2014, McDermott, Hughes et al. 2016, McDermott and Roen 2016, Ussher, Baker et al. 2016, McDermott, Hughes et al. 2017), as is family support and attitude (Rivers, Gonzalez et al. 2018). Research also shows the importance of protecting young people through mentoring and fostering (e.g. The Albert Kennedy Trust) as well as the role of inclusive anti-bullying policies (Hatzenbuehler and Keyes 2013). The research also demonstrates that developing resilience within mental health support is crucial for future health protection (Nodin, Peel et al. 2015, Rivers, Gonzalez et al. 2018).

Evidence of effective mental health interventions for LGBT+ people

The majority of psychological interventions with LGBT+ service users are Cognitive Behavioural Therapy (CBT) or counselling based with very few studies being carried out in the UK context. There are a number of traditional face-to-face CBT programmes that have been modified to be LGBT-affirmative; some LGB youth facing (Pachankis, Hatzenbuehler et al. 2015, Craig and Austin 2016), some trans facing (Austin and Craig 2015, Austin, Craig et al. 2018). Other face-to-face interventions include a Compassion Focused Therapy (CFT) programme for LGB youth in Australia (Pepping, Lyons et al. 2017).

A growing body of evidence is demonstrating mental health benefits of gay-straight alliances (GSA) within school settings (Lee 2002). Gay-straight alliances (GSA) can be defined as a youth-led, or a school or community-based group that provides a safe, welcoming, and affirming physical and emotional space for LGBT+ young people, often based around a peer mentoring or buddy system model. USA research has shown reduction in drug and illicit alcohol use, reduction in suicidality and improved psychological wellbeing as a result of GSA within a school environment (Heck, Flentje et al. 2013). Supportive and inclusive policies within the school structure similarly improve psychological wellbeing, perceived safety (Ioverno, Belser et al. 2016) and reduce homophobic victimisation (Marx and Kettrey 2016).

In a recent narrative review by O'Shaughnessy and Spier (2018), a number of key factors for successful therapy outcomes for LGBQ service users were identified. These include a person-centered approach with overt LGBQ affirmation, good therapist fluency regarding integration of sexual identity into the process and strong skills for working with LGBQ people to facilitate processes such as coming out. This study also found that the sexual orientation and/or gender identity of the therapist was important to the LGBQ person receiving treatment.

There is a strong belief within LGBT+ communities that LGBT+-specific services are needed because existing mainstream services are heteronormative, homophobic and transphobic (Ash and Mackereth 2013, Intercom Trust 2020). In a health needs assessment in the North East of England, Ash and Mackereth (2013 p26) found that resources other than those referred to as 'straight resources' were considered as being so 'inadequate in providing help, advice and support, that [LGBT people] do not seek [them]'. There was also a strong feeling that any services that were set up to be LGBT-facing should consult with LGBT people and have workers recruited from LGBT communities.

The majority of studies point to LGBT+-specific resources as a necessary outcome, certainly while so little LGBT knowledge and so much negative attitude is present in existing mainstream services (Robertson, Pote et al. 2015, Rivers, Gonzalez et al. 2018). The impact of discrimination and in some cases, social isolation, demonstrates the importance of fostering connectedness for LGBT+ people and community services are beginning to step into the gap of providing mental health support for LGBT+ people. These services can also allow LGBT+ people to connect with other LGBT+ people in an affirming environment, facilitating the social connections and everyday friendships that many cisgender, heterosexual people take for granted (Johnson, Faulkner et al. 2007).

The role of online and community-based support services

Given the challenges outlined above for LGBT+ people seeking and receiving mental health services, there is an argument for considering alternative models of service delivery to LGBT+ people. Services delivered through online platforms have the potential to increase engagement, particularly amongst the most vulnerable, as they allow anonymity in disclosure and a sense of safety (McDermott and Roen, 2012; Intercom Trust 2020). Research examining LGBT youth narratives has found the internet to be a useful medium for accessing immediate and authentic material (McDermott and Roen 2012). The recent National LGBT Survey (Government Equalities Office 2018a) similarly found that the internet is an important resource for connecting people and for letting them know they are not alone; indeed, for many it is the first place where help is sought for both issues with identity and mental health (McDermott, Hughes and Rawlings, 2016).

The National LGBT survey also highlighted that respondents found LGBT-specific charities particularly helpful when seeking support. LGBT organisations and charities were viewed as the most helpful when handling the most serious incidents experienced by respondents in a number of areas. For example, 77% of those who reported an incident in education to an LGBT organisation or charity said that they had found them very or somewhat helpful (Government Equalities Office 2018a).

Key gaps in the evidence and directions for future research

Knowledge about the mental health disparities for LGBT+ people is well-established. However, there are still a number of key gaps in knowledge which need to be addressed in order to enhance the decision-making of commissioners and the development of inclusive practice by service providers and individual health practitioners. The principal gaps which this review has identified include:

1. A lack of understanding about the causal pathway between marginalisation and psychological distress, and evidence for appropriate interventions that reduce mental health inequalities for LGBT+ people.

2. More understanding of the applicability of interventions for the differing needs of L G B and/or T+ people, with emphasis on less common identities such as pansexual, trans and non-binary, and the intersections between LGBT+ identities and other aspects of identity such as age, ethnicity and socio-economic status.

3. Better monitoring and recording of LGBT+ identities both in national surveys and within primary care and mental health services, including creating the conditions where LGBT+ people feel safe to disclose their identities.

4. The training needs of health practitioners need to be better understood, with this knowledge being used to develop more comprehensive and up-to-date culturally competent training resources.

5. Little is known about appropriate interventions for LGBT+ people and their success. Promising examples include third sector involvement in delivering mental health services, for instance MindOut in Brighton & Hove[9], as well as the use of online support and other uses of new technologies. These approaches need further exploration to assess the potential for replicating such initiatives in the Nottingham City context.

6. New interventions need to be subject to robust evaluation, as well as careful consideration as to the appropriateness of replicating any intervention in a different social, cultural and/or geographical context.

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[9] MindOut is a nationally recognised charity based in Brighton & Hove that has been leading the field in providing community-based LGBTQ mental health services for over 20 years. Services include peer support, peer mentoring, advocacy and online support. https://www.mindout.org.uk/

3. Quantitative analysis of national and regional statistics: overview

Following on from the rapid evidence assessment, this section of the report offers a summary of an analysis of existing national survey data and, where available, regional and/or Nottingham-specific data. This analysis aimed to establish what is already known about the size and characteristics of the LGBT+ population in Nottingham, its mental health needs and healthcare experiences.[10] The findings of this analysis were used to identify knowledge gaps and inform priority areas for consideration in the qualitative phases of this research. This section offers key highlights from that analysis, focusing primarily on data from the Nottingham and/or Nottinghamshire context.

Before continuing, it is important to recognise the limitations of quantitative survey data in this area, and their impacts on knowledge. Measuring sexual orientation and gender identity is fraught with methodological complexities, with competing views about how this data should be collected, as well as whether it should be collected at all (see Bell 2017). The UK is in the early stages of systematic and robust data collection about sexual orientation and gender identity. There has not yet been a national census question about sexual orientation or gender identity in England & Wales, but the Census 2021 will be the first to include voluntary questions about both of these variables.

Despite the health disparities for LGBT+ people that are highlighted in the rapid evidence assessment, official population surveys that include questions about health and healthcare have only recently started to collect data about sexual orientation[11] and have never done so about gender identity. One notable exception, discussed already in the rapid evidence assessment, is the UK Government's National LGBT Survey, which collected data from 108,100 LGBT+ people aged 16 and over (Government Equalities Office 2018a). This is the largest ever survey of LGBT+ people, and it collected important data about LGBT+ people's lives in the UK, including health data that will be discussed later in this section. However, because the National LGBT Survey – as with some of the other surveys discussed in this analysis – recruited a self-selected convenience sample, its representativeness cannot be assured.

Importantly, how sexual orientation intersects with people's other identities (for example, their race or ethnicity, or whether they have a disability) is critical to consider to enable a more nuanced analysis, but small numbers of LGB people in many of these surveys (with the exception of the National LGBT Survey) have inhibited any sufficiently robust intersectional analysis. Despite these limitations, triangulating data from different survey sources helps to build a more complete understanding of LGBT+ people, and their healthcare needs and experiences, as illustrated below.

The size and characteristics of the LGBT+ population – national and local data

In recent years, since the introduction of a question about sexual orientation in some government sample surveys in England & Wales, efforts have been made to estimate the size of the LGB population

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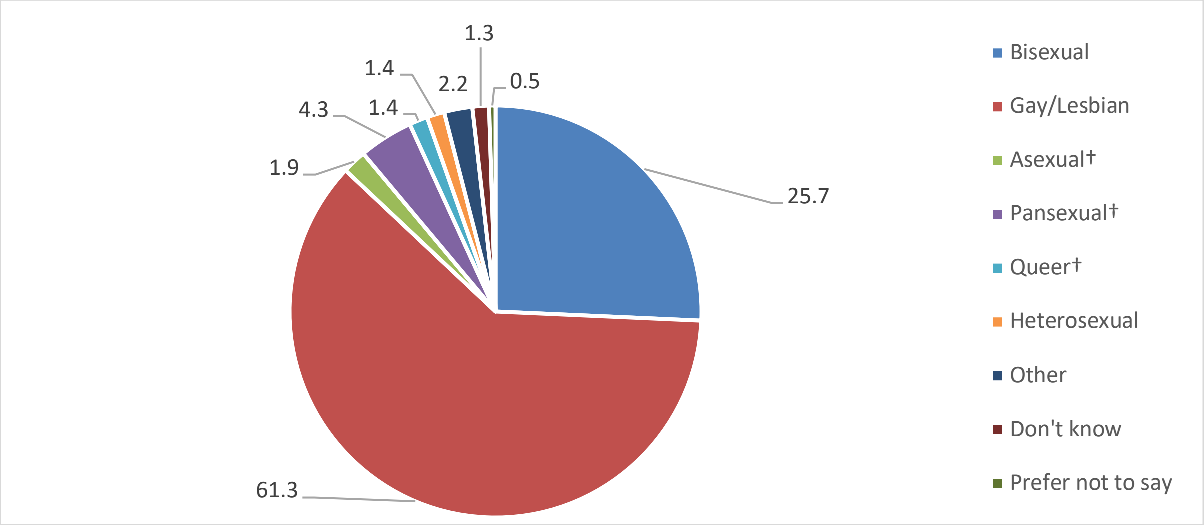
[10] The full report can be accessed at: https://www2.le.ac.uk/departments/criminology/documents/ayres-et-al-lgbt-mental-health_statistical-analysis-final-june-2019.

[11] These only ask about lesbian, gay, bisexual (LGB), heterosexual and 'other' identities.

in the UK[12]. In light of the early stage of this work, the Office for National Statistics (ONS) has argued that these estimates need to be treated with caution due to missing data; an issue exacerbated by the flaws associated with measuring sexual orientation (e.g. inconsistent categories, definitions and measurements). This makes comparisons across estimates problematic, if not impossible (ONS 2017a, 2017b).

Nationally, the latest figures[13] from the Annual Population Survey (APS) indicate that 2.2% of the UK population (1.2 million people) identified as LGB in 2018; this has increased from 1.6% in 2014 (ONS 2020). This includes 1.4% who identified as gay or lesbian, and 0.9% who identified as bisexual. A further 0.6% selected other[14] and 2.5% said 'don't know' or refused to answer. Data about a greater diversity of sexual identities was collected by the National LGBT Survey in 2017 (Government Equalities Office 2018a (see Figure 1). The majority of respondents identified as gay/lesbian, followed by bisexual. However, sexual identities such as pansexual, queer and asexual were more commonly reported by younger respondents, indicating that how people describe their sexuality is an ever-shifting landscape. This survey also found that 13% of respondents identified as transgender. [15]

Figure 1: Sexual identity in the UK, 2017 (Government Equalities Office 2018a)



Turning to the intersections between sexual orientation and other aspects of identity, the 2018 APS found that, as in previous years, men (2.5%) were more likely to identify as being LGB compared to women (2.0%). However, women (1.1%) were almost twice as likely to identify as bisexual than men (0.6%). Younger people were more likely to identify as LGB (with 4.4% of 16-24 year olds doing so), but the likelihood of identifying as LGB decreased with age (e.g. only 0.7% of over 65s defined as LGB). Regarding ethnicity, those identifying as being of mixed ethnicity or belonging to multiple ethnic

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[12] As noted previously, gender identity data is not currently collected in government population surveys, therefore population estimates for transgender people are not available.

[13] These are updated figures based on data released since the original quantitative analysis was conducted.

[14] There is 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.

[15] Of these, 6.9% identified as non-binary, 2.9% were trans men and 3.5% were trans women.

groups were most likely to identify as LGB (5.4%[16]), compared to 2.3% of white people, while only 1.2% of Asian/Asian British and Black/Black British respondents identified as LGB (ONS 2020). It is however important to be aware that some of these low rates of reporting may result from barriers to disclosure, such as stigma or heightened confidentiality concerns, and that there may be particular mental health implications for those groups who feel that they have no choice but to keep their sexuality hidden or suppressed.

Whereas government surveys typically focus on sexual identity, asking participants whether they identify as heterosexual/straight, gay/lesbian, bisexual or other, using more different or multiple measures of sexual orientation, such as asking about attraction and sexual behaviour, leads to substantial increases in the percentage of people whose sexual experiences/attractions are not limited to heterosexuality (Geary, Tanton et al. 2018). For example, data from the latest wave of 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[17]) found 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). Although many of these respondents self-identify as heterosexual, this finding shows greater fluidity of sexuality than sexual identity figures alone reveal, whilst highlighting the potential for identity conflicts that could adversely affect mental health. It also indicates that LGBT+ population estimates based on sexual identity data are significantly under-estimated.

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[18] population in April 2020 of 394,665, this equates to 7814 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.

The mental health of Nottingham's LGBT+ population

Following on from the rapid evidence assessment highlighting the increased prevalence of mental ill-health, including self-harm and suicidal ideation, amongst the LGBT+ population, data about the local context is the focus of this section.

In line with national trends, data collected from 505 visitors to Nottinghamshire Pride in 2017 (NHS 2018a) found that LGBT+ people had high rates of poor mental health, as well as 56% reporting poor physical health. Another key finding from this survey is that 39% of gay/lesbian participants had ever self-harmed compared to 15% of heterosexual/straight respondents. Levels of self-harm were highest

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[16] This figure should be treated with caution due to the much smaller sub-sample size of those belonging to mixed/multiple ethnic groups.

[17] NatCen Social Research, which is a non-governmental research organisation.

[18] The number of people registered with a General Practice in Nottingham City Clinical Commissioning Group.

amongst people identifying as trans, where 57% had reported having ever self-harmed and 48% to having ever attempted suicide (NHS 2018a).

Another source of local data, the GP Patient Survey (GPPS), found that poor mental health was more prevalent among bisexual and lesbian women, with data for Nottingham City CCG (NHS 2018b)[19] indicating that 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) or gay/lesbian (10%, n=9). This survey also shows that those identifying as bisexual and 'other' were more likely to report a long-term physical, mental health condition, disability or illness compared to heterosexual respondents (two-thirds compared to around half) in the Nottingham City CCG area (NHS 2018b).

Nottingham and Nottinghamshire-based people with poor physical health were three times more likely to have seen mental health services in the last year, compared to 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. Further, these higher rates of poor physical health might be exacerbated by the fact that LGBT people are more likely to engage in certain health risk behaviours such as smoking, high alcohol consumption and recreational drug use, particularly for those identifying as gay/lesbian and bisexual (NHS 2015). As is the case nationally, Nottingham and Nottinghamshire's LGBT+ population is more likely to smoke, have taken illegal drugs and sought professional help due to drug or alcohol issues, when compared to their heterosexual counterparts (NHS 2018a).

LGBT+ people's healthcare experiences – national and local data

Encouragingly, the majority of LGBT+ people rate their healthcare experiences positively, both nationally (Government Equalities Office 2018a), as was outlined in the rapid evidence assessment with regard to mental healthcare, specifically, and in Nottingham City (NHS 2018b). However, despite these predominantly positive experiences, a significant minority of respondents to the National LGBT Survey reported a range of negative experiences because of their sexual orientation or gender identity, ranging from being misunderstood to receiving inappropriate treatment and discrimination (see Table 1). This survey also found that respondents tended not to routinely, or even ever, disclose their sexual orientation to healthcare staff, 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 highest among both men and women identifying as asexual, followed by bisexual women (69.6%) (Government Equalities Office 2018a).

Mirroring national trends (NHS 2018b), LGB people in Nottingham are more likely than heterosexual people to rate their experiences of their general practice negatively, with this varying according to specific sexual orientations. For example, those identifying as lesbian/gay in the Nottingham City CCG area are almost twice as likely to report a negative experience with their General Practitioner (GP) compared to the national average (NHS 2018b). Lesbian and gay patients were also more than three

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[19] This data was collected from a national sample of 750,000 GP patients. The sample included 4,557 respondents in the Nottingham City CCG area, 4% of whom identified as LGB, and 1% as other.

times as likely to report a negative experience compared to their heterosexual/straight counterparts. Although the number of LGB respondents here was small, meaning that percentages are susceptible to being skewed, there are indications here that GPs within Nottingham City CCG are less effective at consistently delivering quality and empathic care to LGB patients.

Table 1: 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 (Government Equalities Office 2018a)

	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)

Studies of the Nottingham and Nottinghamshire context have also 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 (NHS 2018a) were almost twice as likely than heterosexual/straight respondents to leave negative feedback about mental health services. Furthermore, just over a third (36%) of the 76 LGBT+ respondents surveyed by Healthwatch felt that their experiences had been affected by their sexual orientation and/or gender reassignment (Healthwatch Nottingham and Healthwatch Nottinghamshire 2017). Those identifying as bisexual, transgender and queer were more likely to report negative healthcare 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. However, importantly, positive experiences were also reported, with 86% of these being attributed to good practice from healthcare staff.

Areas where data is lacking include LGBT+ people's views about disclosure of their sexual orientation and/or their gender identity and correspondingly, health professional's views about sexual orientation and gender identity monitoring, in light of the recent introduction of the NHS Sexual Orientation Monitoring Standard. In addition, the current evidence offers little scope for discussion of the intersections between sexuality, gender identity and other aspects of identity, as well as less well-understood sexualities and gender identities. Perspectives on LGBT+-inclusivity from both LGBT+ patients/service users and health professionals would also usefully add to the existing knowledge base. With this in mind, this report moves on to present the findings from the qualitative components, beginning with the analysis of interview and focus group data from LGBT+ service users.

4. LGBT+ service user analysis

Methodology

Semi-structured interviews and focus groups were conducted between November 2018-January 2020 to gather qualitative data about LGBT+ people's perceptions and experiences of seeking mental healthcare in Nottingham.

Focus groups collected data about LGBT+ people's perceptions of seeking mental healthcare as an LGBT+ person, as well as their views about what helps and hinders the maintenance of good mental health. A purposive sampling approach was adopted, with inclusion criteria which required that participants:

- Were aged at least 18 years old;
- Identified as LGB and/or T or described/understood their identity in other terms which differ from being both heterosexual and cisgender
- Resided in and/or most often accessed NHS health services in Nottingham City

Participants were recruited through a range of avenues including Nottingham City Council's staff LGBT+ network and an advert for participants in *QB*, Nottingham's LGBT+ newsletter.

Individual interviews gathered in-depth data specifically from people who had sought mental healthcare from either their general practice (primary care) or from community mental health services commissioned by NHS Nottingham City CCG (see list on p.5, footnote). Questions covered what helps and hinders participants in maintaining good mental health; participants' mental health and healthcare journeys, with a focus on the use of NHS primary care and community mental health services in Nottingham City within the last five years; and participants' experiences of, and views about, seeking mental healthcare as an LGBT+ person.

Again, a purposive sampling approach was adopted with the above inclusion criteria, but with the additional criterion that participants needed to have sought (with or without success) mental healthcare from their NHS general practice or from the community mental health services in Nottingham City that were within the scope of this research within the last five years. Participant recruitment took place exclusively in the community, as opposed to within NHS settings. To recruit as diverse a sample as possible, interview participants were recruited via multiple channels, including:

- Contact cards left by visitors to the research team's stall at Nottinghamshire Pride 2018;
- Advertisements for participants in *QB*, Nottingham's newsletter for the LGBT+ community and on the Lesbians in Nottingham Konnected (LiNK) email list;
- Dissemination of our research request by various other LGBT+ groups and networks in Nottingham; and
- Our community researcher's outreach to her personal and professional networks and to other local LGB and/or T+ social and support groups.

Additionally, three interview participants were recruited after they took part in a focus group for this research. Importantly, this is a self-selected sample and therefore no claims to its representativeness of all LGBT+ mental healthcare service users can be made.

Interviews were conducted with 20 participants, and three focus groups were conducted with 10 participants in total. Notably, numerous interviews needed to be rescheduled, over half of the registered focus group participants did not attend, and interviews with a larger pool of prospective participants were not ultimately arranged, often because of the fluctuating mental health of this population. Demographic data was collected via a simple questionnaire. In terms of the characteristics of the service user sample[20]:

- The majority of the participants (17) were aged either 25-34 years old or 35-44 years old. Six participants were aged 18-24 years old, three were aged 45-54 and one was aged 55-64 years old. No participants were aged over 65 years of age.
- The vast majority of participants identified as White British or White. One identified as Asian Indian and two identified as mixed ethnicity (one as Black African and White British; one as 50% Black and 50% White, to use the participant's own words). In addition, one participant identified as White American and one as White Portuguese.
- Approximately half of participants (14) identified as female and 10 identified as male. One of each of those who identified as female or male also identified as non-binary or 'genderless'. Two participants identified as non-binary and one as 'other gender identity', which they described as transgender.
- Three participants identified, or have at some time identified, as transgender. One was unsure and one responded, 'prefer not to say'.
- Participants most often described their sexuality as either queer (9) or gay (8), followed by bisexual (7). Three identified as lesbian, two as pansexual and two as 'me' or 'just me', respectively. Some participants identified with more than one sexuality, while one ticked 'prefer not to say'.
- Several participants disclosed disabilities other than mental health needs, including autism and Asperger's Syndrome, ADHD, rheumatoid arthritis, Ehlers-Danlos syndrome and fibromyalgia.

Since there is a lack of data about the mental health of older LGBT+ people, their under-representation in this research is a limitation. There is a gap in knowledge related to the mental health of LGBT+ members of Black, Asian and minority ethnic populations too; however, the lack of ethnic diversity in the sample – despite efforts to reach out to local groups for LGBT+ people from minority ethnic backgrounds – limits opportunities to explore the challenges associated with these intersecting identities.

The research team was committed to an 'ethics of care' (Miller, Birch et al. 2012) which prioritised participant wellbeing and ensured that participants were clearly informed about their rights to anonymity, confidentiality and withdrawal from the research. Participants often became emotional during interviews when reflecting on periods of mental ill-health, thwarted attempts to seek mental healthcare and their concerns for friends who have not been able to access support. All participants were provided with a list of local sources of LGBT+ and mental health information and support, as well as signposting for how to complain about NHS healthcare experiences.

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[20] The interview and focus group sub-samples combined comprise 27 unique participants, given that three people participated in both a focus group and an individual interview.

Interviews ranged from 43 minutes to 2hrs 23 minutes, while focus groups lasted approximately one hour. Interviews and focus groups took place in accessible public spaces in the city centre. Each focus group was facilitated by the community researcher and at least one other member of the research team. All interviews and focus groups were audio-recorded with participants' consent and were subsequently transcribed. A thematic analysis was adopted, and the qualitative data analysis software, NVivo 12, was used to collate and code data. The analysis which follows focuses on the individual interview data, with focus group data and data collected via the creative stall at Nottinghamshire Pride 2018 (henceforth, 'the Pride activities') being used for triangulation.

Analysis

Participants' mental health and healthcare journeys

Regarding participants' mental health needs, 15 out of the 20 interview participants described having depression and/or anxiety, typically in combination. Six participants described having post-traumatic stress disorder (PTSD) or complex PTSD, while another spoke extensively about symptoms of trauma, but did not refer specifically to PTSD. Four reported that they had Borderline Personality Disorder (BPD). Two participants reported having an eating disorder and one participant respectively reported suffering from Bipolar Disorder and Obsessive-Compulsive Disorder (OCD). One participant said that their diagnosis was non-specific psychosis. One participant was in the process of being diagnosed with their Bipolar Disorder or BPD, while another participant thought that they had either Bipolar Disorder or PTSD.

For the majority of participants, the onset of their mental health struggles was during older childhood or in their teenage years. Some had suffered continuously with poor mental health since that initial onset, whereas others reported intermittent episodes of mental ill-health. Participants' mental health needs had had a significant impact on their lives. Some spoke about losing their jobs, having to leave university courses, losing friends and becoming homeless and/or in serious financial hardship, specifically because of their poor mental health. Many disclosed self-harm and suicidal thoughts, both historically and currently, and a few participants had attempted suicide.

All but one participant had sought mental healthcare from their GP, and 17 participants had done so from community mental health services. Most focus group participants had also sought mental healthcare from their GP and over half had accessed community mental health services. Because of this research's focus on primary care and community mental health services, participants' experiences with secondary mental health services commissioned by the CCG or specialist services commissioned by NHS England (e.g. The Nottingham Centre for Transgender Health) have been largely excluded from the following analysis[21]. However, all bar three interview participants had had recent or historic engagement with secondary services, primarily for mental health, but also via specialist autism clinics and the Nottingham Centre for Transgender Health. Secondary services that participants had recently engaged with for their mental health included personality disorder services, the local mental health team, the crisis team, Early Intervention in Psychosis service, psychiatrists, community psychiatric

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[21] They may however be incorporated into future publications, since very rich and insightful data has been collected about secondary mental healthcare experiences too.

nurses, psychiatric in-patient units, the Step 4 Psychology Service, a bipolar education group and the eating disorder service. At the time of the interview, a few participants were on long waiting lists to access some of these secondary services. One participant had also paid to see a private psychiatrist.

Additionally, seven participants were currently receiving, or had previously received, private therapy. Five participants had accessed counselling via employee assistance programmes, college and university counselling services and counselling provided by third sector organisations

Participants' experiences of mental healthcare in primary care

Of the 19 participants who had sought mental healthcare from their general practice, all had done so primarily from one or more GPs within their practice. Seven participants gave negative accounts of their experiences with GPs, while seven gave predominantly positive accounts. The remaining five reported mixed experiences, but felt well-supported by their current GP. In the analysis of participants' healthcare experiences both in primary care and, further below, in community mental health services, the factors that characterised LGBT+ patients'/service users' experiences included generic issues that any individual could experience, regardless of sexuality or gender identity, as well as LGBT+-specific issues. Both sets of issues are considered to provide a holistic analysis of LGBT+ people's experiences of seeking and receiving mental healthcare. Further, it is important to be mindful that ostensibly generic issues may have a disproportionate impact on LGBT+ people; for example, stigma about seeking mental healthcare may be accentuated by concerns about fear of being judged as an LGBT+ person.

Positive experiences with GPs

Participants who described positive experiences with their GP typically felt that their GP had a good understanding of mental health and of their needs. They felt that they could be open with their GP and that their GP would listen and respond compassionately. For example, one participant, a gay woman aged 35-44 years old, said of her current GP, 'She's just, you know, a caring person and she's quite easy to talk to' (SU6).

Some participants also emphasised that it was important their GP took a holistic approach, which for some participants meant not only focusing on medications, but trying to understand the root causes, and which for others meant not treating physical and mental illnesses separately. With regard to the former, one participant, a gay man in his early 50s, reflected on how, in his experience, how GPs approach mental ill-health had improved in the 35 years he had been seeking mental healthcare:

> you don't get that 'pull yourself together' mentality, either spoken or implied. There's, you know, in some ways there's almost a reluctance to simply start you on a course of medication, you know, without seeing, you know, what else is behind it (SU7).

Having regular contact with their GP was important, especially during episodes of poor mental health. As one participant, a queer woman aged 25-34 years old, reflected:

> That's the first time I've had like a GP that will see me regularly and like keeps track of stuff, and that's actually really, really helpful (SU13).

Two participants identified their GP as someone who was willing to liaise with other health professionals and to advocate for them. For example, one participant, who defined as lesbian and asexual, said that her GP had put in a complaint on her behalf after she was ridiculed for being asexual by a health professional in a secondary service. Whilst no participant indicated that their GP had demonstrated an extensive understanding of LGBT+ people's lives and inequalities, those who had had positive experiences had not felt judged or treated differently when they had disclosed their sexuality or the gender of their partner.

Negative experiences with GPs

Dissatisfaction with mental healthcare in primary care was most often discussed in relation to two key issues: the perceived lack of knowledge of GPs about mental health and mental health services; and not being listened to and a lack of compassion and concern.

Firstly, several participants talked about experiences with GPs that had minimised or dismissed their mental health symptoms. This had led either to inaction, or to inappropriate referrals to services which were unsuitable for the needs which they had presented with. A notable example is of one participant, a gay woman aged 35-44 years old, who reported that she went to her GP because she was hearing voices and suffering from extreme paranoia. Her GP reportedly advised her to self-refer to Let's Talk Wellbeing, a talking therapies service, which she considered inappropriate for her needs:

> I'm not being funny, there's a scale of mental health problems, and Let's Talk Wellbeing are great if you've just got a bit of passing depression or anxiety but you can still function. I was at the point where I wasn't functioning, so she should've done something (SU1).

This participant felt that given her symptoms and history of having been receiving mental healthcare since the age of 12 years old, she should have instead been referred to Early Intervention in Psychosis, a secondary service. She was ultimately referred to that service via another secondary clinic that she was attending and was still accessing secondary mental health services at the time of the interview. Similarly, another participant sought a referral from her GP for the personality disorder service, having previously been receiving group therapy for a personality disorder where she lived previously. However, she was instead referred to a talking therapies service, who reportedly said, '"I don't know why you're here because you are above our pay grade", pretty much' (SU15). These accounts highlight a critical barrier in relation to early intervention as inappropriate referrals can delay patients from receiving the specialist support they needed, particularly for more complex mental health needs.

Secondly, not being listened to and being treated with a lack of compassion and concern was another key reason for participants' negative evaluations of their GP. Some participants expressed distress and frustration in relation to receiving responses that they felt were uncaring. One participant, a gay man aged 35-44 years old, explained that when he recently tried to see his GP during a period of particularly bad depression, he was told explicitly that there was no point coming to see the GP:

> I'd sat in a restaurant in tears telling my partner that I'd been thinking about ways to end my life a few weeks previous. Everybody encourages you to go to a GP and they're kind of going, 'you're not an emergency. There's no point coming in because we're just going to up your [medication], or we'll send you to the self-referral [service] which you already know about' (SU10).

Another participant, a bisexual woman in her early 20s, knew others who had had more positive experiences of seeking mental healthcare in primary care, but she felt that her GP had perhaps ‘given up’ after trying her on three different medications that did not work, and not referring or signposting her to other support: ‘And I don’t know whether they’ve just kind of given up or, but no I’ve not really had any contact with anyone. No one really checks up’ (SU2).

Some interview and focus group participants held the view that GPs would not take any action unless the situation was very serious; for example, a patient was imminently likely to take their own life. As one queer, trans male/non-binary participant, aged 25-34 years old, stated:

> So it’s a case of not only are the services incredibly difficult to access […] , you have no idea who to go or who to speak to, you have to threaten them, almost with the cost of your life, for them to go “you are genuinely ill. We will support you” (SU4).

Again, this is contrary to the aims of early intervention and to one of the key principles in the *Mental Health Crisis Care Concordat* (Department of Health 2014) which stipulates the need for a more proactive approach which intervenes prior to a situation escalating to crisis point. Relatedly, some participants, particularly those who had gone to their GP in a state of crisis, felt let down by a lack of follow-up. This was expressed by one participant, a pansexual, queer woman aged 25-34 years old, who had disclosed suicidal thoughts:

> I mean considering that I told someone in a GP a couple of months ago that I was having regular suicidal thoughts and I’ve not heard anything since, I just think like it doesn’t fill me with… […] you know, it’s not surprising that people continue bad habits and bad coping mechanisms and continue to get further and further down this like path (SU5).

Because of these unhelpful experiences, some participants had subsequently decided not to consult their GP about their mental health any further, or to not do so unless the situation was really desperate. As one participant reflected,

> I used to be okay with going to the doctors, but now it’s kind of like I don’t really like going because it’s, I end up getting a bit nervous and a bit anxious because I just wonder like is there a point in telling them everything and are they going to listen and stuff like that (SU2).

This raises further concerns about the potential for early intervention, since experiences of feeling unsupported can mean that in future, mental healthcare may not be sought until these individuals’ mental health has substantially deteriorated.

In addition to these two main issues, concerns surrounding medication were raised by some participants. This included, on the one hand, participants who felt that their GP was over-reliant on medication as opposed to providing access to other therapies, and on the other hand, participants who were not able to access medication that they were confident would alleviate their mental health symptoms; typically, anti-psychotics.

Some other generic issues were identified. The first was difficulties getting appointments, which some participants had found particularly demoralising, having made the decision to talk to their GP about their mental health. One participant talked particularly about finding the gatekeeping role of receptionists in her general practice to be difficult to cope with when her mental health is poor, and not feeling comfortable to explain to a receptionist why an appointment is needed. Moreover, several participants explained that they would typically see a different GP each time, making it difficult to establish a relationship. For those with long histories of mental health struggles and/or trauma, especially, this lack of continuity was a barrier to seeking mental healthcare.

Participants' experiences of mental healthcare in community mental health services

As noted above, 17 participants had referred themselves to (or occasionally been referred to) community mental health services. The most commonly used were Improving Access to Psychological Therapies (IAPT) services which provide short-term[22] talking therapies; namely, Let's Talk Wellbeing, Trent PTS and Insight Healthcare. Two participants had had prior contact with Child and Adolescent Mental Health Services (CAMHS), although only one had done so within the last five years, and only very briefly. One participant had attended mental health courses at the Recovery College, and a few participants had used the Wellness in Mind telephone helpline. Five focus group participants had also used IAPT services, and one had used CAMHS. This range of service use is rather limited when considering the larger variety of community mental health services commissioned by NHS Nottingham City CCG (see footnote, p.5). Similarly, focus group participants' awareness of which community mental health services existed was also limited to IAPT services, Wellness in Mind and CAMHS. This indicates that there needs to be greater awareness of other commissioned community mental health services among LGBT+ people but potentially among GPs too, who – especially in a shifting landscape of service provision – may lack knowledge of which services exist, what they provide, and for whom.

The referral process

The majority of the referral experiences for community mental health services that participants talked about, especially talking therapies, involved their self-referral into services, usually via an online form. Wellness in Mind operates an open telephone helpline, online support service which service users can self-refer into and some face-to face appointments and advocacy. The participant who accessed courses at the Recovery College was referred to these by a day centre for people who are homeless or vulnerable, while the CAMHS referral was made by the hospital following a participant's brief in-patient admission.

With regard to self-referrals, a few participants felt that they would have liked to be supported to make this referral, with one focus group participant saying that 'you kind of feel like there's no sense of care in the system for where you're at'. Another focus group participant reported that because of their poor mental health when they had sought mental healthcare from their GP, they had felt overwhelmed by being given leaflets for all three talking therapies services and having to decide which to approach. Others, however, found the process to be simple and convenient. Another participant

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[22] Most interview and focus group participants who had accessed an IAPT service for talking therapies reported having received six sessions of either counselling or cognitive behavioural therapy (CBT).

felt that self-referral was beneficial in situations where a GP might obstruct a patient's access to specialist mental health services.

The overriding issue raised regarding the referral process was the waiting time. Whilst this varied between services and time points, it was not uncommon for participants to report having waited for three to six months between first going to the GP, being assessed by the community mental health service, and then, if applicable, commencing therapy. Some participants reported that their mental health further deteriorated in the interim; for example:

> It's just the waiting times are ridiculous. You know, because you struggle. […] I certainly do, and certainly have for the past twelve weeks, you know, and I feel my health has deteriorated because of the waiting time, definitely (SU11).

This same participant, a gay man aged 45-54 years old, said that the year before he had been on a waiting list for six months and was then told that the service was closing. Several participants also felt that there needs to be clearer communication about waiting times and expectations. As one participant, a pansexual, queer woman aged 25-34 years old, commented:

> I think, to be honest like communication is a huge issue, the lack of communication. Like even if it was something, like you can track parcels from Amazon from the depot to your home, knowing exactly what stage it is at. Why can't we know whether someone is considering us as part of a mental health team or what stage we're at, you know, in that process? (SU5).

Issues were raised also about the assessment process requiring service users to share difficult or distressing information, but then being left without support while waiting to find out when, or if, they would be able to start receiving talking therapies. For example, one participant, a lesbian woman aged 35-44 years old, reported that the telephone assessment that she had had for talking therapies had left her feeling very 'unsafe and vulnerable' (SU20) but having to deal with this on her own while waiting a further four months before the therapy commenced. In addition, one focus group participant commented that telephone assessments miss the nuances of non-verbal communication, therefore only providing a partial picture.

Some potentially transferable good practice that one participant who was on the waiting list for secondary services shared was being invited for regular check-ins with the service whilst waiting for therapy to commence. This also involved being told exactly where they were on the waiting list for that service, which for them was helpful.

With regard to managing expectations, one participant who self-referred into the service was rejected on the basis that she was 'too complex' for talking therapies. However, she was not signposted or cross-referred to an alternative service. She said she felt 'completely unprepared' for this outcome and that being 'dropped' was 'very painful' (SU8). Further, another participant explained that with one talking therapies service, they were not aware until they arrived that the first session was a group session.

The accessibility of community mental health services

The majority of those who had accessed community mental health services had found these services to be accessible. Many of those who had accessed talking therapies had been given leaflets for all three services that operate in Nottingham City, and therefore had a choice of locations. Some participants shared that their talking therapies sessions took place in rooms at the premises of various businesses in the city, such as solicitors' or accountants' offices. One participant felt that this was more discreet and less stigmatising then potentially being seen visiting a health facility.

Participants generally described the waiting and therapy areas of community mental health services as being comfortable and pleasant. Most participants felt that there was sufficient flexibility in the scheduling of sessions, although one participant reported that there had been no opportunity to negotiate the timings of the initial appointment. One focus group participant felt that accommodation needed to be made for people who struggle with time management due to autism – as was their situation – since they had reportedly been discharged from a service due to not arriving on time.

However, in terms of physical accessibility, some participants had noted that there were stairs and potentially no lift access at the facilities that they had used. Access issues were a particular issue for one participant who had rheumatoid arthritis and was now a wheelchair user. They had received one course of talking therapies at home while they were housebound. However, when they self-referred to that same service for talking therapies again, they were not accepted for support (for reasons related to complexity, as discussed above), and were also advised that it would be preferable for them to approach the service again when they were able to visit the service at its base. They took from this that their access to mental health support was thus contingent on their physical health and mobility first improving. However, they expressed concern about what would happen if their physical mobility did not make sufficient improvement to be able to attend in person, and whether those premises would be sufficiently accessible even if they could get there.

Positive experiences with community mental health services

Regarding talking therapies, which are the services that participants most often discussed, some participants praised these services as being 'fantastic' or 'very good' and/or spoke very highly of particular counsellors/therapists who had helped them, as the following quote illustrates:

> I would say, I mean I can distinctly remember one counsellor I had who I found really, really helpful and really good and I enjoy, you know, sort of enjoyed is perhaps the wrong word but, because I didn't. Every time I used to go there I used to be nervous, but then once you're there and talking you relax and then you come out of there and you think, aha. So he was very good in that respect (SU11).

Personal preferences tended to shape what participants had found helpful: for example, one participant found it positive that they could choose which issues to talk about, whereas another participant preferred to receive more direction from the therapist and had found some of the focused input more useful. Several participants talked about talking therapies helping them to cope with periods when they were struggling with their mental health and finding out which coping and self-care strategies worked best for them.

Besides talking therapies, some participants shared positive experiences of other community mental health services. One participant had found courses on mindfulness and anger management at the Recovery College useful and another had found it helpful to call the Wellness in Mind helpline and had also used them for advocacy to challenge plans to discharge them from secondary services. One focus group participant praised the support that she had received from CAMHS and had felt supported by them when they asked her directly about her sexuality and whether it was causing her any difficulties.

Negative experiences with community mental health services

Aside from waiting times, discussed above, and the short duration of support, discussed in the next section, some participants gave negative feedback about the treatments/interventions that they had received and the expertise of the health professionals or therapists that they had had seen. A key point which was made by some participants, echoing the previous discussion about inappropriate referrals from GPs, is that talking therapies are not suitable for more complex mental health needs. This was particularly the case in relation to those who had been referred to talking therapies for support with complex trauma and personality disorders. Importantly, the perception that the referrals made are not always appropriate is supported by other evidence, such as the views of some practitioners in community mental health services, discussed later in this report. Furthermore, the IAPT manual (National Collaborating Centre for Mental Health 2019) does not list personality disorders within the list of the conditions that should be treated within IAPT or talking therapies services, while only high-intensity support for post-traumatic stress disorder is recommended within talking therapies.

Regarding health professionals' expertise, some participants said that they felt that the support that they had received lacked depth and was not as rigorous as either they had hoped it would be, or as they had previously experienced. One participant, a bisexual, queer woman aged 55-64 years old, compared her experiences of receiving talking therapies to previous experiences with private and third sector counsellors, and reflected that:

> my impression of the two counsellors that I had through [NHS talking therapies service] was they were very nice, but I didn't get that sense that they were very skilled or very experienced at what they were doing. They were quite good at saying 'and how did that make you feel?' (laughs) […] They helped, they both helped me a bit, but nothing like the kind of quality of help that I'd had before from other people, where it really, really helped and really, got to the really nitty-gritty of things (SU8).

Another participant, a lesbian woman aged 35-44 years old, relayed a particularly distressing situation in talking therapies which 'ended up becoming a really bad experience, and I ended up leaving with, re-traumatised' (SU20). She went on to explain that she disclosed experiences of sexual abuse to him, but later regretted this after feeling that he did not deal with this appropriately, such that her trust was broken:

> I think the, the therapist that I had I knew had only just actually been accredited, very recently, a couple of months before my therapy started. […] And so I knew he wasn't experienced, but I thought, I trusted that anybody working for the NHS would, if they didn't know what to do they would know where to direct you to, and that's what I put

> my trust in [tearful]. And this person had built up my trust, and I thought that, I trusted that if he didn't know what to do he would, himself, he would do the right thing (SU20).

Further, a gay man, aged 35-44 years old, was critical of the quality of the CBT that he had received, and felt that there was a lack of depth and rigour:

> I don't feel I've ever had proper CBT of looking at theories and concepts and ways of changing your own thoughts and how they connect to your feelings. I feel like I've learnt more about that from just reading stuff online than I have from a support service (SU10).

He said that the focus of the therapy had been on solving 'today's problem', rather than enabling him to address issues from his earlier years which he sees as being central to his depression and anxiety.

In addition, one participant - a man aged 35-44 years old who describes his sexuality as 'just me' – spoke about feeling very invalidated by his CBT therapist:

> And I went for CBT in Nottingham and my impression from start to finish was that I felt like they saw me as a time-waster [pause], which was really disappointing (SU9).

Whilst this was not a typical experience for those who accessed talking therapies, it does emphasise the importance of a consistently affirmative approach that recognises how difficult it can be for people to seek mental healthcare.

Discharge from services

Whilst some participants expressed understanding that services could not be open-ended and that over-stretched services could only offer a limited number of sessions, participants – particularly those who had accessed talking therapies – tended to report that they had not felt ready to be discharged after a course of, typically, six sessions.

Several participants stated that short-term therapy can actually make the situation worse because it dredges up challenging issues and painful memories, but without there being sufficient time to fully address these. This was particularly the case for participants who had suffered from various forms of trauma. One participant, a bisexual, queer woman/non-binary person aged 25-34 years old, talked about finding it difficult to be asked to bring to the surface her experiences of childhood trauma as part of her CBT homework, but not able to work through it all in six sessions of therapy:

> I think it was supposed to be a CBT-type therapy, and the woman who tried to help me, she tried to tell me to go all the way back to my childhood because a lot of my trauma starts from there, and to work my way through it. And she told me to get a journal and write everything down that I could remember. Unfortunately there's quite a lot, and there was just not enough time to get through it all, there just wasn't. So what ended up happening was all these memories and all this trauma got trudged up and by the end of the final session I was sat wondering, well what do I do now? (SU18).

Another participant reflected that as a person with autism, it was difficult to develop a rapport with a therapist over six sessions, and then for those sessions to stop. This is an important point in terms of recognising how some service users may have communication needs that mean that it will take longer to build trust, rapport and communicate what it is that they are struggling with. Treatment duration therefore needs to be more flexible to ensure equitable and inclusive services.

Whilst participants sometimes reported that they had been advised that they could self-refer into the service again after a period of time, this would typically be with a different therapist. For some participants, the idea of starting again with a new therapist was a barrier to accessing that service again:

> he said 'you can refer back again', but I found it quite draining and the thought of going back in for, you know, six sessions again with somebody, without that continuity, kind of put me off (SU6).
>
> When you're not well, rehearsing why you're not well and dealing with people's, not so much preconceptions but just going through the whole process again, can be sort of, can be quite exhausting (SU7).

Others said that they had gotten what they could out of that service, but needed alternative long-term support to tackle issues in a deeper way. As a result of these difficulties, as well as experiences of being referred into inappropriate services, discussed below, approximately a third of participants had previously received, or were currently receiving, private therapy. For some, this offered the opportunity to explore issues over a longer period of time, and in some cases with an explicitly LGBT+-identifying or -affirmative therapist, or with a therapist with specialist expertise such as working with trauma. In one case, a private therapist was sought to address the detrimental impacts of the NHS talking therapies received. However, the costs of private therapy are high and some participants alluded to the financial strain of these costs. Private therapy is therefore not an accessible substitute for quality, comprehensive and tailored NHS mental healthcare.

Seeking and receiving mental healthcare as a LGBT+ person

The role of self-care and social support

Participants were asked what helped them to maintain better mental health. A wide range of strategies of self-care were listed, including exercise, fresh air, spending time with friends, eating well, not drinking too much alcohol and trying to get good sleep, amongst others. For some participants, keeping busy and having routines was key to them staying well, whereas for others, having breaks from work or study were highlighted as being important. These examples largely mirror examples of self-care practices given by participants in the focus group and the Pride activities, though additions from these data sources are art, creative writing and playing role-playing games.

In terms of their social support networks, for some these were very good, whilst others described friendships that lacked reciprocity and significant social isolation. Several participants explicitly talked about being estranged from their family – something that is more common amongst LGBT+ people. Some participants talked about the implications of many of their friends, but sometimes family members too, having mental health needs. Whilst this offered a level of shared understanding and experience, it also resulted in participants sometimes needing to withdraw from those social support networks to protect their own mental health, or not being able to rely on being supported when they needed it. Some also held back from sharing their mental health struggles with friends in order not to over-burden them.

Most participants had opportunities to socialise with other people who are LGBT+, either through their friendship circles, involvement in LGBT+ social groups and activities, and membership of staff LGBT+ networks. Meeting people with shared experiences was typically considered important: as one participant, a queer Christian woman aged 18-24 years old, articulated, ‘I guess it’s finding somewhere you feel like you belong, sort of partly that sort of sense of tribe’ (SU12). Some participants did not feel part of an LGBT+ community and this was something that they felt the absence of. An issue highlighted by several participants was prejudice towards, and exclusion of, bisexual people in gay and lesbian groups and spaces. Further, one participant, a gay man aged 45-54 years old, shared his experience of gay men’s communities imposing a pressure to conform that is not positive for mental health:

> You can find that after a while, I mean certainly with things, the apps Grindr and Scruff, that you’re constantly trying to live up to someone else’s expectation and, you know, you’ve got to be one or the other, you sort of, there’s no room for sort of fluidity or movement in it (SU7).

Some felt that the opportunities to be part of LGBT+ communities in Nottingham had dwindled over the years. Others who had previously lived in bigger cities described feeling quite isolated as an LGBT+ person in Nottingham and finding fewer LGBT+ support services.

Barriers to seeking mental healthcare

Whilst many of the obstacles to early intervention that have been discussed are systemic issues, many participants also spoke about their reluctance to seek mental healthcare during times of mental ill-health. Key reasons for this reluctance included fear of being judged and, relatedly, the stigma which surrounds mental illness.

> I think initially I was a bit, I was reluctant to access the services and I was worried about things like, oh it’s going to be on my record, what are people going to say? And I had my own prejudices about discrimination, and my own sort of […] warped view of what mental health was (SU17).

For this latter participant, his preconceptions were influenced by the denial and taboo that, in his experience, surround mental ill-health in South Asian communities. Relatedly, lack of awareness of mental illness was also a factor for another participant who was an EU student who had moved from a country where mental ill-health was less talked about. In addition, one focus group participant spoke about not having sought mental healthcare because of their concerns about receiving negative responses from health professionals as an LGBT+ person:

> And also in relation to sexuality and gender identity, I don’t know if every professional would necessarily be respectful or keep an open mind when they know that that’s the topic. So that is another reason why I really didn’t want to look for anything (focus group participant).

Guilt and shame were also described by a few participants. One queer male/non-binary participant aged 25-34 years old worried about being considered to be ‘attention-seeking’, and felt that this would resonate with others who self-harmed. Other barriers included pride and not wanting to ‘give in’ to mental health struggles: as one participant said, ‘I didn’t want to let myself down, I didn’t want to let other people down’ (SU10).

Especially for those who had had negative experiences previously, concerns about not being taken seriously or being considered a time-waster were also important barriers.

> I mean it’s a difficult subject to start with a GP, I mean even a GP that knows you, sort of it can be quite difficult to get in to them and to say, you know, ‘I’m having this problem, I’m having it again’ […] Sometimes you feel that things have got to get bad before you’re going to be taken seriously (SU7).

This idea of things needing to be sufficiently bad to be taken seriously was raised in one of the focus groups too:

> I was only able to access, with CAMHS, any help after I hadn’t left the house for three months, and when I did go to the GP I couldn’t get two words out and were, you know, crying the entire time. And like that’s the level of just complete mess you have to be in before they’ll actually do something (focus group participant).

Thus, there is clearly incongruence between wider public health messages which are encouraging people to talk about mental health struggles, and the implicit messages which many patients receive when their needs are minimised or met with inaction.

Perceptions of health professionals’ understandings of LGBT+ people’s lives and mental health needs

It was overwhelmingly the case that participants did not express much confidence in health professionals’ understandings of the inequalities that LGBT+ people experience and the implications that this may have for their mental health. In addition to this being discussed at some length in the interviews and focus groups, lack of understanding – both among health professionals and in wider society – was also an issue raised by contributors to the Pride activities. Key issues that were highlighted included practitioners’ lack of understanding about the impacts of living as a minority in a heteronormative world, and lack of understanding about the particular challenges that are faced by particular groups under the umbrella of LGBT+, as well as how being LGBT+ intersected with other aspects of identity.

Firstly, many participants talked about the need for health professionals to have a better understanding of living in a heteronormative and cisnormative world; that is a world that is organised around the assumption or expectations that everyone is firstly, heterosexual, and secondly, has always identified their gender with the sex to which they were assigned at birth, and that this understanding of sex and gender fits within the male/female binary. For LGBT+ people, there are constant reminders of ‘not fitting in’ within this heteronormative and cisnormative world, and of the potential penalties of failing to fit in, such as encountering prejudice, discrimination or violence. This is a barrier to being understood and a source of pressure – described by some scholars as minority stress (Meyer 2003, Testa, Habarth et al. 2015) – reflected in the words of one gay male focus group participant who said that he felt that as an LGBT+ person ‘sometimes you feel you’re being tolerated rather than understood or accepted’ and that there is a need:

> to select when it’s safe to make that disclosure of your partner, and then the assumption is ‘what does she do?’ So again that sense of heteronormativity kind of transcends, not through kind of willing discrimination, but […] there’s almost an underpinning or tacit kind of misunderstanding (focus group participant).

This same participant also explained that he thought that his difficulties with coming to terms with his sexuality as a young person have had longer-term impacts on how he has dealt with difficulties in relationships as an adult:

> I think that fear in those early years of rejection and all of those things, from family and friends, and how you build unhealthy coping mechanisms as a protective kind of mechanism at that point […] And I think, if I think about relationships, when things get tough, I’m not sure I always make the best decisions and choices at that point […]. And I think that comes back to kind of some of the early kind of years of just surviving rather than being comfortable and confident in, you know? (focus group participant).

Importantly, whilst some might consider that it is easier for young people to come out in today’s society, some of the youngest participants also discussed the impacts of heteronormativity. One focus group participant, a sixth-form student (aged 18 years old), described the latent heterosexism that she was regularly exposed to in family contexts, such as homophobic remarks directed towards others and same-sex relationships being portrayed as ‘a bit inferior’.

However, most participants did not express confidence that health professionals would typically understand their everyday lived experiences and their implications for their mental health, as the following quotes indicate:

> And it hadn’t occurred to me that, at that stage, that a mental health professional would not understand that coming out is an important thing for LGBT people and that it’s a factor for your mental health, whether you feel able to come out or not, whether you feel scared about coming out or not, and all those kind of things. And it floored me, because I hadn’t been expecting that (SU8).

> I’m not sure if people can understand kind of what it’s, what it’s like to have them inequalities and the prejudice that you face. I’m not sure that they would really get it, unless they experienced it themselves (SU1).

Secondly, regarding the diversity within the umbrella of LGBT+, there are many examples within the data of the importance of recognising differences between gay, lesbian, bisexual and/or trans people, but also recognising that identities are intersectional. In relation to not treating LGBT+ people as a homogenous group, one focus participant said:

> if a kind of a layperson thinks of my needs [as a gay man] being the very same as a trans person or as a lesbian woman or as a bisexual […] individual […], that also misses the point (focus group participant).

This particular focus group included a discussion steered by participants regarding their perceptions that gay men tend to have more of a voice, having 'paved more of a standing for themselves' (focus group participant), compared to bisexual and trans people. Bisexual participants described particular needs, including the sense of being misunderstood due to bi-exclusion and biphobia both within and without of lesbian and gay communities. One participant spoke about having had a breakdown when she realised that she was bisexual rather than lesbian, and had to withdraw from a lot of lesbian social networks as a result. As well as dealing with the prejudice of others, she described struggling with her own 'internalised biphobia' (SU8).

The needs of trans patients/service users were highlighted by numerous trans and cisgender participants. Participants who were transitioning were typically dealing with long waiting lists for the Nottingham Centre for Transgender Health and were also very aware that they were expected to have stable mental health in order to progress with treatment options. However, this felt to them like an implausible expectation, given the vicious circle of delays to treatment intensifying gender dysphoria and thus exacerbating mental health symptoms. Trans participants also had to deal with aspects of seeking or receiving mental healthcare that triggered their gender dysphoria. One participant, a queer, trans man in their mid-twenties, explained how this was a barrier to them seeking mental healthcare, including making phone calls:

> in the beginning I didn't want to go to my GP and I didn't want to access services because I was repeatedly either dead-named or misgendered[23]. […] I can understand, as a trans person, that if somebody doesn't know you're trans and you're reading as a particular gender associated to our society, I understand that your pronouns are going to be whichever one they think, if that makes sense, sorry. […] But for a trans person that desperately wants to be seen as their gender that they live as and put time into, it's enough to put you off from, I don't know, going, even making a phone call […] because your voice is actually one of the immediate things that gives you away as a trans person (SU4).

Regarding intersectionality, LGBT+ people inhabit a range of social positions (in relation to gender, ethnicity, faith, socio-economic status and disability, for example) which intersect to shape how they experience mental health difficulties and their experiences of seeking and receiving mental healthcare. Participants gave a number of examples of challenges that they or others had faced, that they felt health professionals lacked an understanding of.

While there was limited ethnic diversity in the sample, those who did identify as belonging to a minority ethnic group identified specific challenges. One participant, a South Asian, Muslim, gay man, discussed the taboo and denial which surrounds both mental-ill health and homosexuality in his family and wider community. He reported having been told by one doctor that it was not 'compatible' to be Muslim and gay. He described facing judgement from other South Asian people, and said that in his experiences of accessing NHS and local authority services, 'there's an element of stigma and discrimination. It's not overt discrimination, or direct discrimination, but you get treated differently'

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[23] Misgendering refers to assuming someone to be a different gender to that which they identify as. An example would be somebody who identifies as non-binary or male being referred to as 'the lady over there' or being attributed she/her pronouns. Deadnaming refers to using someone's birth or pre-transition name rather than the preferred name that they have chosen for themselves, and that may or may not now be their legal name.

(SU17). It is perhaps for this reason that he was reluctant to ever complain about healthcare that he had received, in case this then pitched him as a troublemaker and prevented him from receiving further support. This account resonates with the findings of the health needs assessment of Black and Minority Ethnic populations in Nottingham City (Burton, Hadid et al. 2017), which similarly found cultural barriers to accessing mental health support, stigma and the lack of cultural competence.

Another participant described the struggles that her gay male friend who has a very conservatively religious family has had:

> I think that [health professionals] don't understand how much it can affect your life, especially if you're growing up in a household where it's completely viewed as a sin and you can't talk to anyone about it and you're depressed and you don't know what to do. You would think that the doctors would maybe take that into account, that people who do suffer from mental health issues, that that might be a big reason why (SU2).

As will become apparent in later sections of this report, commissioners and practitioners did not typically express a good understanding of how being LGBT+ intersects with other aspects of identity. Further training and awareness-raising is vital in order to build LGBT+ people's confidence in health professionals' understanding of their lives and their needs, and to ensure that this confidence is not unfounded. Further, it is essential that LGBT+ people's mental healthcare gives them the opportunity, if needed, to talk about how their life experiences as an LGBT+ person have shaped their thoughts, behaviours and self-concepts[24].

Views on disclosure and equality monitoring of sexual orientation and gender identity

Following on from the above discussion, participants were asked both whether they tend to disclose their sexuality and/or gender identity to their GP and other health professionals and whether they have been asked about their sexuality or gender identity. As noted earlier, the NHS has recently introduced the Sexual Orientation Monitoring Standard (NHS England Equality and Health Inequalities Unit 2017), marking a commitment to start to collect equality and diversity monitoring data about sexual orientation. Thus, it was timely to ask participants how they felt about disclosing this information.

Most participants felt that it was important for people who are treating them to know their sexuality and/or gender identity, and some considered their sexuality to be a factor in their mental ill-health. However, many felt wary or uncomfortable about actively disclosing this information, but said that it would have been made it easier had they been asked. Some participants expressed the view that had they been asked about their sexuality and/or gender identity, health professionals would have been able to direct them to more specialist LGBT+ health services or social support:

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[24] It is important, however, not to assume that an LGBT+ person's mental ill-health is a product of their sexuality and/or gender identity. Later in the analysis, concerns are raised about seeing LGBT+ identities as the *cause* of poor mental health, which is pathologising. This is different from recognising how LGBT+ people's mental ill-health can be impacted by their experiences of inhabiting a minority status in a heteronormative and cisnormative world. As many participants shared, traumatic experiences such as familial rejection; shame, stigma and secrecy concerning LGBT+ identities; and experiences of homo/bi/trans-phobia are commonplace, and affect mental health, wellbeing and the quality of support networks.

> And if I was told, if I was asked the question about my sexuality and they then knew, I would hope that they would point me in the direction of people who understand my circumstances and my situation better (SU2).

For this participant, a bisexual woman in her early 20s, this could arguably have included signposting towards LGBT+ youth groups which may have helped her to feel better supported and less isolated as a bisexual young person.

A lesbian woman aged 35-44 years old, who had only recently come out, made important points about the lack of understanding amongst GPs and other health professionals about the relationship between physical and mental health, and the need to be aware that along with other forms of trauma, long-term repression of one's sexuality can be at the root of both physical and mental health needs:

> I think for a GP, any medical professional, to understand that […] if you're going to the doctor with physical symptoms of, you know, abdominal pain and menstrual problems, but you're not addressing that actually this person is, you know, I'm living under the effects of trauma, and actually repressed sexuality is a trauma as well. And unless they address that you're not going to get proper treatment (SU20).

A few participants initially expressed the view that that their sexuality was not relevant to their mental health needs, but started to think differently about this as they talked this through in the interview. For example, one gay man reflected that the need to constantly make decisions about whether it is safe to be open or not in any given situation means that it is relevant, because it breeds a continual state of being in fear of how others would receive his sexuality:

> That sense of disclosure and whether I'm willing to disclose that as a minority part of society is with you every day. That's with you when you meet people in the street, in a shop, at work. And I suppose as part of that process you guard yourself from disclosing it as part of this. On reflection do I think it was relevant? Yes because I think part of it is all about I've had to go through life always considering whether I'm going to be judged in a different way (SU10).

In addition, one older gay male focus group participant expressed how the legacy of how homosexuality has been viewed in recent history has shaped his reluctance to disclose his sexuality: 'I think partly it's, I'm old enough to remember a time when it was dangerous to be gay and you didn't have the conversation unless you needed to'. While older LGBT+ people's voices were under-represented in this research, this participant's concerns resonates with other research with older LGBT+ people, especially those who grew up at a time when sexual relations between men were illegal and homosexuality was still classified as a mental disorder.[25] The legacy of this very repressive and punitive social climate means that many older LGBT+ people continue to consider it risky to be open about their sexuality and fear receiving discriminatory responses if they are open about it (Almack and King 2019, Ward, Pugh et al. 2011).

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[25] Consensual sexual relations between men aged 21 years old and over were decriminalised in England & Wales in 1967. Homosexuality was removed from the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1973.

A minority of participants were unsure about the benefits of sexual orientation monitoring and were concerned about how this data would be used. Some considered that unless their sexuality is relevant to the presenting health issue, health professionals did not need to know about. One participant expressed concern that if someone's sexual orientation was a marker on their medical records, they may receive inferior care from some health professionals. Further, some participants worried that health professionals might pathologise their sexuality and/or gender identity and assume that this is at the root of their mental health struggles. This was also an issue that was raised in contributions to the Pride activities. A few interview participants experienced this previously, such as the participant quoted below, a queer trans man/non-binary person, aged 25-34 years old:

> Like you've gone in [to a health service […], you've mentioned that you're part of the LGBT community, and then it's like (clicks fingers) 'it's about that'. Mainly to do with mental health, if you're depressed. 'Oh it's because of your', yeah, 'your gender dysphoria', or 'it's because of your gayness' or whatever. Yeah, I've seen it happen and I've had it happen to me (SU4).

Other participants expressed a fear of being subjected to prejudice or discriminatory treatment if they disclosed their sexuality or gender identity, or that they were in non-monogamous or polyamorous relationships. This is illustrated in the following quote:

> Here's another one of those who's wasting time because they think they're bisexual. […] Is how I kind of felt. And [pause] that's quite a strong feeling to, you know, nobody's, no GP's ever said that to me. That's just kind of how I've felt. Is that my issue or is it their issue, I don't know (SU9).

Importantly, these views were more often grounded in a fear of being treated differently rather than actual experiences of homo-, bi- or transphobia, and the majority of participants who had talked about their sexuality or relationship with their GP or a health professional had not received negative responses. However, as will be discussed below, this reinforces the importance of general practices and community mental health services outwardly promoting LGBT+-inclusive messages, in order to enable patients/service users to disclose information which could improve their healthcare experiences and help to tailor the treatment that they receive.

Heteronormative and cisnormative assumptions

Echoing a theme that was evident in the analysis of data collected via the Pride activities, most participants felt that GPs and other health professionals that they had encountered had assumed that they were heterosexual and, though less frequently discussed, cisgender:

> Because I think that, it's like I think there's an assumption, there's a big assumption that because most people are heterosexual, and so healthcare is based upon people being heterosexual (SU20).

Some participants said that the reinforcement of the heterosexual assumption by health professionals further emphasised their sense of difference and marginalisation. This is illustrated in the quote below, from a gay woman aged 35-44 years old:

> So if someone’s assuming that you’re heterosexual that’s putting you further, you’re feeling more social stigma, and they’re saying, they’re giving you examples of being heterosexual or being like this […] So they’re talking to you about stuff and basing it on a sort of nuclear family. That just […] exacerbates your feelings of isolation (SU6).

However, it was encouraging to find that some participants reported that this was not the case and/or that they had noticed improvements in more recent years. As one participant, a gay man aged 35-44 years old, reflected:

> I would say that the language is inclusive. I’ve never had somebody presume that my partner is a woman. I’ve never had the question asked, ‘have you got a girlfriend or a wife?’ You know, the questions are always broad enough to say ‘what’s your support network at home?’ (SU10).

Phrasing questions in this way is an important example of good practice.

The importance of visible signs of LGBT+-inclusivity

All participants were asked whether they had seen any visible signs or symbols of LGBT+-inclusivity such as LGBT+ support leaflets or rainbow flag stickers when attending their general practice or community mental health service. A small number said that they had seen a rainbow flag sticker or leaflets, and a couple of participants had seen posters that stated that their general practice had zero tolerance for discrimination, which helped them to feel safer. The vast majority, however, had not seen any signs of LGBT+-inclusivity, but were emphatic that this is something that they would like to see:

> To me that makes a huge difference. If I went in and, you know, a member of staff was wearing a rainbow badge or a lanyard I would immediately feel that they are doing something to understand LGBT issues (SU20).
>
> Well it kind of says we’re alright with this sort of stuff, we’re alright with you talking to us about this sort of stuff, you don’t have to be guarded, you know? (SU10).

Similarly, one focus group participant reflected that whether or not healthcare services provide information about LGBT+ services or include images of same-sex couples on posters, for example, impacts on the extent to which they see themselves within that service:

> some of those are really basic things and they don’t cost money, and it’s just people having kind of a consideration about what do you represent? Who’s represented and what does that say to you? Because if you have that image of same-sex couples […] if I see that when I go in I think, oh they kind of get it, or they’re at least making an effort (focus group participant).

Thus, stepping outside of a heteronormative and cisnormative way of seeing the world is essential if commissioners and health professionals are to understand how inclusive their service appears to LGBT+ people, and therefore to take steps to increase uptake of healthcare services by LGBT+ service users. However, as two participants cautioned, it is critical that signs of LGBT+-inclusivity are reinforced by actual LGBT+-inclusive practice in that service. Arguably, it is even more damaging for patients/service users to be led to believe that there would be understanding of their needs as LGBT+ people, and then to receive uninformed or insensitive responses.

Participants' views on improving mental health services

General issues about service delivery and improvements

Several participants made specific reference to services having lost resource due to austerity cuts, and being overstretched. Some recognised that services were doing the best that they could with the capacity that they have. Nonetheless, participants also made a number of suggestions of how services need to improve to meet mental health needs in a more timely, flexible, compassionate and effective way.

A key issue raised was waiting times. One participant suggested that by providing improved access to short-term counselling support, this may prevent escalation into more serious mental ill-health:

> So I guess if money was no object there being able to, people to access it just once or twice if they needed when their mental health wasn't that bad, just as a sort of prevention thing […] rather than waiting until people are at crisis point (SU12).

In a similar vein, a few participants suggested that there ought to be target times to be seen by specialist mental health services, as there are for some types of cancer referral:

> So in an ideal world there would be something along the lines of a two week wait, you know, emergency. We have crisis teams, but you shouldn't have to get to the point of self-harm or being a suicide risk, being [pause] sort of at the point of doing, you know, serious harm to yourself to get, you know, blue-lighted through an emergency department full of people who can't see anything wrong with you, and the whole thing has just gone too far at that point (SU7).

These are both key points in relation to early intervention, with services needing to be more responsive and able to provide therapy/intervention that, for some patients/service users, may alleviate the need for more intensive support and A&E admissions further down the line.

The lack of flexibility around the duration of support, discussed previously, and discharge from the service, were also identified as areas for improvement. In addition, one participant commented that it would be valuable to be able to re-enter talking therapies services without a fresh referral within a certain window after discharge:

> Having some sort of [pause] if it all falls apart in the next six or eight weeks some way of getting back into it, getting back into it quickly […] Without having to go back to the beginning. […] At the end of the session you can feel quite buzzed and 'yeah I can do this', and then for some reason something happens, it doesn't quite work (SU7).

Offering this window to return as a kind of safety net could potentially be less resource-intensive than making someone wait for several months before they can re-refer back into the service and require another full course of therapy for needs that may have intensified in the meantime[26].

Whilst participants highlighted training needs specific to enabling health professionals to better understand LGBT+ lives and mental health needs, more generic mental health training needs were also identified. A few participants suggested that in the face of long NHS waiting times, GPs could signpost patients to other free services such as The Samaritans and/or make them aware that their workplace may offer counselling via an employee assistance programme[27]. Another area identified related to trauma and the need for health professionals to both be more receptive to disclosure of trauma, and to know where to signpost people for relevant support. As one participant said, 'Even if a GP can't, they should be able to make you feel that there is a safe place that could help you' (SU20). It is therefore timely that the *Nottingham City Mental Health and Wellbeing Strategy 2019-2023* places a significant emphasis on the importance of developing trauma-informed approaches and ensuring that training is provided for this.

Given that several participants had reported feeling dismissed or invalidated by GPs and healthcare professionals, the need for greater validation of mental health needs and their impacts was highlighted. This is articulated by one participant, a bisexual woman aged 25-34 years old:

> having healthcare professionals that take you seriously and believe you is really important. […] that's something I've found I've really struggled with, but when things seem to go smoother and when they're better is when you get that instant support from someone, who not only acknowledges that you might have a problem but then validates you when you express what that problem is (SU18).

Other participants highlighted the need for mental first aid training to improve responses to crisis situations, and to be able to change talking therapist if the relationship is not working.

Views on receiving mental healthcare online

Participants were asked for their views about accessing services online, with mixed responses. Some participants were open to the idea, but as a supplement rather than as an alternative to existing provision, such as being able to access online CBT in between face-to-face sessions. Younger participants tended to feel more positively about the idea of accessing peer support via online LGBT+ chatrooms. Others felt that whilst online support would not suit them, it might be useful for others, especially where anxiety and other health needs make leaving home difficult. One focus group participant highlighted that LGBT+ people from certain religious or cultural backgrounds may benefit from accessing support anonymously online.

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[26] This is a suggested follow-up mechanism in the IAPT manual for service providers and commissioners (National Collaborating Centre for Mental Health 2019).

[27] Since data collection finished, the Nottinghamshire Healthcare NHS Foundation Trust has launched a 24-hour mental health crisis helpline (0808 196 3779) for people across Nottingham and Nottinghamshire, which GPs and other health professionals will be able to advertise and signpost patients to.

For those participants who did not think that receiving mental healthcare online would work for them personally, reasons including the view that it would not be possible to build high-quality rapport with a therapist or health professional online:

> It's always very important to sit with your doctor or therapist or person that's supporting you, because not only is it personal preference, it's also getting to meet them, establishing that safety, who they are, and being in their presence. I think it's very, very important (SU4).

There was a little more openness to the idea of Skype counselling (and one participant had received this via one of the talking therapies services) and one participant spoke positively about apps that provide daily advice and goals, for example. However, participants expressed less favourable views towards online chat services, with concerns including how they would know that 'this isn't a bot somewhere responding to me, you know, it's not someone having three conversations on the go at the same time' (SU7), finding it difficult to keep up with an online chat in terms of typing speed, and finding group online chats overwhelming because of the fast pace[28].

Notably, all data for this research was collected prior to the advent of the Covid-19 pandemic, during which time the majority of primary care and mental healthcare from community mental health services has been delivered remotely. Therefore, it would be timely to conduct further research on patients' openness to receiving mental healthcare online and their experiences of telephone or online therapy sessions during the pandemic, to inform service development and improvement. Some research has already been conducted elsewhere in the UK. An online survey of 407 LGBT+ people in south-west England found that 49% of respondents reported a preference for continuing to receive services remotely after the pandemic. Echoing our findings, remote delivery was identified as being particularly beneficial for those living in rural areas, those who struggle to access services in-person for mobility and/or financial reasons, and those who are not out about their sexuality and/or gender identity. Importantly though, whilst there is demand for remote service delivery which could make services more accessible and approachable, 51% of respondents would still prefer to access services in person (Intercom Trust 2020).

Further, a rapid evidence review conducted by Youth Access (2020) highlights both the opportunities for remote mental healthcare delivery to young people, but also the limitations of digital technologies and the needs for health practitioners to develop specific skills in building rapport, tailoring communication and fostering in-depth engagement. However, issues such as the unavailability of smartphones and internet access to some young people were also highlighted, as well as disruption caused by poor call/connection quality, background noise or delays. It is critical therefore that the development of remote delivery needs to be *in addition to, not instead of*, face-to-face provision.

Finally, whilst greater use of video calling and other online applications may have increased people's confidence with accessing various services online, the pandemic has highlighted particular vulnerabilities for LGBT+ people, such as the difficulties faced by LGBT+ young people in particular who are living with family or others who they are not out to or who are homo/bi/transphobic (LGBT Foundation 2020). In such situations, lack of privacy or fear of repercussions may inhibit LGBT+ service

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users' opportunity to openly discuss their sexuality or gender identity with health professionals or therapists[29].

LGBT+-specific areas for improvement

Participants were asked about different ways in which they could receive mental health services as a LGBT+ person, for example, in bespoke services for LGBT+ people, or through partnerships between existing NHS mental health services and local LGBT+ organisations.

Echoing the rapid evidence assessment, many interview and focus group participants felt that there was a need for LGBT+-specific services, and that that they would currently or have previously been keen to use such provision. One participant, a queer, trans man in their mid-20s, highlighted the need for support especially for younger LGBT+ people who have been rejected by their families:

> If you are a gay person, for example, that has an incredibly supportive family, brilliant, because you're told from the get-go that it's okay. And even if you experience homophobia in the future you've still got that solid support network. But a lot of these young people especially don't have that. So if there is LGBT-specific therapy, if I send myself back to when I was younger, I would've gone to that service immediately, because it lets me as a young person know that I'm going to be heard and I'm going to be accepted (SU4).

A similar point was made by another participant, highlighting, as others did too, the importance of safe spaces and of providing, as a means of early intervention, easily accessible counselling support, potentially on a drop-in basis:

> my wish for younger people would be to have more accessible, not waiting for two, three months to get in and talk to somebody, doesn't have to be a programme of six sessions, because that might not be what I need. I might just need to go and talk to somebody impartial about an experience I've had today that was quite hurtful and stems from my sexuality (SU10).
>
> But something branded LGBT would make me feel safe, because they have an understanding that an LGBT person is, you know […] And I think actually a centre with, you know, maybe counsellors or support groups, it would make the biggest difference and it would be much more low-cost than a lot of the things that the NHS do offer (SU 20).

One focus group participant highlighted the LGBT Foundation in Manchester as a model example of such provision – in effect, a one-stop shop for sexual health, mental health or simply 'a chat and a

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[29] The findings of the *Queer Futures 2* study, which one of this report's authors, Prof. Katherine Johnson, is co-investigator on, will provide important data on LGBTQ+ young people's experiences of remote service delivery during Covid-19. The final report is due in December 2021 but interim progress can be followed at https://queerfutures2.co.uk/

coffee with someone’. The need for safe spaces both within mental health services and within LGBT+ communities were also highlighted by some of the contributors to the Pride activities.

The majority of participants were also very receptive to the suggestion of receiving mental healthcare from an existing NHS service being hosted at an existing LGBT+ organisation. However, a small number of interview and focus group participants were concerned that some people might be deterred because of the stigma or fear of being seen entering or leaving the premises of an LGBT+ organisation, thus emphasising the importance of choice, rather than a one-size-fits-all approach. In addition, one participant, a queer pansexual woman aged 25-34 years old, emphasised the importance of this being a professionally delivered, trained service and not simply peer support, based on her concerns about existing LGBT+ support groups potentially doing more harm than good because of a lack of formal training. Other participants expressed the view that generic services should be able to meet everyone’s needs, and that all health professionals should have the necessary training to recognise and respond to LGBT+ people’s needs.

Participants were also asked whether they would ideally want to receive mental healthcare from a health professional who themselves identified as LGBT+. Participants were mixed in their responses to this. A small number of participants talked about having had this experience and finding that it made a positive difference; as one focus group participant indicated, ‘it was easier to be myself within that’. Numerous participants felt that there would be greater empathy, shared experience and fewer barriers to discussing certain topics with a LGBT+-identifying therapist. Others, however, considered that health professionals having the requisite skills was more important than their identity. A few participants felt that it would be unreasonable or inappropriate to expect health professionals to disclose their sexuality and/or gender identity, as the following quote from a gay man aged 45-54 years old illustrates:

> in a therapeutic relationship it shouldn’t be necessary for me to know that level of background about the person treating me, and if they’re treating me with, what’s the other phrase, unconditional positive regard, then it shouldn’t be an issue (SU7).

For another participant, a woman aged 25-34 years old, who prefers not to label her sexuality, explained, it was more important to address the problem of non-affirming health professionals than to have LGBT+-identifying ones:

> No, it’s more about having a removal of the people who would not treat you with respect after finding out a fact, that’s all it is. I don’t have to be sitting opposite somebody who has my shared experience, but I would like to be sat with somebody who would understand, and not flinch if I said something that might upset somebody else (SU19).

When asked how services could improve to meet the needs of LGBT+ people, training and education was most commonly mentioned. This is captured well by the following quote:

> my dream (short laugh) would be all medical health professionals, regardless to what their job title is, is just aware of it, aware, educated and completely in the know about it. So that ranges from all of the LGBT, so somebody can sit in the, it would be so that I can sit in the room with a medical health professional as a man, when I’m passing as male, and say ‘my boyfriend’, and it’s a non-issue (SU4).

Specific areas for training including recognising the difference and diversity within the LGBT+ umbrella and developing understanding of lesser-understood sexual orientations and gender identities such as gender-fluid and non-binary identities and asexuality:

> I don't get the impression that anyone I've come out to as asexual has been aware of what it was and had an understanding of what it was before I entered the room […] Like, you know, when you do LGBT training just throw in asexuality, you know? I feel like it's, yeah, just a concept that not a lot of people are particularly in with (SU14).

Other areas for training included the pressures related to coming out, including the difficulties of coming out later in life; the nature and impacts of gender dysphoria; the higher prevalence and impacts of familial rejection for LGBT+ people; and some of the difficulties that LGBT+ people may experience in entering and maintaining intimate relationships. Importantly, some participants emphasised that it was particularly important that receptionists received this training too. In addition, one participant, a South Asian gay man, talked about a particular need for more South Asian doctors to show leadership and become role models for challenging the stigma related to both mental ill-health and sexuality. Further, some interview and focus group participants suggested that general practices could have a GP who has had specialist training who can act as a champion, or a kitemark for services to indicate that they have received LGBT+ awareness training.

A queer trans, male/non-binary participant aged 25-34 years old emphasised the importance of health professionals finding out and using patients' preferred pronouns:

> It's, it's so, it's absolutely mind-bending when you meet a mental health professional and they say "what are your pronouns?" Not to every single person, but if they can acknowledge you as an LGBTQ person and they're entering your space, "so what are your preferred pronouns? What is your name?" Just that, do that (SU4).

Some participants spoke about the need for more gender-inclusive language on letters, forms and other patient information. Other improvements that participants felt were important included ensuring that health professionals are able to signpost patients/service users to local LGBT+ services and groups in order to access appropriate social support and making it easier for someone to change their name on their patient record. For such requests, one participant also said that it would be helpful for there to be a more private area for conversations with receptionists without others overhearing.

Early intervention and the role of schools

Whilst the focus of this report is on NHS primary care and community mental health services, it would be remiss not to acknowledge a key finding; namely, that most participants had begun to suffer mental ill-health while they were at school or sometimes at university. Whilst this is not unusual, specific contextual factors for LGBT+ young people is that, in spite of changing attitudes, they may not feel able to turn to their family or their heterosexual and/or cisgender friends for support, and may also experience homo-, bi- or transphobic bullying at school. Acceptance at school was a key protective factor for good mental health that was highlighted in the analysis of contributions to the Pride activities, and the need to focus on prevention of poor mental health amongst young people was also raised in the focus groups.

One example from the individual interviews that is particularly significant to share concerns a bisexual woman in her early 20s, talked about her experiences of trying to find support for her mental health struggles from teachers at school. She initially wrote a letter to a teacher to explain how she was feeling, and whilst one teacher would check up on her and ask how she was, there was no referral or signposting to specialist support. She briefly saw a school nurse but she reported that the nurse 'kind of just said that I was a bit low at the minute and I'd feel better soon'. Her mental health subsequently deteriorated further and she was regularly self-harming and attempted to kill herself, which she disclosed to her teachers:

> I had actually told one of the teachers that I wasn't doing well and that I was hurting myself, and I don't think she believed me. So it wasn't until after, I remember I had [pause], it was (sighs), I had tried to kill myself and then [tearful] sorry [crying] it was the next day, I didn't know what to do because I was still alive […] So yeah the next day I went into school and I basically told the teachers what had happened, and I guess they still didn't even believe me, and it wasn't until then I said, I think I got quite angry at the time and I said "I've been hurting myself, I'm not okay". And it wasn't until then that they asked if they could see that I'd hurt myself, and then (short laugh) you could just kind of see the shock on their faces […] And so I, that was when I was taken to hospital, that night they took me straight from school. But yeah, it was crazy to think that like no one really did anything through school (SU2).

Thus, no action was taken until the situation escalated to crisis point, even though there were multiple missed opportunities to intervene and to provide signposting and/or referral to specialist mental health support.

Any holistic consideration of improving mental health outcomes and promoting early intervention needs to take into account the organisations which individuals are already engaged with, and therefore the role of schools, colleges and universities is critical as part of a public health approach to improving mental health (Faculty of Public Health and Mental Health Foundation 2016). It is therefore very encouraging that the NHS Long-Term Plan (NHS 2019) sets out provisions for increased access to school- and college-based mental health teams over the next five years, but it is crucial that these teams are aware of LGBT+ children and young people's mental health needs.

In the next sections of this report, the focus turns to the qualitative data collected from commissioners, community mental health practitioners and health professionals in general practices.

5. Commissioner interview analysis

Methodology

Five commissioners were interviewed between 2nd July 2019 - 10th January 2020 about commissioning decision-making practices and their awareness of LGBT+ people's mental health needs; one over Skype and four within their primary place of work. Four commissioners worked in the Nottingham and Nottinghamshire region and one in Sussex. Participants had worked in their roles between 1-15 years and had extensive experience in commissioning in CCG and/or Local Authority settings. Commissioning activities covered a range of services including crisis and urgent care, children and young people's mental health, Black, Asian and Minority Ethnic (BAME) services and advocacy services for mental health. Of the five commissioners interviewed:

- All were women, none had ever identified as trans and all defined as heterosexual
- Three were aged 35-44 and two aged 45-54
- Four self-defined as White British and one as British. None reported having a disability

Interviews were transcribed and analysed following the broad principles of thematic analysis. In line with the aims of the project, initial analytic steps focused on processes involved in commissioning, national and local influences, knowledge and understanding of LGBT+ mental health needs and experience of commissioning services that met those needs. None of the commissioners from the Nottingham and Nottinghamshire region had experience or knowledge of models of good service provision for LGBT+ mental health, so this thematic area was reshaped into knowledge requirements for commissioning services for LGBT+ people. Themes were reorganised into the following codes: 'considerations for commissioning mental health services', ''Inclusion for All' and LGBT+ mental health' and 'knowledge gaps, specifications and service provision.'

Analysis

Considerations for commissioning mental health services

All participants described the complex mix of national and local considerations that must be taken into account as part of the commissioning role, as well as the central influence of finance:

> So financial value is the biggest, biggest thing, and any decision is 'and what outcomes will it deliver?' We've spent the last twelve months or so reviewing every single service, outside of secondary care …and the whole process around that is 'is it value for money? Is it a must-do? What health outcomes does it deliver?' (C3)

Commissioner 3 also acknowledged the complexity of measuring positive outcomes in the field of mental health, in comparison to physical health, given the range of social factors that contribute to good mental health:

> So mental health is, it feels, hasn't quite got that senior champion yet, to be able to go 'well okay we know that health outcomes should include housing, employment, all of these other things', so we can't just be measuring health outcomes in the traditional sense.

Commissioner 2 summarised the range of influences on the commissioning process as responding to 'national must-dos' as well as defining 'how we adapt services for our local population…what the gaps are and what the service model needs to be to address those.'

The background context stipulating the balance between national requirements and local need is set out in two recent major policies, *The Five Year Forward View for Mental Health* (Mental Health Taskforce 2016) and *The NHS Long-term Plan* (NHS 2019), and were referred to by the Nottingham- and Nottinghamshire based commissioners. It was apparent from the interviews with CCG commissioners that the new funding landscape offered opportunities for improving mental health, with additional funding available after years of under-funding. However, challenges still remained in terms of determining local need and meeting nationally set targets based on predictive models of prevalence.

As Commissioner 4 describes:

> They're both quite prescriptive in terms of what it is that we need to deliver, but they'll also come with investment, the long-term plan particularly…There is flexibility in terms of how they look locally, and that will be influenced by things like joint strategic needs assessment, by community engagement, and by what we know about the people who are already using those services. And I suppose, studies…with people who we think might need to be accessing the services but aren't and where the gaps are.

Notably, as with the service user data, all interviews with commissioners took place prior to the Covid-19 pandemic. Since then, national discussions of the impact of Covid-19 on mental healthcare commissioning strategies and priorities have taken place. For example, a webinar co-hosted by the Joint Mental Health Commissioners Network and Mental Health Network in June 2020 emphasised the immense progress that had been made in shifting to remote delivery and launching 24/7 crisis lines ahead of schedule. However, it also anticipated the likely increase in mental health distress and suicide as a result of the impacts of the pandemic. This will require agility in commissioning to meet the resulting needs, informed by up-to-date data about mental health needs, suicide and service usage[30].

'Inclusion for all' and LGBT+ mental health

In response to questions about delivering mental health support for LGBT+ people, all participants referred to the need to improve mental health services for everyone. Many cited Equality Impact Assessments as a key mechanism for assessing whether services were inclusive, but the Nottingham

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[30] A summary of the webinar discussion can be found at: https://www.nhscc.org/wp-content/uploads/2020/08/Looking-Forward-How-the-Mental-Health-System-Will-Model-and-Meet-the-Demand.pdf (accessed 24 August 2020).

and Nottinghamshire-based participants all suggested uncertainty in whether services were being delivered to meet the needs of the local LGBT+ community. For example:

> One of the things we need to do is get good services in place for everybody, and what we will do whenever we are commissioning a service is obviously do an EQIA [Equality Quality Impact Assessment] … I think what we need to do for LGBT people is…look at specific services and specific needs. And we probably don't do that as much as we need (C2).

Although several participants mentioned issues with stigma around gender and sexual identities as an explanation for LGBT+ mental health concerns, others were more explicit about their lack of knowledge around the mental health needs of LGBT+ people and concern that delivering mental health services for specific identity groups would lead to the proliferation of services:

> Hand on heart I don't think I could necessarily say what their needs are…[but] if we were to commission separate services for everybody we'd end up with hundreds of different services… So I've been much more focused on trying to ensure we commission services that are accessible for all… I don't actually know what that particular group would say in a piece of engagement (C3).

While 'Inclusive for All' was also the approach of the participant working in commissioning for children and young people, she was more explicit about how 'inclusion for all' might translate into requirements for service providers to deliver services that were accessible for LGBT young people with key indicators including accreditation, diverse staff and training.

> To be inclusive, yes, that would be a bottom line…LGBT people will feel that your services are friendly and accessible… providers have Stonewall accreditation and things, and they are a mixed population themselves… we know what training they do and, you know, when we're commissioning services it will be written into the spec, not necessarily specifically about LGBT, but about how these services will be accessible to everyone, regardless of race, disability, sexuality, all those kinds of things (C1).

Despite noting important issues that work for LGBT people, the 'Inclusion for All' strategy still overrode her focus on need for clear specifications that expect providers to have LGBT mental health knowledge and experience. Others specifically recognised the challenge of how to ensure that the 'inclusive for all' model of service delivery was actually experienced by LGBT+ people as inclusive in practice:

> So, you can kind of design a service on paper and say 'we need it to be inclusive' and this, that, and the other. But that doesn't then translate to someone's own experience of accessing and trying to access that service or feeling like they don't want to access that service. And that for me is the biggest gap (C4).

This final point about gaps in knowledge about how services were experienced was a key concern in the last major theme.

Knowledge gaps and service provision

All participants had experience and knowledge of commissioning from both CCG and Local Authority sectors and discussed differences between the approaches. A central theme was the role of evidence and assessment of gaps in available knowledge and being required to make evidence-based decisions. Commissioner 1 spoke positively about the focus on evidence in the commissioning process for services within the health sector. However, most participants also discussed issues with the type of evidence that was available to guide what services were required to meet need, as well as how well those services then subsequently met that need: 'some of the data that we would look at, it will look at people who are LGBT who access services, but some of that data isn't complete' (C2).

Commissioner 3 spoke at greater length about concerns with data availability and ability to assess the effectiveness of different types of services:

> It's really interesting because the way we commission the smaller services from voluntary sector providers and what we ask in terms of data from them is very different to the kind of bigger services from our core provider… I don't get [core provider data], our analysts get it… but with our smaller providers we ask for monthly or quarterly or six-monthly, depending on the size of the service, data that will include demographic data and that sort of thing. So, as we're performance managing we can make sure that they're including, you know, a diverse population…But, as a commissioner how can I not know those very basic things about the [core provider] services I lead on?... It's just not been joined up and drilled down enough. But then when, you know, you're focusing on some of our new national targets that kind of has taken over… we focus very much on the targets and not pure data, which is wrong, and I have been aware of it.

In this discussion, the participant outlines the key issue of whether the right type of data is available to assess whether services are being delivered to meet the needs of the local LGBT+ population. This issue is exacerbated by poor recording of gender and sexual identity in interactions with core provider health services and a breakdown in sharing of available information across commissioner roles. Despite her advocacy for an evidence-based approach to commissioning, this participant outlines that specialist providers from the voluntary sector are more closely assessed than core providers and, following the new national policy context, core provider data is problematically focused on meeting nationally set targets, rather than assessment of local need.

Commissioner 1 outlines a further complication in the data aspects of delivery of services for LGBT young people, in terms of having any accurate assessment of the number of people who identify as such:

> I suppose the other challenge around meeting the needs of LGBT young people is that […] it's not something you can map and know how many young people are out there.

This is important as sexual and gender identities are still in development during childhood and adolescence, and the age at which people come to call themselves L, G, B and/or T varies. For this reason, it is important to be able to work with specialist providers (e.g. youth groups) who might offer appropriate and accessible services that appeal to LGBT+ and gender and sexuality questioning young people and offer engagement routes that assist in understanding what and how barriers to access can be reduced.

Two participants spoke about their experience of working in Local Authority settings, one in advocacy and one in children and young people's mental health (funded by the CCG). Needs assessment had been central to commissioning activities described in Brighton (C5) and youth-led engagement activities were key in the MH:2K report (2018) in Nottingham and Nottinghamshire (C1), which had recruited a high number of LGBTQ+ young people as citizen researchers. These types of activities were crucial for highlighting 'patient voice'; something that other commissioners thought lacking (C4, C3), and a clear gap in current knowledge.

The analysis moves next to examine community mental health practitioners' perspectives, where issues related to data about sexual orientation and gender identity and knowledge gaps were overlapping themes.

6. Community mental health service practitioner analysis

Methodology

Semi-structured interviews with Nottingham-based community mental health practitioners were conducted between the 27th November 2019-31st January 2020. The interviews aimed to assess the frequency with which LGBT+ patients sought support for their mental health, to explore practitioners' understandings of these mental health needs, to consider the monitoring of sexual orientation and gender identity by services, and to identify how to better prevent mental health distress, facilitate early diagnosis and promote self-care.

The 12 community mental health services commissioned by the CCG at this point in time were targeted for recruitment (see footnote, p.5). Of the 12 services approached, staff within eight participated in an interview. These eight services were delivered by a mix of NHS, Nottingham City Council, private and voluntary organisations, offering a range of distinct and overlapping provision to groups aged 0 upwards. Provision included one-to-one emotional, practical, financial and housing support; online/digital mental health support and counselling; face-to-face counselling; advocacy and advice; group work; educational workshops; family work; peer mentoring; prevention-focused activities; yoga, mindfulness and exercise; signposting and referral to other services (voluntary, statutory and NHS); outreach in schools and 'hard to reach' communities; psychological therapies; medication management and training and consultation for other organisations. For certain services, there was 'no fixed length of time (P2)' associated with support, whilst most were bound by the delivery of a specified number of sessions.

Across the eight services, eleven staff participated in an interview; a mix of service manager, team leader, therapist and practitioner. In three of the services, interviews with two staff members took place. For the remaining five, just one interview occurred. Small numbers therefore mean that individual findings must be treated with caution. Participants were approached for recruitment by email invitation from the Head of Research and Evidence for NHS Nottingham City CCG and interested parties were requested to contact the research team to schedule an interview. In certain instances, further rounds of reminder email were necessary in order to maximise interview uptake. Interviews took place at the participant's primary place of work or a satellite venue and lasted between 35-90 minutes. Of those participants interviewed:

- Eight identified as female, two as male and one participant preferred not to say. Ten participants had never identified as trans whilst one preferred not to answer
- Four participants were aged 25-34, two aged 35-44 and five aged 45-54
- Seven identified as heterosexual, one as gay, two as lesbian and one participant preferred not to say
- Five participants self-defined as White British; two as White; one as Black; one as White/Black Caribbean; one as White Other and a final participant preferred not to answer
- Ten participants stated that they had no disability, whilst one preferred not to say

Participants had been in post for varying levels of time and came with a range of experience. For some, they had been integral to developing the commissioned service, whilst the most recently recruited had been in post for five months.

The interview transcripts were scrutinised for recurring key themes and structured hierarchically. Four overarching themes emerged from this process with lower order codes sitting underneath. The analysis is presented within these themes and sub-codes.

Analysis

LGBT+ People

Monitoring of sexual orientation and gender identity

Most participants stated that their organisation collected sexual orientation and gender identity data from their clients, albeit for one service, only gender identity was purportedly being recorded. A minority of respondents were unsure if this data was being collated and for one service, whilst the wider organisation collected the information, the specific services within it did not. For a minority, there was a nuanced appreciation of why collection of this information was important. Namely, to evidence the relationship that could exist between poor mental health, 'self-harm and suicidality and wanting to recognise the prevalence [within] the LGBTQ+ community (P1)': data that could be used to convince commissioners of need. For these practitioners, asking clients about their gender identity and sexual orientation was argued to set an all-important tone, or 'set the trend' (P3), for the future therapeutic relationship:

> I know from young people that I've spoke to... that say 'if someone asks me I've got a choice then to answer it, but I feel like that then, that's the first step forward to my treatment, you know, my support, because they're actually acknowledging that, you know, I may be or I can be [LGBT+] (P1).

However, for others, there was much less appreciation of the need to monitor sexual orientation and gender identity characteristics, and despite being aware that their service did, there was not always clarity as to what then happened with the information: 'I don't know where it goes or what we do with it' (P7). Hence, there is a need for work within certain services that communicates the value and purpose of collecting this demographic information; namely, to better understand one's own service users, but to also inform the commissioning of the right mix of services to meet local need (Mental Health Taskforce 2016).

Frequency of engagement with LGBT+ individuals

Although most participants were aware that their service collected gender identity and/or sexual orientation information, that did not typically mean that the practitioner was able to identify, with certainty, the number of LGBT+ individuals accessing their service: 'Do you know what, without looking at the information, I wouldn't know (P2)'. This lack of specificity sometimes related to the practitioner being new in post or not holding a caseload, but more often, linked to a lack of appreciation of what was happening outside of one's own practice. Thus, in a number of instances, the monitoring of gender and sexual orientation information did not appear to filter into one-to-one work with clients or broader, more collective service delivery discussions:

> ...We don't ask, apart from the monitoring questions we do, about sexuality, you know, or unless somebody kind of specifically highlights that it's, you know, sexuality or gender that's... impacting on their mental health. We wouldn't make a point of asking specifically about it [in the context of intervention] (P2).

Based on one's own casework, or a more managerial overview, it was assumed that engagement with LGBT+ people would be 'happening quite a lot' (P7), was occurring 'every day' (P4) and that services would be working 'overtly and unknowingly' (P9) with LGBT+ people. It was surmised that numbers were increasing, especially for those services working with children and young people. Despite this, most providers did not offer specific mental health services/provision for LGBT+ clients, even though most felt that their service would be improved if they did. Of those providers that offered specific provision, this included an LGBT group and delivery of LGBT training and advocacy for LGBT people experiencing mental health difficulties. All practitioners argued that if it became apparent through one-to-one work that sexual orientation or gender identity were related to a client's mental health distress, they would work productively with that disclosure and develop strategies for intervention accordingly.

LGBT+ service user mental health and wellbeing

Knowledge around the mental health needs of LGBT+ service users ranged substantially[31], and perhaps unsurprisingly, linked to the frequency with which a practitioner engaged directly with LGBT+ people. A significant minority had a detailed appreciation of the ways in which experiences of stigma, exclusion and heteronormativity (including within health services) may impact mental health, link to self-harming behaviour, anxiety, risk taking, suicidal ideation and a worsening of one's condition. There was awareness that LGBT+ people can be 'doubly marginalised because there's still stigma about mental health and there's still stigma about sexuality' (P2) and that whilst LGBT+ identity wasn't the issue that brought people into therapy, once engaged in that process, 'it will always come into it' (P7). However, for most, a detailed knowledge of LGBT+ people's mental health, the different needs that may exist within the different identity categories and intersections with other protected characteristics[32], was absent, even though there was an intuitive appreciation that LGBT+ identity could leave 'a heightened risk around mental health' (P5).

For most practitioners there was a theoretical, and in some instances an experience-based, recognition that different groups of LGBT+ people would present with different mental health needs. Reflecting the findings from our GP healthcare professionals' survey, it was often transgender or non-binary individuals who were perceived to have distinct needs, because as a society, within the spectrums of gender identity and sexual orientation, these remained the least understood categories. There was also recognition that those who identified as bisexual experience additional stigmas and sometimes, exclusion from others within LGT communities (Pompili, Lester et al. 2014, Semlyen, King et al. 2016). Again, most practitioners intuitively understood that mental health would be additionally

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[31] In light of the lack of related training received for a number of participants (as is subsequently discussed), this should not be considered remarkable.

[32] A failure which may lead to a homogenised treatment response.

or differentially impacted if the individual was older, had a disability or was of a particular religious or racial group:

> There were a lot of issue around, sort of like culture. So one client springs to mind, who was Asian Muslim, and had a lot of questioning around whether or not he was going against god's plan (P8).

For those with greater knowledge, there was also an appreciation that not being 'out' to family and friends often had an additional, intersecting (negative) impact on one's mental wellbeing.

Stretched services

It was evident that participants wanted to provide the best support possible to service users and recognised that a range of factors, including one's LGBT+ identity, could impact mental health. However, it was clear that services had been stretched substantially in recent years, that 'everyone's under so much pressure' (P5), 'everybody's overstretched' (P8) and services were 'constantly fire-fighting' (P11). This was due to funding cuts, service closures and the requirement to then meet certain needs in-house (with the Primary Health and Wellbeing College being named as a key loss), increased referrals and staff sickness, sometimes due to work stress. All of these factors made the time to up-skill on LGBT+ mental health and integrate specific responses something of a luxury that time had not permitted. This did not mean that there was not an appetite to integrate such work. Typically, the opposite was true: 'I know that we don't touch on this at all and it, you know, we should' (P3).

Within this context it was argued, by some, that money was being taken away from prevention activities and services demonstrating a positive impact, under the guise of this problem having now been 'fixed'. However, such an approach does little to sustain improved mental wellbeing and stands contrary to the *Nottingham City Mental Health and Wellbeing Strategy 2019-2023*, which highlights prevention as one of its three key areas of action:

> If you take away these prevention services because actually it seems like things are getting better, and we do that too quickly, then I think, you know, all we're doing is... bringing everything back to the forefront and going back into kind of almost crisis (P1).

New provision, was however, seen to be replacing decommissioned services, resulting in a shifting terrain of providers, where 'there's lots of different incarnations of services, and it, you know, it's easy to forget who's who and what's available' (P2). Changing providers resulted in a constant cycle of needing to research and identify new services and promote one's own, in order to be visible in the community. However, in a landscape of stretched provision, often, this work could not be prioritised:

> So work like liaising with GPs, liaising with primary care services, is like on the bottom of our priority, although it should be happening... it's a bit of a vicious circle, so because we're not liaising with primary care service and GPs they don't know what our threshold is, so they're constantly referring people in (P11).

In certain instances, due to funding only being allocated to the number of patients seen/treated, there was no resources allotted to this all-important profile raising: '...the money that we get just about covers the treatment, never mind any additional promotional work' (P9). This again impacted the ability to 'really build quality liaison across the NHS' (P10) as well as support people to easily identify and access mental health services and intervention.

Working with other services

Referral and signposting

All services worked with a range of organisations: voluntary, statutory and NHS. The shifting nature of services often resulted in lack of familiarity with newer providers (irrespective of the sector they were located within), impacting referral accordingly. Relationships with, and referrals from and into, a range of NHS services occurred, including GPs; paediatricians; nurses; midwives; other community mental health services; secondary mental health provision; crisis teams and gender identity services (in Nottingham and London). Whilst positive relationships with these organisations/groups were noted, frustrations were also aired around it being 'very hard to engage with the NHS' (P3). For example, a significant minority of participants spoke about secondary mental health services not accepting a referral, on the basis that the client did not meet the threshold for support: 'It's really difficult when you get somebody you know needs more, but [name of provider removed] won't take the referral' (P3). Thus, commissioned services often found themselves working with very complex cases and 'bridging the gap' (P8) in support, on the basis that the individual was 'a threat to themselves (P5)':

> I said 'oh I think this case would be better suited to yourselves. You're probably going to need a CPN [community psychiatric nurse], could do with a psychiatric review, and then maybe some more specialist CBT or something once those other things have occurred'. And they said 'well are they currently at risk of harming themselves?' And I said 'not right this moment, but in six weeks' time'... 'Well, what do you think we can do that you can't?' (P8).

Work with and referrals to and from social care; schools and colleges; children's centres; the Department of Work and Pensions; housing; alcohol and drugs services and the police were also frequent, with links often being described as 'good'. Positive relationships and working practices with a range of voluntary organisations across the city were also noted. Although none of the commissioned services delivered any mental health provision with a third-sector organisation, examples existed of co-delivered training, future plans to jointly deliver group work and co-located working practices when referral pathways were being established. All of this suggests that innovative precedents with voluntary organisations have been established, which could be harnessed in plans for future mental health delivery.

Familiarity with non-NHS services providing social support and advice for LGBT+ people ranged substantially, from 'not that confident' (P4) through to 'very'. However, all participants felt able, even if they did not know the organisations directly, to find the necessary information through a Google search, calling known contacts and/or using the ASKLiON Nottingham City directory of community groups, health and welfare support and services: a facility described as 'brilliant'. Certain gaps in voluntary services for specific groups of LGBT+ people were noted, especially around support for older lesbians and parents of young people transitioning. The latter is noteworthy in light of evidence that suggests when parents know how to support their children, this improves self-esteem in young adulthood and is linked to improved overall health (Ryan, Russell et al. 2010).

Several participants argued that collaborative relationships and integrated working practices had been supported by the Nottingham City SPA - a pathway whereby all referrals for children and young people needing services for behavioural, emotional or mental health need and assessment are received at a single Point of Access. Described as a 'joined up approach across the city' (P5) designed to support timely and appropriate allocation to services, this pathway was flagged as being particularly valuable.

General practitioners

Whilst relationships with GPs were sometimes described as 'good', there was also concern that GPs were not referring clients into certain community mental health services or were referring inappropriately: 'there's a reluctance for them to engage with us I think a lot of the time' (P11). Typically, inappropriate referral related to an individual's mental health need being too chronic (or for one service, not chronic enough) for the provider to support. Sometimes, as noted, this related to the lack of work undertaken around promoting one's service and its threshold for intervention. Problems also related to a perceived increased practice of giving young people the option to self-refer into community mental health services, instead of the GP doing so directly. Whilst some argued that 'taking control themselves' (P4) over referral was an important part of enabling young people to feel empowered by health services, the possibility of delaying early intervention, is of concern. In addition, unease was expressed by one practitioner around young trans people being referred into mental health services by their GP, when other forms of social support and group work were considered more appropriate. Here, however, referral may reflect an absence of more appropriate services to link in with:

> ...we should be offering some more specific work, you know? Because it's not mental health... it's developmental and it's not a condition... we're missing a little bit of something there, you know, to support rather than young people all coming through mental health services for gender dysphoria (P1).

Concerns around transitioning young people needing to travel to London to receive treatment from the Gender Identity Development Service (GIDS) were also noted here. This was a process perceived to enhance the young person's mental distress and which runs contrary to the aim of receiving treatment in the right place, at the right time and as close to home as possible (Department of Health 2015).

For one commissioned service, GPs were not completing the standard referral form for that organisation, but sending through their assessment of the patient with the worker required to extract the necessary information. Whilst this was seen to be a time saving exercise for GPs, it could result in information being missed and the practitioner having to chase it before client contact could be made. This approach was put down to the NHS having the power to dictate 'how they do it and how they refer' (P4), implicating that processes underpinned by (unspoken) power dynamics can act as a further barrier to individuals receiving timely support.

Improving services to facilitate early diagnosis, treatment and prevention

Feedback on community mental health services

Across the board, community mental health services were perceived to have 'moved forward' (P1) and be more aware of and responsive to LGBT+ individuals than has ever been the case. Participants had heard of some 'really positive stories' (P1) about the support received from their own or another CCG commissioned service. In reading the feedback received from one LGBT+ patient, it was identified that within the service: 'my therapist made me feel comfortable and listened to and worthy of help; I also felt like I could fully express myself and be honest' (P8). One practitioner spoke about her own feelings of pride in the organisation she worked for (albeit still recognising that there was 'a way to go' P10) and how its ethos of inclusivity and non-judgment were instrumental to her own coming out:

> During my time in this service is actually when I came out. And actually I don't feel like I was discriminated against in any way... I felt I could talk about those things without any kind of prejudice (P10).

Certain services spoke about their own and other commissioned providers' affiliation with Nottingham City Council, a Stonewall Top 100 employer, and their increased participation in LGBT+ awareness raising events such as Nottingham Pride and Trans Visibility Day. These were viewed as signs of good practice and progress, the latter being considered an approach which proactively reached into LGBT+ communities to help build and 'maintain that [NHS] presence' (P9).

However, these stories co-existed around patients' gender identity and sexual orientation being assumed by clinicians, service users not being referred to by their pronouns of choice and more generic frustrations related to excessively long waiting lists (see also Government Equalities Office 2018a). This, specifically, serves as a key barrier to timely intervention, exacerbates poor mental health and undermines notions of being responsive: 'we've got one waiting list in particular that's got people that are quite complex, maybe they are unwell, they really need some support and they're waiting forty-two weeks' (P11). Concern was raised specifically around the waiting times for the Nottingham Centre for Transgender Health, commissioned by NHS England (see Nottinghamshire Healthcare NHS Foundation Trust 2020 for current waiting times), the knock-on effect of which was patients being referred into community mental health services in the interim. Here, it was felt that time was being bided and for service users, the 'real problem' (P7) left unmanaged:

> A number of people complained about 'there is no access, there is no support'. Two and a half years to gain therapy is, and they're just sat in limbo, and some of these people are heavily suicidal (P7).

Training

In light of some of this feedback, and recognition that most services were not delivering any mental health support/provision specific to LGBT+ people, most participants felt that their own and other commissioned services could be better delivered in order to meet need. In developing a more responsive service, it was surmised that LGBT+ people may engage with mental health provision earlier and in turn, support timely diagnosis and prevention of long-term mental ill health. Suggestions for improvement frequently focused on the necessity for regular training and education around LGBT+

mental health, the barriers these groups face, the best ways of working with LGBT+ clients and the work happening in Nottingham and Nottinghamshire (and elsewhere) around LGBT+ mental wellbeing:

> You know, things like being aware of the language that you use, looking at what type of work we get into. What's appropriate and what's not appropriate and how to deliver that in a compassionate way (P8).

There was also an appetite to hear from LGBT+ people who had accessed support within their service about '[what] their experience has been of accessing mental health services and what would make their referral, process, treatment better' (P9). Half of those interviewed had not received training related to LGBT+ equalities, health or mental health: 'I don't think we've ever had any specific training at work ever on LGBT communities' (P7), even though most had completed generic equalities training which touched, broadly, on gender identity and sexual orientation. It was argued that training and education would enable staff to understand how to better respond to/treat LGBT+ individuals, develop culturally competent practitioners, instil an ethos of inclusivity and an environment where clients felt able to be open about their sexuality and gender identity. The ability to do so was seen to be a crucial factor in ensuring patients engaged with mental health services, maintained that engagement and felt some degree of autonomy in working towards recovery. Of those practitioners who had received training on LGBT+ equalities, health or mental health, all described it as 'brilliant', 'very good' or 'invaluable'.

LGBT+ champions and staff

Through discussions of ways in which services could be improved, several participants suggested the development/use of LGBT+ 'allies' or 'champions' within community mental health services. In the first instance, it was felt that champions should identify as LGBT+, in recognition that 'lived experience' (P1) attuned individuals to the issues more astutely, as well as having the potential to raise the knowledge-base of the wider workforce by 'breaking down any sort of stigma or barriers' (P9). It was felt that champions should be tasked with leading the agenda, identifying LGBT+ training events and literature to cascade to all staff and play a central role in outreach activities. It was argued that time and resource needed to be made available for such work, in order to avoid tokenism and allow staff to balance the position with other commitments: 'I'd like to be more of a champion but I can't do that and keep up the targets that I individually have too' (P10).

In practice, certain participants questioned whether it would always be easy to recruit the necessary practitioners - people with clinical capabilities, who identified as LGBT+, who may also need to identify as Black, Asian or Minority Ethnic (BAME) - depending upon the service worked within. For these individuals, it was felt that having culturally competent practitioners in champion positions would prove just as effective. This should not negate, however, certain evidence that suggests the sexual orientation and/or gender identity of the practitioner is important to the LGBT person receiving treatment (O'Shaughnessy and Spier 2018).

Indeed, all participants argued that it was crucial to have LGBT+ people working within community mental health services and in most cases, this was happening. It was felt that services need to be representative of the groups they provide care for. However, LGBT+ practitioners were not typically being assigned to work with LGBT+ clients, although in one service this choice was reportedly available. Certain participants questioned whether this ‘matching’ of client to practitioner could be done when working from a certain therapeutic and/or organisational standpoint which prevented too much self-disclosure and in turn, sexual orientation ‘not necessarily being something that’s visible’ (P4).

Symbols of LGBT+-inclusivity

In terms of the display of symbols related to LGBT+-inclusivity, a minority of practitioners were unsure if such motifs were displayed within their service, others stated that they were not and for the remainder, these symbols had been introduced. In the majority, there was positive receptivity to their use, or to the idea of introducing them, in recognition that they promoted inclusivity, would be read as important to the LGBT+ individual viewing the symbol and could serve to facilitate their engagement with the service. However, for a minority, there was concern that placing such motifs within a clinical environment, in the absence of making visible all other protected characteristics, ran the risk of ‘pathologising’ and ‘diagnosing that as a condition’ (P7). Here, there was also recognition that whilst the display of markers of inclusivity could be a low cost, ‘easy win’ for services, their inclusion meant very little if practice did not reflect the principles: ‘I want the inclusivity, I want our services to thrive on that, but at the same time, I don’t want it to be done as a token’ (P1). This echoes the aforementioned concerns of a small number of service users, as well as perspectives which are considered further in the following general practice healthcare professional survey and GP interview analysis.

7. General practice healthcare professional survey and GP interview analysis

Methodology

Between 17th-31st October 2019 an online survey was distributed to all general practitioners, nurse practitioners, nurses, pharmacists and practice managers working within Nottingham City's 50 general practices,[33] using GP TeamNet to do so. The survey explored practitioners' views on the mental health of LGBT[34] patients, referral and signposting into community mental health services and the monitoring of gender identity and sexual orientation. The survey took ten minutes to complete and respondents were not required to have had direct experience with LGBT individuals in order to participate.

Eight respondents completed the survey: three GPs, two practice nurses, one Adult Nurse Practitioner, a respondent who identified their role as 'other' and the eighth who did not specify. The survey data indicated that participants were more likely to be experienced practitioners; one having been practising between 11-15 years, three for 16-20 and four for 21 years or more. Demographic information for survey respondents is outlined in Table 2.[35]

Table 2: Gender identity, age, sexuality and ethnicity of survey respondents

	Male	**Female**		
Gender identity	3	3		
	No	**Prefer not to say**		
Have you identified as transgender or trans?	6	1		
	31-40	**41-50**	**51-60**	**61+**
Age	1	2	3	1
	Heterosexual or straight	**Gay or lesbian**	**Prefer not to say**	
Sexuality	3	3	1	
	White-British	**English**		
Ethnicity	6	1		

In order to explore the issues raised in the survey in further detail, two semi-structured interviews were conducted with Nottingham City-based GPs in December 2019 (lasting an average of 40 minutes). GP TeamNet was again used to recruit participants, with emails that targeted practitioners with a specific interest in mental health or inequalities also being sent. Of the two GPs recruited:

- Both were male and had never identified as trans
- Classified as heterosexual, White British and as not having a disability
- Fell into the age brackets 35-45 and 45-54

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[33] The full survey analysis is available upon email request from Rachel Illingworth: Rachel.illingworth1@nhs.net

[34] The need for brevity in the survey led us to ask only about LGBT identities, as per the original brief for this research. Therefore, we have not used LGBT+ in this chapter as this would not accurately reflect the scope of the data collection.

[35] Throughout, incomplete survey responses mean that totals do not always add up to eight.

- One had been practising for 26 years (nine as a commissioner) and the second for 10 years

The following analysis provides an overview of key findings from the survey, augmented with the interview data. Again, in light of the very small sample size, no significant conclusions can be drawn from this survey alone; however, when triangulated with other evidence from the rapid evidence assessment (Chapter 2) and qualitative data, they strengthen the overall findings and recommendations of the research.

Analysis

Type of mental health support offered by practices

Survey respondents identified a range of ***mental health support and services*** provided by their general practice. Seven reported this to include both ‘referral to specialist mental health services’ and ‘information and advice about mental health and support services’. Six reported their practice to ‘prescribe medication’, four identified ‘signposting to non-NHS support and advice for LGBT people’ and two identified ‘regular clinics held by NHS mental health practitioners not employed by the practice’. This was expanded through the interview data, to include substance misuse clinics, acute mental healthcare slots, a mental health worker and for one participant who was based in a University Health Service, University-led wellbeing and counselling provision.

When asked ***how often*** participants were involved in providing mental healthcare to LGBT people, six survey respondents had ‘encountered some patients that I know to be LGBT’ whist two stated that they ‘regularly encounter’ LGBT people. As one interview participant noted, they provided mental healthcare to LGBT patients ‘on a weekly basis’, whilst for the second, it was ‘about six times a year I would estimate... Although as a practice, I think it’s common’. For this participant, it was surmised that students often chose to go to university in Nottingham because ‘we have got a gender service, which is why I think as a practice, we have quite a large group [of people identifying as trans]’.

LGBT people

Five survey respondents perceived LGBT patients to present with ***specific/additional mental health needs*** compared to heterosexual/straight people, whilst one did not and two remained unsure. Both interview participants recognised that these needs included being ‘more likely to experience self-harm, they have higher risks of suicide and they experience unique challenges and social pressures.’ In addition, ***Specific groups of*** LGBT people were perceived to have unique mental health needs. Namely, all survey participants either ‘strongly agreed’ or ‘agree’ that transgender individuals had distinct needs, whilst no participant strongly agreed that this was the case for lesbian women, gay men or bisexual individuals (see Table 3). For these latter three groups, perceptions around need were relatively similar (and the number of ‘disagree’ and ‘unsure’ responses should be noted, implicating knowledge gaps).

When thinking about the ***intersections*** with other characteristics, survey participants were more likely to ‘strongly agree’ or ‘agree’ (compared to ‘disagree’ or ‘strongly disagree’) that LGBT people aged under 25; those aged over 55; those who had disabilities (physical or sensory) or who were BAME had distinct mental health needs. Again, the numbers within the 'unsure' category are worthy of note.

Table 3: The distinct mental health needs of specific groups of LGBT people

	Strongly agree	**Agree**	**Unsure**	**Disagree**	**Strongly disagree**
Lesbian women have distinct mental health needs	0	2	3	3	0
Gay men have distinct mental health needs	0	2	3	3	0
Bisexual individuals have distinct mental health needs	0	3	2	3	0
Trans individuals have distinct mental health needs	4	4	0	0	0
Younger LGBT people (under 25) have distinct mental health needs	2	3	3	0	0
Older LGBT people (over 55) have distinct mental health needs	1	3	4	0	0
LGBT people with disabilities have distinct mental health needs	2	3	2	1	0
LGBT people who are BAME have distinct mental health needs	0	5	3	0	0

Interview participants spoke specifically about what they described as the 'lower-level' mental health needs observed in lesbian patients related to fertility and parenting and the perceived 'anxiety if they want to become pregnant'. Certain psychological difficulties faced by gay men were also discussed, particularly in relation to their sexual health e.g. genito-urinary problems and colorectal issues, which often caused stress and anxiety. In line with survey respondents, transgender patients were considered to present with a 'lot of complex psychological issues' which also related to their 'drug treatments and physical surgery and things.' The intersections between LGBT identities and other characteristics were flagged, with participants noting the challenges faced by gay Asian men who had children from arranged marriages, for lesbian Muslim women who have been ostracised from their communities, as well as being gay being 'frowned upon' in African-Caribbean groups.

LGBT patients and primary care services

In response to the survey question asking ***whether primary care services could be better delivered*** to address the mental health needs of LGBT people, most participants said 'yes'. Free-text survey responses articulated the need for 'more accessible services', 'creating areas of specialism', more training related to 'inclusivity and hetero-centric language' and use of 'LGBT friendly symbols'. One interviewee argued 'absolutely, yes' and outlined the need for GP practices to have mental health workers who were trained in issues related to sexuality and ethnicity. However, for the second, it was felt that 'I don't see that we should be doing anything different for this cohort. Otherwise, we might be discriminating against other groups'; a perspective which fails to consider that when structural inequalities increase the likelihood of poor mental health for certain groups, different and additional forms of intervention are required.

Half of the survey participants perceived LGBT patients to experience specific ***barriers*** accessing mental health support from their GP surgery. However, half did not; a view which contrasts with evidence (Elliott, Kanouse et al. 2015). Barriers were considered to be a mix of generic issues e.g. difficulties getting an appointment - factors also raised by interview participants - as well as those specific to the individual's sexual orientation or gender identity. In terms of suggestions for encouraging people to ***seek earlier diagnosis and treatment*** from their GP, interviewees recommended increased use of outreach clinics in order to provide an 'informal basis to break down some of the barriers to then attending the practice.' More visibly diverse surgery staff and use of symbols of LGBT-inclusivity were also suggested, on the basis that they 'might break down some of the barriers for people attending if they feel that... for example on reception, they can relate to some of the people there.' Indeed, encouragingly, four survey participants said 'yes', '***openly lesbian, gay, bisexual and/or transgender staff***' were working at their practice (with two being unsure and one saying 'no'). However, a minority of practices were displaying ***symbols of LGBT inclusivity***, even though most survey respondents felt that their surgery 'should'. One interviewee spoke of the need for balance here and that whilst such materials were important, it was 'best' when they were discreet because 'different groups have their own ideas and prejudices.'

In terms of being able to provide information about ***non-NHS social support and advice*** for LGBT patients, most survey participants were 'not very confident' about being able to do this. However, similar to those practitioners based in community mental health services, the ASKLiON directory was flagged by one interviewee as a particularly useful resource for identifying the necessary information.

NHS community mental health services

When asked how confident survey participants felt '***knowing what NHS community mental health services existed in the city***', most were 'very' or 'quite': views also reflected in the interview data. However, this confidence reduced when asked whether those services would be ***LGBT inclusive/friendly.*** Here, four survey participants were 'quite confident' that they would be, whilst three were 'not very confident' and one 'not at all confident'. Whilst interviewees were not particularly sure on this point, there was the assumption that they would be relatively inclusive, based on the fact 'I haven't encountered issues about them being LGBT-unfriendly.'

Four survey participants felt that LGBT individuals experience ***barriers*** accessing support from NHS community mental health services whist three did not – a position which again contrasts with evidence (Government Equalities Office 2018a) and findings from the community mental health service practitioner analysis. Survey participants reported the main barriers to be the consequence of generic factors e.g. long waiting lists and restrictions on session numbers; views shared by interview participants. The length of time taken to access the Nottingham Centre for Transgender Health was raised by both interviewees: 'there's the transgender waiting time barrier… So the resource doesn't fit the need', the impact of which was more people seeking medical intervention within the private sector, an approach which proved complex when care was brought back into the NHS:

> I think a real challenge for us is the waiting time, and then consequently patients go and see private providers who might not make the equivalent assessment to the NHS and

> would [prescribe] medication much quicker and then leave patients in a very difficult position, suggesting that a GP should prescribe when they've maybe not had an especially thorough assessment, which then makes it really difficult for the GP...

When asked whether survey respondents had received ***any positive or negative feedback*** from LGBT patients regarding the NHS community mental health services they had referred patients to, most participants said 'no' whilst one said 'yes, mostly positive' and another said 'yes, a mixture of positive and negative.' One interviewee stated 'lots of negativity about the length of the waiting times', with the Nottingham Centre for Transgender Health again being noted.

LGBT Training

More survey respondents had received ***training on LGBT equality or health needs*** than those who had not (five participants vs. three); with both interviewees having received training. Of those survey respondents who could remember that training (n=4), all reported being 'satisfied' with its quality. One interview participant noted the introduction of a Blue Stream eLearning module[36] on gender equality as potentially useful, which included sections that focused on specific LGBT intersectionalities.

In response to the free-text survey question, 'what training or support would be useful to you to feel better equipped to understand and meet the mental health needs of LGBT patients', suggestions included more training about the 'mental health needs' and 'specific issues experienced by these groups that may not be obvious'. For both interview participants there was a perceived pressure to become literate in medications, and their monitoring, related to transitioning. Hence, more training on this topic and 'the pharmacological effects of the medication' were called for:

> Prescribing is a huge issue, referral and prescribing in, to transgender patients, you know? How you ought to manage that situation, where someone's come back from Thailand having had surgery, with a bagful of drugs, and then they'll want you to prescribe them. What should you do?

NHS sexual orientation monitoring standard

More survey respondents (n=5) were not aware of the recently introduced ***NHS sexual orientation monitoring standard*** than those who were (n=3; see Table 4), with no respondent reporting 'having a good understanding' of that standard - a view reflected in the interview responses. One interviewee believed that their practice would not be implementing the standard on the basis it was not mandatory.

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[36] The Bluestream learning modules are eLearning (online) training courses for healthcare professionals in various settings, including general practices, dental practices, care homes, hospices and urgent care providers. A new eLearning package on care for LGBT patients, including a module on LGBT mental health, was released for GPs in January 2020 (see https://www.rcgp.org.uk/about-us/news/2020/january/rcgp-launches-trailblazing-lgbt-elearning-suite-for-family-doctors.aspx, accessed 3 August 2020).

When survey participants were asked ***'how ready'*** their practice was to start collecting sexual orientation information, three indicated that the data was currently being collected, two stated that their practice was not yet at the stage of planning to collect it and three were unsure if this data was being collected. In terms of whether participants were experiencing, or anticipated experiencing ***challenges*** associated with the collection of this information, one respondent said there 'are no challenges', five perceived inconsistencies amongst staff in its collection to be a problem and four flagged a lack of time to collect the data as a challenge; a view also expressed by an interview participant. Five survey participants felt that staff would feel uncomfortable or embarrassed asking for sexual orientation information, whilst six said that this would also be the case for the patient being asked.

Table 4: NHS sexual orientation (SO) monitoring standard

	Yes, I have a good understanding	**Yes, I have heard of it but do not know much**	**I do not know what this is**
Are you aware of the standard?	0	3	5

	Currently collecting SO data	**Not at the stage of planning to collect SO data**	**Unsure**
Readiness for standard	3	2	3

	No challenges	**Staff inconsistencies**	**Time**	**Staff unease**	**Patient unease**	**Unnecessary**
Current/anticipated challenges	1	5	4	5	6	3

Three respondents felt that it was unnecessary to collect this data, which may again show a lack of appreciation around the greater prevalence of poor mental health and psychological distress experienced by LGBT+ groups (Semlyen, King et al. 2016, Woodhead, Gazard et al. 2016). Arguably, issues around the (consistent) collection of sexual orientation information are ones that will need to be revisited when considering the study's set of final recommendations, with which this report next concludes.

8. Key findings and recommendations

Based on the key findings of this study, this report includes six core recommendations for improving the mental health outcomes of Nottingham's LGBT+ population. These recommendations have been developed in collaboration with the steering group and other key stakeholders:

1. Regular comprehensive training is needed about LGBT+ identities, health needs including mental health and trauma, and cultural competence in creating inclusive services.

2. Patient/service user data about sexual orientation (and where appropriate, gender identity) needs to be systematically collected, recorded, collated and shared.

3. The needs of LGBT+ populations, including barriers to care, must be specifically identified and reflected in the commissioning and delivery of services.

4. Primary care and community mental health services need to more visibly demonstrate that they are LGBT+-inclusive.

5. Access to mental healthcare for LGBT+ people needs to be improved by increasing the visibility of community mental health services, ensuring that referrals are timely and appropriate, and tailored to individual needs.

6. Relationships between a range of services need to be developed and/or strengthened in order to provide more timely, effective and holistic responses to LGBT+ patients/service users with mental health needs.

The table below unpacks these recommendations further and maps them against the key findings of the study, based on a synthesis of all of the data that has been collected and analysed.

Key findings	Recommendations	Recommendation for:
1. All of the data sources indicate considerable gaps in knowledge and awareness regarding LGBT+ people's mental health needs. This includes gaps in knowledge about LGBT+ lives, LGBT+ people's mental health, distinctions that may exist between L, G, B, T+ identities and healthcare needs, and the intersections between them and other aspects of identity. Service users with less widely known-about sexualities or gender identities such as being transgender, pansexual, asexual or non-binary were more likely to report feeling misunderstood by health professionals. Previous research indicates that those who identify as bisexual, queer, pansexual and transgender report disproportionately poorer mental health. Many service users felt that health professionals need more knowledge and understanding of mental health more generally, in addition to greater compassion and sensitivity. Some thought that receptionists, as key gatekeepers, require training too.	**1. Regular comprehensive training is needed about LGBT+ identities, health needs including mental health and trauma, and cultural competence in creating inclusive services.** (i) Training needs to encompass the full spectrum of sexuality and gender identities, including those which are less well understood such as transgender, non-binary, pansexual and asexual identities. (ii) Training needs to embrace intersectionality; that is, to recognise that, like everyone else, LGBT+ people's identities, needs and healthcare experiences are shaped by other aspects of their identity such as their gender, ethnicity, socio-economic status, faith and whether or not they have a disability. (iii) Training should include engagement with lived experience e.g. a training package that has been co-produced with and, where possible, delivered by LGBT+ people. (iv) Training needs to address unconscious bias, values and emotions, and is therefore best delivered face-to-face, or using interactive, discussion-based online platforms. (v) Training needs to be provided to commissioners and health professionals. (vi) Receptionists within primary care and community mental health services also need to participate in training, but a tiered approach is needed to tailor the intensity and depth of the training to different job roles. (vii) Training should be standardised across the Integrated Care System (ICS)[37], and for GPs, it could be embedded within practice learning time. Training and equality and diversity leads across the ICS should be involved in the development and review of this training.	**All system partners working together**

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[37] The NHS Long-Term Plan (2019) set the ambition that every part of the country should be an integrated care system (ICS) by 2021. Nottingham and Nottinghamshire is already operating as an ICS. An ICS brings together all the organisations in the health and care system to work in partnership to meet the needs of their local population and improve health and care.

	(viii) Efforts need to be made to assess the impacts of training on attitudinal and/or behavioural change.	
2. Despite the NHS Sexual Orientation Monitoring Standard having been launched in 2017, awareness and uptake of this amongst NHS health professionals appears to be limited. Amongst both service users and some health professionals, there was confusion about why this data might need to be collected. Whilst some LGBT+ service users expressed concerns about how their sexual orientation data would be used and whether providing it would adversely impact their healthcare, others felt that being asked for this information would facilitate disclosure and provide health professionals with a more holistic understanding of their health needs. Community mental health practitioners and commissioners felt that demographic data about sexual orientation was lacking and that being able to access this data would inform service delivery, review, improvement and commissioning. The collection of gender identity data is not currently mandated. Whilst this is a gap in the data, there is some resistance to monitoring of	**2. Patient/service user data about sexual orientation (and where appropriate, gender identity) needs to be systematically collected, recorded, collated and shared.** (i) Health professionals need to be aware of the reasons for collecting sexual orientation data but also trained about the sensitivities of doing so. (ii) Patients/service users need to understand why it is important to collect sexual orientation data and how their data will be used. (iii) More communication is needed about the NHS Sexual Orientation Monitoring Standard which, whilst not mandatory, promotes best practice in understanding the patient population and individual needs. (iv) Develop a standardised template in F12[38] for GP clinical systems for sexual orientation monitoring, to comply with the NHS England standard. (v) Health professionals and managers need to have access to collated anonymised sexual orientation (and where available, gender identity) monitoring data in order to inform service improvement and better understand who is and who is not accessing their service. Data review needs to be intersectional, rather than examining sexual orientation and/or gender identity in isolation from other protected characteristics. (vi) Commissioners need to have access to and make use of collated, anonymised sexual orientation (and where available, gender identity) monitoring data to feed into the assessment of local needs, identify under-served groups and subsequently inform commissioning decisions. As noted above, data review needs to be intersectional in order to identify specific gaps and needs.	**CCG, Primary Care and Community Mental Health Service Providers**

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[38] The CCG-developed F12 Pathfinder is a series of templates built directly into the primary care clinical systems to aid with navigation, pathfinding, clinical guidance, data entry, and referrals. One key objective for F12 that relates to this recommendation is standardising data input and output.

	gender identity because it can force people to disclose their (trans)gender history.	(vii) Progress towards increasing the collection of sexual orientation data needs to be considered alongside progress and challenges with collecting other equalities monitoring data e.g. in relation to ethnicity.	
3.	Whilst some service users reported helpful and LGBT+-affirming experiences of mental healthcare, service users typically felt that the primary care and community mental health services had limited understanding of their needs as LGBT+ people. This data reinforces the findings from the analysis of existing quantitative research (e.g. Johns 2017, Nottinghamshire Healthwatch and Nottingham Healthwatch, 2017). Commissioners emphasised how important it is to make services inclusive for all, but the needs of each protected characteristic group requires greater differentiation. However, it is key that equality is understood as treating everyone according to their needs, rather than treating everybody the same. Commissioning needs to be evidence-based, but a challenge is that there is very limited evidence about what mental healthcare interventions and delivery models are effective for LGBT+ people.	**3. The needs of LGBT+ populations, including barriers to care, must be specifically identified and reflected in the commissioning and delivery of services.** (i) Ensure that robust equality and quality impact assessments (EQIA) are completed pre-development of service specifications. (ii) Ensure that all protected characteristics are an important part of service specifications. (iii) Commissioners should reach out to LGBT+ community groups and third sector organisations when consulting the public on service development and improvement. (iv) Tender questions should always ask prospective service providers to demonstrate their understandings of the needs of different patient/client groups, including LGBT+ people, and the steps that they will take to address all protected characteristics. In turn, assessors need sufficient knowledge to be able to score these responses accurately. (v) Quality monitoring of all contracts should have improved monitoring of all protected characteristics to check whether services are meeting the needs of all patients/service users, including LGBT+ people. (vi) Data about complaints from LGBT+ patients/service users and/or about non-inclusive behaviour and attitudes should be collected and used to inform service improvement. (vii) Further evidence and understanding is required about causal pathways that might help reduce mental health inequalities for LGBT+ people. Research needs to be inclusive of L, G, B and T+ identities and how these intersect with other aspects of identity e.g. age, ethnicity. (viii) Little is known about appropriate interventions for LGBT+ people and their success. Promising examples include third sector involvement in delivering mental health services, as well as the use of online support and other uses of technologies. These approaches need further exploration to	**CCG** **CCG and system partners, in collaboration with academic researchers**

	assess the potential for replicating such initiatives in the Nottingham City context.	
4. LGBT+ service users rarely report that they can see themselves in the primary care and community mental health services that they use. It was rare for them to report having seen any visible markers of LGBT+ inclusion or information about LGBT+ services in the healthcare services that they have accessed. Many regularly contend with assumptions that they are heterosexual and cisgender, and this is a barrier to having their mental health needs met. The majority of service users said that seeing such markers of LGBT+-inclusivity would put them at ease and increase their confidence that their identities and needs would be understood. However, some service users and practitioners cautioned against displays of LGBT+-inclusivity being tokenistic. One service user and several community mental health practitioners suggested establishing a champions scheme whereby one member of the team would receive additional training about LGBT+ mental health and would work to raise awareness within their healthcare context.	**4. Primary care and community mental health services need to more visibly demonstrate that they are LGBT+-inclusive.** (i) Visible signs and symbols such as rainbow flags and the NHS Rainbow Badge, posters and leaflets promoting LGBT+ social and support services and LGBT+-inclusive mental health services should be used to communicate inclusivity to LGBT+ patients/service users. (ii) However, it is important that signs and symbols of LGBT+ inclusion are not tokenistic, but are reinforced by inclusive practice. (iii) Inclusive practice includes ensuring that verbal and written communication (e.g. patient letters, forms) do not assume that the patient/service user is heterosexual and/or cisgender. (iv) The development of a LGBT+ Champion role could help to communicate information about LGBT+ people's health needs and embed best practice. It is envisaged that the champion would be a health professional who either openly identifies as an LGBT+ person or is a culturally competent ally. This role would need to be adequately resourced, and peer support for champions would be beneficial (for example, a community of interest). In primary care, each Primary Care Network (PCN) could appoint a champion, rather than this operating at practice level.	**Primary Care and Community Mental Health Service Providers**
5. Service users who participated in this research demonstrated awareness and use of only a limited range of the community mental health services that	**5. Access to mental healthcare for LGBT+ people needs to be improved by increasing the visibility of community mental health services, ensuring that referrals are timely and appropriate, and tailoring support to individual needs.**	**CCG and Community Mental Health Service Providers**

are currently commissioned; primarily, IAPT[39] services. This suggests gaps in service users' and health professionals' – especially GPs' – knowledge. Indeed, community mental health practitioners spoke about the changing climate of providers making it difficult to know what provision existed, as well as promotion of one's service often being sidelined for client-facing activity. Several service users felt that being signposted to IAPT services was inappropriate for their needs, especially in relation to trauma, personality disorders and psychosis. Similarly, practitioners in community mental health services spoke about the difficulties of needing to work with service users whose needs were too complex for their service, and who need to receive more intensive or specialist mental healthcare.	(i) Referral criteria for services across the patient pathway need to be reviewed to reduce inappropriate referrals. (ii) Access to services, service capacity and gaps in service provision need to be reviewed in order to increase timely intervention and reduce inequalities. (iii) Innovations in online mental healthcare delivery (especially to complement face-to-face delivery) need to be considered to increase access, especially in light of Covid-19 social distancing measures. However, it should be recognised that remote delivery will not meet all service users' needs. (iii) There is a need for more trauma-informed approaches to therapy to reflect the impact of trauma on LGBT+ people, as well as the need for a more tailored approach to therapy based on need e.g. greater flexibility in the number of sessions offered for talking therapies. (iv) Active promotion of community mental health services is needed amongst LGBT+ people and GPs to improve access and signposting. (v) Services that are not already doing so should ensure that they are listed on AskLion (www.asklion.co.uk) and any barriers to doing so understood. (vi) Community mental health service contracts need to not only cover the costs of treatment, but also be resourced to conduct outreach/ profile-raising work.	
6. Echoing previous research, the majority of service users who participated in the research would prefer to receive LGBT+-specific services and/or to access existing community mental health services in an LGBT+-inclusive environment. Importantly, however, this would not be a safe or comfortable option for all service users, whilst a minority were concerned that this would be segregating.	**6. Relationships between a range of services need to be developed and/or strengthened in order to provide more timely, effective and holistic responses to LGBT+ patients/service users with mental health needs.** (i) Links with social prescribing leads could be made in order to improve access to community mental health services and also raise awareness of LGBT+ social and support groups. This is particularly important to maximise opportunities for early intervention and prevention, especially for LGBT+ patients/service users who are questioning their sexuality and/or gender identity (especially, but not exclusively, young people) and those who are isolated from other LGBT+ people.	**CCG and Community Mental Health Service Providers**

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[39] Improving Access to Psychological Therapies; i.e. talking therapies services.

From the perspective of early intervention and social prescribing, LGBT+ people who are struggling with social isolation and a lack of support related to their sexuality and/or gender identity would benefit from being signposted to LGBT+ support groups and social activities. Stronger relationships between health commissioners, health services and LGBT+ groups and organisations would lead to improved sharing of information and expertise.	(ii) Community mental health services, especially talking therapies services, should explore opportunities for running sessions within inclusive spaces such as the Women's Centre and Nottingham Wellbeing Hub. Nottinghamshire LGBT+ Network is another potential key partner, but they currently do not have meeting space. (iii) Using such locations could facilitate referrals and provide a safe space. Therapists working in these spaces should be openly LGBT+ or culturally competent allies. (iv) It should be recognised that not all LGBT+ service users would feel comfortable accessing a space that was badged as an LGBT+ space. Therefore, maintaining a choice of settings for therapy – as is currently the case – is essential.	

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