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# Health needs assessment of lesbian, gay, bisexual, transgender and non- binary people

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## QUALITATIVE RESEARCH FINDINGS REPORT (FINAL DRAFT)

Prepared for:

NHS Greater Glasgow & Clyde and NHS Lothian

January 2020



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## Foreword

We are delighted to present the first two reports of our Health Needs Assessment of people who are lesbian, gay, bisexual, transgender, or non-binary (LGBT+).

This needs assessment has been undertaken by both of our health boards working in partnership, to more fully describe the health and wellbeing of LGBT+ people living in Greater Glasgow and Clyde and Lothian. A health needs assessment is a systematic method of identifying the unmet **health** and **healthcare needs** of a population, and this will help us to make sure that both our public health support and our health services are more fully inclusive and accessible.

The health needs assessment builds on previous health and wellbeing surveys conducted with our adult population in NHS Greater Glasgow and Clyde. These surveys have been valuable in helping to track changes in the health of the population over time. However, such broad population surveys have not been able to reach sufficient numbers of people with protected characteristics as outlined within the Equality Act.

Following success of conducting a separate survey aimed at reaching people from a Black and Minority Ethnic background in 2017, we have designed this health needs assessment to describe the specific health and wellbeing of the LGBT+ population.

Our first two reports cover our review of the published research evidence from the last 10 years which informed our second stage, the qualitative engagement with LGBT+ people, and staff that work primarily with LGBT+ people in both health boards.

This will inform the next stage which is to conduct a full survey of LGBT+ people early in 2020 with a view to bringing the three stages of work together in a final report that summer.

In Scotland, a reform of public health is taking place making this is an opportune time to conduct our health needs assessment... We have agreed national priorities for public health and have committed to do more to address the widening inequalities in health.

In doing so, we need to ensure we recognise the specific public health issues experienced by people with protected characteristics including LGBT+ people.

Societal, environmental and biological factors influence having good health and resilience. LGBT+ people experience all the same determinants of good and poor health and the same inequalities as the whole population. However, as these reports makes clear, LGBT+ people experience a wide range of additional factors which compound and exacerbate these pre-existing determinants and lead to profoundly different outcomes.

Our approach has been to use this stage of the needs assessment to understand more qualitatively what LGBT+ people experience in relation to the previous broad population health and wellbeing surveys and in the literature review.

Inevitably this approach means what LGBT+ people describe in the report is their experience of where health or health determinants have been poor or adverse for them. We are mindful that it perhaps does this at the expense of a wider context where many aspects of life are positive and improving for LGBT+ people.

However these narratives which describe poorer health on wide range of issues, especially mental health, were the issues which LGBT+ people raised. Even at this interim stage of the needs assessment, it is evident there is much work to do to improve our public health systems reach to LGBT+ people and to ensure it is responsive to LGBT+ people's needs, and to work harder on ensuring our health and care services are fully inclusive.

Our next stage is to develop our partnership working with other Scottish health boards and third sector organisations to develop the survey to measure quantitatively the outcomes for LGBT+ people to enable direct comparison with the mainstream populations. We will run this in the spring of 2020 and we look forward to sharing the final results in the summer.

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## Abbreviations

ABA	Applied Behaviour Analysis
ABI	Alcohol Brief Intervention
ADHD	Attention Deficit and Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
BPD	Borderline Personality Disorder
DID	Dissociative Identity Disorder
GHB	Gamma-hydroxybutyrate (synthetic drug, known as a 'date-rape' drug)
GBL	Gamma-butyrolactone (synthetic drug similar to GHB- together GBH and GBL are often referred to as 'G')
GGC	Greater Glasgow & Clyde
GIC	Gender Identity Clinic
GRS	Gender Reassignment Surgery
LGB	Lesbian, gay and bisexual
LGBT	Lesbian, gay, bisexual and transgender
LGBTQ	Lesbian, gay, bisexual and queer
LGBT+	Lesbian, gay, bisexual, transgender and non-binary and all other non-heterosexual and non-cis identities
MDMA	Methylenedioxymethamphetamine ('Ecstasy')
MSM	Men who have sex with men
NHSGGC	NHS Greater Glasgow & Clyde
PrEP	Pre-exposure prophylaxis
SHRE	Sexual Health and Relationship Education
STI	Sexually Transmitted Infection
WSW	Women who have sex with women

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# 1. Introduction

## Background

The Scottish Government has made a commitment to 'making Scotland a better, healthier place for everyone' and to tackle health inequalities. Health and wellbeing varies significantly according to many factors. In Scotland, those living in poverty and areas of deprivation are consistently shown to have poorer health outcomes for a range of indicators. Health inequalities are further compounded by differing experiences based on a person's identity including those characteristics protected under the Equality Act (2010). This includes those who identify as lesbian, gay, bisexual, those who are transgender and those who have a non-binary gender identity (LGBT+).

## The Research

NHS Greater Glasgow & Clyde (NHSGGC) and NHS Lothian recognise that there are gaps in knowledge about the health and wellbeing of LGBT+ groups. In order to better inform approaches to public health for LGBT+ people, they commissioned a comprehensive health needs assessment of LGBT+ people in both health board areas, differentiated for each of seven groups:

- Lesbian and gay women
- Gay men
- Bisexual women
- Bisexual men
- Trans women
- Trans men
- Non-binary identifying people

The health needs assessment is being conducted in three stages:

1. A literature review
2. Qualitative engagement with LGBT+ people and with staff directly involved in providing services for LGBT+ people
3. Health and wellbeing survey of LGBT+ people

Traci Leven Research was commissioned to conduct the first two stages of the work. The survey will be commissioned separately. A separate report sets out the findings of the first stage (literature review). This report presents the findings of the qualitative engagement.

## Method

A description of the research method is provided in Appendix A. In summary,

- The research was informed by a literature review conducted in March-April 2019 and input from representatives of various statutory and third sector organisations who attended engagement events in May 2019.
- Interviews were conducted with staff and volunteers at 18 organisations/services with a focus on LGBT+ people or providing services of particular need to LGBT+ people. Each of these is listed in Appendix A.
- Interviews and focus groups were conducted with 175 LGBT+ people in Lothian and GGC. The breakdown by identity is shown below:

	<b>Focus group participants (across groups) 18</b>	<b>Interviews</b>	<b>Total</b>
Lesbian/gay women	23	7	30
Gay men	33	14	47
Bisexual women	17	2	19
Bisexual men	8	4	12
Trans women	9	8	17
Trans masculine	10	8	18
Non-binary	23	6	29
Others (asexual, queer)	1	2	3
<b>Total</b>	<b>124</b>	<b>51</b>	<b>175</b>

The age breakdown is shown below:

<b>Age group</b>	
16-21	27
22-29	56
30-39	36
40-49	33
50-59	17
60+	6
<b>Total</b>	<b>175</b>

## This Report

### Authorship

This report has been prepared by Traci Leven who was the lead researcher, with input from Luci Jones who conducted some of the interviews and group discussions.

### Categorisation of Participants

In categorising the 175 LGBT+ people, participants are only counted once, with gender identity taking precedence over sexual identity for the purposes of classification. A majority of trans men, trans women and non-binary people who engaged also identified as gay, lesbian, bisexual or pansexual. When they engaged with the research, most of the discussions related more to their gender identity than their sexual orientation.

In categorising participants and attributing quotes in the report, 'non-binary' has been used as an umbrella category for those who identified as:

- Non-binary
- Agender
- Gender-fluid
- Genderflux
- Genderqueer

The term 'trans masculine' has been used for those who identified as trans masculine or trans men.

The term 'gay/lesbian woman' has been used for any women who identified as either gay or lesbian.

### **Service Providers**

The interviews with service providers gave an overview of many of the issues affecting LGBT+ people. In reporting findings, the emphasis is on the experiences directly recounted by the LGBT+ people, and these largely conformed to the views related by service providers. Information provided by service providers is only provided where they offer additional information or issues not raised directly by the LGBT+ people themselves.

## 2. Social Health

### Being Out

There was much variation in the degree to which LGBT+ people were out about their identity. Those who engaged with the research ranged from those who were out to everyone in all spheres of their life to those who had not told any other person about their identity, but a majority fell between these two extremes, with many not out in all situations. Reasons for not being (fully) out included:

- Fear of rejection
- Faith and cultural influences
- Experience of discrimination
- HIV stigma
- Shame/internalised homophobia
- Exposure to negative opinions online/in other media
- Exposure to 'low level' homophobic attitudes (e.g. in the workplace)
- Not seen as relevant/important

A common theme across LGBT+ groups was that of 'passing privilege'<sup>1</sup>, recognising that those who were generally read by strangers as cisgender and/or straight were able to navigate life without fear of encountering negative attitudes or hostile reactions from strangers. The downside was people making incorrect assumptions about them, and continually having to choose whether to come out. Trans men and women tended to welcome their ability to be read as cisgender, but lesbian, gay and bisexual men and women who were 'straight passing' could be frustrated at heteronormative assumptions made about them in their day-to-day lives.

*"My identity is not outwardly obvious from my appearance –people just assume I'm straight and so being straight-passing has an advantage of not getting harassment or anything. But the advantage of being outwardly queer is you don't necessarily have to have that conversation all the time. When I was younger I would often wear something that had a rainbow on it just trying to signify. But people do assume I'm straight so I do actually have to come out to them – so it's when to come out. Just coming out and saying 'I'm gay by the way' is a bit weird if you're not in a relationship. I used to talk about my partner and say 'she' and that would pave the way for coming out. Now I don't have a partner so it's a bit more difficult when people start talking about relationships and stuff".*

Gay/lesbian woman

*"I don't go out of my way to tell people I'm trans, but by most people's standards I'm not passing (as a woman), so when I introduce myself as (female name) people get the gist, there's no need to say more about it... it's not really possible to be an in-the-closet trans person".*

Trans woman

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<sup>1</sup> 'Passing privilege' was a term used by several participants

Some bisexual men and women felt that it was important that their identity as a bisexual person was known and understood, but felt that they often had to continually come out to people as assumptions were usually made about their sexuality based on their current partner.

*"I'm currently dating a woman, and I feel like if I want to be clear about who I am, I have to try and shoehorn into conversations that I've also dated men. It's awkward and challenging".*

Bisexual woman

Bisexual men and women who had an opposite sex partner were very aware that they were nearly always perceived as a 'straight couple' and for some, it was important that they found ways to assert their identity as a bisexual person. This could include, for example, having a bi pride flag on their desk at work or becoming an active part of the LGBT+ community - but there was clear frustration and fatigue caused by having to continually come out and correct assumptions made about their identity. However, others welcomed the 'passing privilege' their relationship afforded them which meant they could introduce their partner to their family etc without ever referencing their bisexual identity. There were also bisexual men and women who tended not to label themselves as 'bi' but were more comfortable defining themselves based on the relationship they were in at the time.

Across all LGBT+ groups, there were common accounts of how moving to a new place could be a catalyst for coming out, or coming out more fully. Many talked about moving away from home when going to college/university and feeling this was a good point at which to be out about their sexual identity or begin living as their preferred gender. Some felt more able to come out to their family at the point of leaving the family home or shortly after moving out. Others were out in their new city, but were not out to family or friends from the town or village they came from. For some, moving to a city for the first time gave them the opportunity to find friends and social groups with LGBT+ identities, which gave them the confidence to be out about their own identity. Even where trans and non-binary people were out about their identity in their home town, it was liberating for them to move somewhere new where people had not known them in their prior identity:

*"I think coming out and being able to be myself, authentically, has been really good for my mental health. And it was nice to be able to come to uni and start afresh where nobody had any preconceptions about who I was when I was seven or whatever. At home there was this painstaking process of coming out and adjusting to all the differences in the relationships I had had, and everyone else adjusting to my new name and pronouns and stuff. There was no malice in it, but it was an extended process and awkward. Coming (to Edinburgh) and being able to introduce myself as I am now, was really good. And also seek out a social space for myself with most people around me who are also LGBT and choosing who I live with and stuff".*

Trans masculine

Nearly all LGBT+ people had worries and concerns to some degree about coming out to family and friends. In most cases, coming out had been a largely positive experience and family and friends had been supportive and affirming. However, there were also many who had experienced hostile reactions or disappointment to their coming out. It was apparent that

younger LGBT+ people were more likely to have had a positive experience coming out to their families than those who had come out in previous decades.

For those who transitioned gender, coming out was not optional, but a necessity as they changed their appearance, name and gender identity. Many spoke not only of the difficulty in telling people about their gender identity, but also making the steps to first present in their preferred gender.

Where people said they were not out in all areas of their life, the workplace was one of the most common places where they were closeted. Some were concerned about the reactions of colleagues or employers to their LGBT+ identity if they came out. The WOW (Women Out at Work) Network was established in response to evidence that LGBT women were much less likely than LGBT men to be out at work. The groups and interviews also confirmed that many women found it difficult to be out at work, often afraid of the reaction of others in their workplace or how it might affect their career. However, it was also apparent that men found it difficult to be out at work, particularly in some roles or industries which have historically had a 'macho' culture. The police was an example – one gay man had previously worked in the police and not felt able to be out, another spoke of a previous partner who worked for the police and felt that his prospects for promotion would be affected if he had been out. Police Scotland is making great efforts to be LGBT inclusive with their LGBT+ staff association and LGBT allies, attending Pride, and ensuring LGBT+ inclusive policies, but the Police Scotland staff who were interviewed acknowledged that among their officers (around 70% of whom are men), it may be men who find it harder to be out. The military is another example of a 'macho' culture where men in particular may find it more difficult being out. One participant had been in the army at the time when it was illegal for gay men to serve and it was therefore impossible to be out; another had served in the army once it was legal but did not feel comfortable being out. The construction industry was one which was mentioned by a number of LGBT+ people as having a reputation for not being LGBT+ inclusive, and in the NHS it was felt that much had been done to make it an inclusive environment, but there were some areas of work such as surgery where there was still a 'macho' culture, not conducive to gay men coming out.

While many felt that it was not necessary or relevant in any way for their LGBT+ identity to be known at work, it was also acknowledged that it was harmful to wellbeing to not be out in the workplace, hiding an aspect of themselves and not fully engaging in chat about their lives outside of work.

*"I think it's important for a good working environment that we know each other. It's important that people can talk about what they were doing at the weekend, if they've been on holiday with their partners or their family or so on to the same extent as everyone else. When I started in my working life and I was junior I didn't feel able to talk about what was going on at home at all, so you end up being a bit non-committal about what you've been up to at the weekend and people think you're standoffish and it's difficult to engage with people. It's this thing about bringing your whole self to work- to me, that's really important. Hiding part of your life away is quite damaging".*

Gay/lesbian woman

Those whose work involved interaction with the public also had to consider whether or how being out may affect their interactions with the public. Again, police officers were felt to be

at risk of homophobic abuse from the public. A dentist felt that when he was practicing in the 1980s, he would not have had any patients if he had been open about being gay due to the stigma of HIV at the time.

Some of those who were fully out about their identity asserted that they felt it was important to be visibly out in order to encourage and affirm others who were questioning their identity and those who lacked confidence or were concerned about being out.

## Loneliness and Isolation

The literature review highlighted many sources of evidence pointing to LGBT+ people being much more likely than others to feel isolated and/or lonely.

For many, the period prior to coming out was a time where feelings of isolation were acute where they did not feel that they fitted in with the people around them and they had not made social connections with other LGBT+ people. Those who were not out or not fully out often felt that leading a 'double life' or denying their identity to those around them was an isolating experience.

A very common theme across group discussions and interviews was the lack of LGBT+ friendly spaces for socialising. Many felt that it was vital to link with other LGBT+ people in social settings, but they lamented the lack of social spaces to do this, particularly anywhere that did not focus on alcohol. Gay bars were felt to cater for only a small proportion of LGBT+ people (largely gay men, but even then, only a subset of gay men), and in Edinburgh even gay bars appeared to be either closing or being 'taken over by hen nights'. The lack of opportunity to engage with other LGBT+ people contributed to feelings of isolation for some.

Those in rural areas or small towns were more likely to feel isolated and lonely (see Chapter 7).

A number of participants pointed to the circular relationship between isolation and depression, with isolation being both a cause and effect of depression.

Some expressed the view that in modern life there is an over-reliance on apps/social media to meet people and to communicate, and this has led to fewer opportunities for real-life interaction, leading to feelings of isolation and loneliness.

Many of those who participated had autistic traits (see Chapter 3) and they could feel particularly isolated because they found it more difficult to meet people or socialise and found LGBT+ social spaces less accessible.

Disabled people were also particularly isolated (see Chapter 7).

## Discrimination and Negative Attitudes

### **General Exposure to Discriminatory and Negative Attitudes**

A common theme in the interviews and group discussions was the change in recent years to society in general becoming more accepting of LGBT+ people, particularly people with gay and lesbian identities. This was in part attributed to equality legislation. Societal attitudes towards trans, non-binary and bisexual people were felt not to have become as accepting to the same degree. Indeed, many felt that attitudes towards trans people, particularly trans women, had taken a 'backward step' in recent times, largely attributed to a very negative narrative around trans identities widely reported in the media and particularly social media,

often in reference to the campaign around the Gender Reform Act. Many felt that inflammatory media reporting had a measurable impact on how trans and non-binary people were treated in public:

*"The massive media attack on the trans community has had a drip-down effect on the general public. They believe it – the public are becoming visibly more hostile. I have had people sit at my table (on a train), realise I'm trans, and then get up and leave. That's a new thing, and it's totally down to the toxic reporting in the media".*

Non-binary

For non-binary people in particular, it was felt that there was a lack of understanding about non-binary gender identities and constantly battled against ignorance and insensitivities. Often they felt they had to either accept being misunderstood and mis-pronounced etc or become perpetual educators explaining how they identify.

Bisexual men and women often faced biphobic attitudes and/or lack of understanding about bisexual identities. They faced common stereotyping of bisexual people being seen as 'greedy' or promiscuous. 'Bi-erasure' was often referred to, with common perceptions of bisexuality being invalidated in society.

For gay and lesbian people, although there was recognition that societal attitudes were very largely accepting and non-discriminatory, all had experience of being exposed to homophobic attitudes and conversations in a wide variety of settings. Those who 'appeared straight' or who were not out could more often be included in, or exposed to more of these homophobic types of conversations in workplaces, places of study, public spaces, etc. Most gay and lesbian people had encountered hostile or negative reactions to their own identity in some contexts (e.g. from a taxi driver on being directed to a gay club), but many were keen to point out that such encounters were rare and were the exception rather than the rule.

### **Workplace Discrimination**

Among those who were out at work, most felt that their workplaces and employers were supportive and their LGBT+ identity was rarely an issue of concern. Most trans men and women felt that their employers had been supportive and had handled their transition appropriately in terms of sharing information with colleagues and associates, supporting medical transitions and associated needs, and dealing with the administrative requirements around name and gender changes. Most gay, lesbian and bisexual people who were out at work also felt that there were no negative consequences of being out. However, many participants had at least one story of a time they felt they had been discriminated against by an employer because of their LGBT+ identity, often to the point of losing their job. Examples of incidents which had occurred after equality legislation was introduced in 2010 included:

*"I was doing my probationary year as a primary teacher and I kind of kept (my gay identity) to myself because I didn't know the people. But then me and my partner got engaged so I was wearing an engagement ring and I was getting lots of questions – so eventually I came out to the staff. Up until that point everything had been going really well, I was signed off and the headteacher was really pleased with me and she gave me a really good reference. Then she found out (about my identity) and suddenly it completely changed and apparently I wasn't doing well and not meeting*



*the standards, and she wanted to cancel my registration and a whole load of other things. The only thing that had changed was she knew I was gay; I wasn't doing anything different. I ended up mentally unwell and I couldn't finish my probationary year".*

Gay/lesbian woman

*"My work were happy for me to work flexibly when my best friend was dying and I was providing end-of-life support. I managed a team at the time – they seemed alright with it. After my friend died, I took a couple of weeks off and I was back at work, but still a bit upset. People were a bit strange for a while. About three months after, my manager asked to speak to me and said my team were uncomfortable because I was 'upset on average once a month'. He said, 'if I'm honest, I think they feel it's inappropriate that you're this upset about another woman'. They all knew I was gay and I didn't think this was a problem, but apparently I had 'kept that out of work until then'. I was incredulous and asked if there was anything in my work I wasn't doing well – he said 'there's absolutely nothing wrong with what you're doing, it's just who you are'. Which is quite a bold statement! (she asked for an investigation and subsequently took paid leave while this happened, during which time she was offered a job by another employer and her current employer said she should take it. During her leave she was not contacted by her employer which she felt isolating).*

Gay/lesbian woman

*"I was made redundant. I had just won (the firm) a lot of work, and I wondered why I'd been targeted when I'd been working so hard. My scores did not add up, and I had to take them to a tribunal – they were forced by the judge at the tribunal to hand over the actual score sheets and they showed that one guy had targeted me. I discovered that the boss really didn't like me and he'd said to the person who had brought me into the firm that if he ever brought another gay person into the office he would be fired. I thought I'd had prospects at this place, but it turned out this guy had an issue with me all along".*

Gay man

Despite experiences such as these above, most LGBT+ people felt that legislation regarding employment equalities was adequate and ensured that LGBT+ people should not be at risk of losing their job or failing to obtain a job or a promotion based on their LGBT+ identity. However, it was felt that it was much more difficult to legislate against, or otherwise prevent, 'low-level' discrimination among colleagues which were encountered by some – e.g. not being included in conversations about personal lives or not being invited to social events. Negative attitudes expressed about LGBT+ people in casual conversations in workplaces were often a reason for people not feeling safe or comfortable being out in the workplace.

*"I'm very conscious that in my office I'm the only one (gay man), so I don't know how other people will perceive that. There have been conversations and jokes that make me worry that I might be excluded if I came out in my workplace".*

Gay man

*"I'm out at work, and nobody makes a particular issue of it, but I do feel a bit of an outsider – the chat's all about boyfriends and families and – ok, I can't really relate to that, but there's not really any attempt to draw me into the general office chat".*

Gay/lesbian woman

## Hate Crimes

Many LGBT+ people who participated in the research recounted incidents where they had been threatened or intimidated because of their identity – but they rarely viewed incidents such as being shouted at in the street or name calling as 'hate crime', and did not report them to the police. Some mentioned recognising some incidents as hate crime only some months or years after the event.

There were, however, some who had experienced incidents which were very serious and unambiguously hate crimes including serious assaults which had resulted in hospitalisation. There were also incidents of being followed and threatened which had been frightening. Most of these incidents had been perpetrated by strangers, often targeting people leaving a gay club or being visibly with a same-sex partner in public (e.g. holding hands). There were also some instances of people being set-up by arranging to meet someone on a gay dating app who had the intention of assaulting them. Not all incidents of serious hate crimes had been reported to the police, but when they were, victims were usually satisfied that the police had taken the incident seriously and dealt with it appropriately. Two trans women who had been the victim of intimidating behaviour both said that they had reported the incident to the police, not because they expected the perpetrator to be caught, but because they felt it was important that transphobic crimes were recorded and counted.

## Feeling Safe or Unsafe

Most LGBT+ people said that they largely felt safe. However, most also acknowledged that there were certain situations in which they would avoid being visibly LGBT+ due to safety concerns – e.g. in certain areas or late at night.

Although it was felt that homophobic or transphobic abuse and assault were rare, some had a fear of this based on reports in the media, knowledge of people who had been attacked, and past experience. The perception was that homophobic abuse and assault had been more common in previous decades, but past experience could colour the degree to which people felt safe nowadays:

*"My partner's a bit younger than me and she's quite happy walking down the street holding hands. I have this fear just because of my past experience (of homophobic assault and abuse in the 1990s) that people are looking, people are judging, you're going to start getting abuse in the street or people are going to punch you because you're holding hands – whereas she doesn't see it because she's never been in a situation where that's happened to her because of her sexuality. It's horrible – I just want to feel comfortable doing that, but I see people coming and I draw away just in case something negative happens – I know that's from my past experience".*

Gay/lesbian woman

Exposure to negative opinions and stories in the media, particularly social media had an effect particularly on how safe trans women felt. Many trans women spoke about how media reports affected their anxiety and feelings of safety:

*"The online stuff has an effect in the real world. For example, I was invited to a conference on promoting equality for women in (my industry). I didn't know how 200 women would feel with a trans woman turning up. You think is this the night I'm going to get yelled at? It's because I'm reading online about the abuse other people are being exposed to".*

Trans woman

## Domestic Abuse and Sexual Violence

Several LGBT+ participants described a history of abusive and violent relationships and sexual encounters.

Some groups felt that they were particularly vulnerable to falling prey to abusive and unhealthy relationships and these included:

- **Disabled people** who felt physically vulnerable, often suffered from low self-esteem and felt that their pool of potential partners was very limited and therefore they were more likely to settle for relationships that were unhealthy. A lack of sexual health and relationship education for disabled people was also felt to leave disabled people ill-equipped to make appropriate choices with regards to relationships (see Chapter 7).

*"For years, virtually every relationship I had, had some element of abusive power in it – physical abuse or sexual abuse, because I didn't have an understanding of what a good relationship was. There was no reflection of how to be in a relationship as a disabled person. There was also this thing of 'at least I've got someone – someone is willing to be with me'. You never think, 'is this actually good?'"*

Disabled bisexual man

- **Autistic people** who were less equipped to recognise healthy or unhealthy attachments or relationships and less likely to have awareness around issues of consent. Some felt that that ABA (Applied Behaviour Analysis) left them particularly vulnerable:

*"ABA is basically compliance training teaching autistic people to act like 'normal' people, but what you are really doing is training them to submit to authority without thinking, so they'll basically do everything they are told. It's putting (autistic people) at risk from both caregivers and potential future partners".*

Bisexual woman

*"I had elements of ABA when I was a kid where I would have to do this thing otherwise they would do that thing. When my abusive partner did the same thing, I never twigged. It took me years to get it. I didn't really understand consent".*

Bisexual man

- **Bisexual women** often felt they were vulnerable to abusive or unhealthy relationships because:
  - Bisexual women were often fetishized by men, and a common assumption was they would be 'up for a threesome' with a woman, and could be persuaded to engage in sexual behaviour they were not comfortable with
  - Partners made assumptions that that their bisexuality meant they would be accepting/tolerant of non-monogamous relationships
  - Partners made assumptions that their bisexuality meant they would be unfaithful with someone of the opposite gender, meaning partners could become unreasonably jealous or controlling
  - Partners denied their bisexual identity, insisting they were either lesbian or straight based on the partner's gender/identity
  - Bisexual women may be more willing to stay in an abusive or unhealthy relationship because they found it more difficult to find partners (the perception was straight men generally preferred to be with straight women; lesbian women generally preferred to be with lesbian women).
- **Trans women** who, similar to bisexual women also felt that their 'potential pool' of partners was smaller and also that they were frequently fetishized for being trans.

Across LGBT+ identities, some felt they were ill-prepared to make good choices regarding relationships because they had not dated at a young age:

*"There's definitely developmental stages that I missed – the whole dating people in school, having relationships which everyone does by trial and error, you just miss that, you don't get to do it. So you're doing that at an older age in the context of gay bars where alcohol and drugs are in the picture...and dating apps and porn are teaching unhealthy lessons about how sex looks and how relationships are".*

Gay man

Victims of abuse within same-sex relationships pointed to the lack of public awareness relating to same-sex abuse, meaning they sometimes failed to identify the behaviour as abusive at first. Moreover, service provision to support victims of sexual violence or domestic abuse was considered lacking for any situations other than male perpetrators against female victims.

*"I was in a relationship that was definitely abusive, but I didn't recognise it as that at the time. I knew the relationship was bad, but didn't realise it was domestic abuse and I could have got them charged. We don't get told about it, or we get told it can't be domestic abuse if it's two females".*

Gay/lesbian woman

*"I was sexually assaulted by a woman. I spoke to (a third sector organisation supporting victims of sexual violence) and it was just not geared up for that at all – all the literature and their website and everything was about men perpetrating against woman. Being the victim of sexual assault is traumatic and isolating, and trying to get help was even more isolating".*

Bisexual woman

*"My last relationship was toxic. Being a male, nobody really had an understanding of same-sex domestic abuse. There is nothing out there – absolutely nothing. When the relationship broke down, I had to have the police involved and I was explaining things to the police officer and he said, 'that's an abusive relationship'. I had never considered myself a victim of domestic abuse, the term didn't sit well with me, but that's what it was. But there was not a single domestic abuse service – nothing I could engage with to help me come to terms with and understand what I'd been through".*

Gay man

There was also a feeling that generally people tended to view same-sex abusive behaviour as less serious than men against women:

*"I had a stalker after going on a couple of dates with a woman. Everyone thought it was hilarious, but it felt like it wasn't taken as seriously as it would if it was a man. Woman on woman violence and sexual violence is a thing".*

Bisexual woman

Some also had been sexually assaulted in their youth or prior to coming out. In these cases, there were complex issues around questioning whether their past abuse had affected their sexuality, and it took time to reconcile that these were unrelated (although at least one person alluded to a sense that his self-denial of his gay identity made him more vulnerable to abuse). This was recognised by a third sector service provider:

*"Some of the LGBT people I've worked with have a lot of internal tension around does the sexual abuse that happened to me, is this why I feel like this, is this why I'm gay. Obviously it isn't, but it can be a real process reconciling that. So it increases shame around sexual orientation. They need to reconcile that so that they can be positive about their sexual identity and recover from their experience of trauma at the same time".*

Service provider

## Marriage and Relationships Prior to Coming Out

Several people had experience of getting married to an opposite gender partner prior to coming out as gay. This was often done to appease family, social or cultural pressures and/or to try to suppress their gay identity. It was recognised, only in retrospect, the damage this did to both partners. In one case, a gay man's former wife had committed suicide and her family had blamed him.

Several of the trans women who participated in the research were married to women prior to coming out. In most cases, relationships survived their transition, but in some cases transitioning lead to the breakdown of the relationship.

Gay and bisexual men identified a large sector of men who are married to women but seek sex with men (but do not necessarily identify as bi or gay). It was recognised that these men are less likely to engage with sexual health services or health promotion messages aimed at

the gay community/MSM. It was also recognised that these men have particular mental health risks associated with the stress of their 'double life', that they were vulnerable to abuse or blackmail and they risked severe trauma if outed. Many gay and bisexual men said that they had known men like this who had committed suicide.

## Support from Family, Friends and Others

There was much variation in the extent to which LGBT+ people felt supported by friends, family and others. Some had total estrangement due to families rejecting them or relationships breaking down after coming out; others felt loved, supported and accepted by their families. Most had supportive, positive relationships with friends although many talked about acquiring a new set of friends after coming out. Most indicated that their friends and social groups tended to also have LGBT+ identities. For some, this was very deliberate; for others their friend groups had organically developed and it seemed natural they would gravitate towards people with a similar outlook or similar identities.

## Parenting

The experiences of those LGBT+ people who were parents were largely positive. Many had had concerns or anxieties about becoming parents (either through fertility/pregnancy, adoption or kinship care) with fears that they would face discrimination. However, concerns largely proved unfounded. None of the parents who engaged with the research had experienced any discrimination from schools or nurseries, all of which were felt to be welcoming and inclusive for LGBT+ parents and their children. Children were generally felt to be largely accepting and unconcerned when they encountered children who had same sex parents or trans parents.

Some trans women had transitioned after being a father to children. Generally, younger children were accepting of the transition but relationships could be more difficult with older or grown up children.

## Role of the LGBT+ Community

Many LGBT+ people stressed the importance of being part of the LGBT+ community on their wellbeing. Being part of this community provided them with support, validation and a sense of belonging.

Although there was particular complaint among people of all LGBT+ identities about a lack of social spaces for LGBT+ people which did not focus on alcohol, there were some examples of interest groups including sports clubs, choirs etc for people with LGBT+ identities and these were enjoyed and appreciated by those who participated in them. Many larger workplaces also had LGBT+ staff networks or groups and these were also valuable to their members.

Nonetheless, there was also much discussion about the negative aspects of the LGBT+ community and how this could be detrimental to mental wellbeing.

Firstly, the LGBT+ community itself was not felt to be fully inclusive, and LGBT+ participants talked about:

- Biphobia from within the LGBT+ community
- Transphobia from within the LGBT+ community
- Lack of inclusion of people with identities other than LGBT, such as asexual
- Discrimination and lack of access for disabled people
- Discrimination on the basis of race and/or religion

- Rejection of certain LGBT+ identities or intersections as potential partners (including bisexual people, disabled people).

LGBT+ people found discrimination from within the LGBT+ community particularly hurtful:

*"I find biphobia from within the community more hurtful because although we might not have the same orientations, we've all been through similar things of trying to work out who we are, and it's just as difficult coming to terms with the fact that you're bi as it is if you're gay, and it's just as difficult coming out to people. When (biphobia) comes from someone that's not in the community, I can tell myself that it comes from a place of ignorance or innocence – they just don't get it. That I can forgive. But when someone who had the same experiences as me still acts like that, I find that harder to get on board with".*

Bisexual woman

Gay and bisexual men also talked about the 'toxicity' of the gay scene, characterised by:

- An emphasis on physical appearance and pressures to conform to unrealistic expectations of physique
- Idealisation of 'macho' gay men and 'camp shaming'
- A scene where alcohol and drugs are an integral part and a key focus of social activity
- Promiscuous, risky and exploitative sexual behaviour
- A concentration of men with insecurities, mental health problems and addictions which could have a negative effect on one another.

*"I think a lot of people don't feel safe in gay bars because you're going to be judged, put down, sniped at".*

Gay man

*"The scene can be quite toxic sometimes. It stands to reason that if you've got a high proportion of people with poor mental health and addictions, all congregating together in small places where alcohol's being plied to them, you're going to end up with some toxic behaviour. And then there's the stuff with transphobia, racism, camp shaming, misogyny, sexual behaviour that's not of the highest moral standards – and I include myself in all this. All that kind of stuff is on the scene, but it's the main place where you can meet other people like you. If the community wants to demand rights, improve things, the community has to come together. But sometimes when it comes together it's nasty, and we actually damage each other quite significantly, never mind wider society".*

Gay man

Those who did not have identities or labels of lesbian, gay, bisexual or trans could feel excluded or unsure of their eligibility when services etc. advertised or named themselves as catering for 'LGBT' people. For these people, it was felt that the '+' at the end was important in order for them to know the service included them or they would be welcome:

*"When I see something that says it is an LGBT group, I'm looking for that 'plus'. I'm looking for something to say 'we mean everybody', and not these specific four".*

Asexual woman

## Volunteering and Activism

The literature review highlighted that LGBT people were much more likely than heterosexual people to be volunteers and to engage in activism. This was reinforced by the interviews and group discussions, with most participants demonstrating past or current experience of volunteering in some way. The vast majority of voluntary activity centred on LGBT+ services or campaigning for LGBT+ issues. However, there were also examples of other types of voluntary work and activism such as climate change protests, working for animal charities, volunteering at the Commonwealth Games and serving on children's hearing panels. The motivations for volunteering, particularly in LGBT+ services were:

- Being involved and included in the LGBT+ community, making friends and socialising with LGBT+ people
- Helping young LGBT+ people ('being the person I needed when I was younger')
- Giving back to the community and/or a particular organisation who had helped them
- Political or social activism to improve lives of LGBT+ people.

Benefits which LGBT+ people reported they had received from volunteering were the development of skills, improvement to self-esteem, less isolation and a sense of belonging to the community. They also reported satisfaction from being able to do something meaningful and helpful for other people.

*"When I first came out, I started volunteering with (a youth service) and that was really helpful because I was kind of doing something productive while I was on the waiting list to transition medically. It was good doing something for other people, and it helped me with my confidence".*

Trans masculine

*"I think volunteering helps confidence – finding the right environment where you've got the flexibility to do different things and grow your skills. And you get pride in yourself that you've helped somebody – that feeds your self-esteem, your confidence, and it opens up avenues to meeting people and making friends".*

Gay man

*"When I first came to Edinburgh I didn't know a soul. I thought...there used to be a couple of gay bars and I was like a scared bunny in the headlights and I thought how the hell am I going to meet people because I'm not that out there. So I volunteered for (LGBT charity). To be brutally honest, I did it because I wanted to meet other people, but what I got out of doing it was also helping people and I love it.*

Gay man

*"I volunteer quite a bit in a queer youth charity, and the funny thing is we rarely talk about our queerness or identities; it's one of the things I love about it - an assumption that most of the people working and attending there are LGBTQ. I really like that, because it's probably the one space*



*where my queerness and identity get correctly assumed. So volunteering has been a really positive experience because of that. It's been a nice way to take the good experiences and education I've had as a queer person and use it to be helpful, and that is affirming enough- that's enough of a way for me to get to feel my sexuality as a culture rather than as something that's purely sexual. It gives me access to community."*

Bisexual woman

### Summary of Key Differentiated Findings for Social Health

LGBT+	Often a move to a new place facilitated coming out; Range of reactions/consequences of being out; Workplace was area least likely to be out, some experiences of workplace discrimination Experiences of hate crime Links with the LGBT+ community were important Lack of opportunities to socialise with LGBT+ people in spaces without a focus on alcohol
Bisexual women	May be vulnerable to abusive/unhealthy relationships
Gay and bisexual men/MSM	Problems associated with the 'toxicity' of the gay scene including pressures to conform to expectations of physical appearance
Bisexual women and men	Difficulties of being out compounded by perceptions/assumptions of identity based on current partner; Biphobia and bi-erasure from general population and within LGBT+ community
Transgender men and women	Less choice regarding to whether to be out, high level of visibility
Transgender women	Recent rise in negative attitudes; May be vulnerable to abusive/unhealthy relationships
Non-binary	Lack of understanding/recognition of non-binary identities
Disabled and autistic	Many be vulnerable to abusive relationships; Excluded from LGBT+ community; More isolated

### 3. Mental Health

#### General Mental Health, Depression and Anxiety

The literature review identified a wealth of evidence which indicated that LGBT+ people in Scotland are at much higher risk of mental health problems than heterosexual/cisgender people. Indeed, the vast majority of those who participated in the research had either past or current mental health problems including depression, anxiety, stress, and also conditions including Bipolar Disorder and Borderline Personality Disorder (BPD).

The literature review showed that studies have linked mental health problems with minority stress, but have also highlighted that mental health problems are compounded by experiences such as bullying, discrimination, hate crimes and social isolation. This was also apparent from the group discussions and interviews in which the issues around social health (covered in the previous chapter) and mental health were clearly interlinked. Other people's attitudes and actions clearly had a direct effect on mental health:

*"I've had a lot of issues with anxiety and stress for pretty much as long as I can remember. It was made worse by people not accepting me, especially the two long-term partners I had before – they would just deny whenever I tried to bring up my identity. That's kind of shattered my self-esteem to the point..I guess the anxiety of how people are going to view me – that worry is always in the back of my mind".*

Non-binary

*"You become hyper-aware of the possibility of being judged. For 40 odd years I was told people like me were sick, perverted. You internalize that, and you have guilt and shame".*

Trans woman

Experience of both depression and anxiety was very common, and most LGBT+ people indicated that they had suffered from both.

A common theme for all LGBT+ identities was the struggle to work out their sexual orientation and/or their gender identity, and the toll which their period preceding their self-discovery took on their mental health. Usually, there was a period where they fought against their identity or did not want to accept it. This was more pronounced in environments and circumstances where having an LGBT+ identity would be more difficult (e.g. more deprived areas, rural areas, certain faith and cultural groups), and could lead to internalised homophobia/transphobia which could prevail after coming out.

Trans and non-binary people were often acutely affected during the period of wrestling with their identity. Confusion around their gender identity could often be compounded by confusion around their sexual identity, and it was not uncommon for young trans and non-binary people to identify in a number of different ways before they reconciled both their gender and sexual identity:

*"I went the full circle. I came out as bisexual, then as a lesbian, then as a straight man. Then I realised that trans men can be gay as well, and realised: that's me – I'm a gay trans man".*

Trans masculine

Most indicated that mental health improved after they had both accepted their identity and come out to people close to them.

*"I decided to come out about eight or nine years ago. It felt hard and it was isolating because I didn't know many gay men, I didn't have any family members or friends who were gay. I just felt like I had a massive weight on my shoulders, I felt horrible and anxious all the time. I decided to come out to my family and although it wasn't exactly the best reaction I could have anticipated, it took the weight off my shoulders".*

Gay man

However, coming out was not always an immediate facilitator of improved mental health, and it often depended on how people around them reacted to their identity. Coming out was often problematic or traumatic particularly for trans and non-binary people, as they often faced a lack of understanding (particularly for non-binary people) and had to consider and implement how they presented in their new identity.

The decision to transition usually marked a period of resolution and an improvement in mental health for trans people, but mental health problems could subsequently be significantly exacerbated by the lengthy waiting period to access the services at Gender Identity Clinics which itself caused both depression and anxiety as trans people felt in limbo and unable to proceed with their medical transition. Moreover, trans people frequently said they avoided seeking help for mental health problems for fear that this would be used as a reason for refusing or delaying access to medical transition (see Chapter 6).

Several people described a perpetual state of hypervigilance, constantly worried about other people's reactions of feeling unsafe – particularly if they presented in a way where they could be identified as LGBT+.

Some trans people noted that their moods or emotions could be affected by hormone therapy.

## Self-Harm

The literature review highlighted the prevalence of self-harm among LGBT+ people, particularly young people. This was supported by the interviews and group discussions in which people of all LGBT+ identities disclosed histories or current practice of self-harming. Self-harm appeared to be most common in younger years and prior to coming out or transitioning. Non-binary and trans men and women were among those who more frequently mentioned self-harming, and this was often linked to their gender dysphoria or hatred of their body. LGBT+ people of all identities who self-harmed also spoke of self-harm as a form of release from their feelings of anxiety, turmoil or overwhelm and was often (but not always) linked to their struggle to reconcile their identity or difficulties with relationships. While most LGBT+ people were very open and candid in their dialogue in both groups and interviews, self-harm was a topic which was frequently raised as something they did but people were often unwilling to speak in detail about it. However, cutting appeared to be one of the most common forms of self-harm.

## Eating Disorders

A few LGBT+ people mentioned they had history of eating disorders, and many more described a 'difficult relationship with food' rather than a recognised or diagnosed eating disorder. Many referred to either over- or under-eating when they were depressed or anxious.

Eating disorders among trans and non-binary people were sometimes linked to their gender dysphoria. Service providers spoke about trans men and women deliberately delaying puberty by not eating, but none of the trans men and women who engaged with the research spoke of doing this. However, both trans men and women spoke about either over or under eating in a deliberate attempt to change their body shape in a way they perceived was more in accordance with their preferred gender.

*"I'm quite particular about my diet. It has gone through periods where I've been super strict with my diet and cut out a lot of stuff. I still keep close tabs on what I eat, and maybe I'm a little bit obsessive – keep very tight wraps on my food. In part it's to do with anxiety and wanting to feel in control of stuff - but I'm already quite tall and quite broad shouldered, and I'm wanting to stay in the window of where I can still get nice women's clothes and feel attractive, which isn't something I do a lot of the time".*

Trans woman

The pressures around physical appearance, particularly for men on the gay scene, were also felt to be catalysts for body dysmorphia and eating disorders.

## Suicidal Thoughts and Behaviours

The literature review highlighted many sources which demonstrate a high prevalence of suicidal thoughts and behaviours among LGBT+ people. Indeed, many of those who engaged with the research had contemplated or attempted suicide. Trans men and women and non-binary people were particularly likely to speak about suicidal thoughts, although these tended to subside after transition.

*"When I was just starting to transition I still had a short back and sides, and I wasn't totally comfortable wearing women's clothing yet and I didn't really know how to put a male body into women's clothes and stuff. That was turbulent in terms of my mental health. My thoughts were very dark and I was thinking get out, end it all".*

Trans woman

For all LGBT+ groups, those who appeared most susceptible to suicidal thoughts included those growing up in cultural or religious groups who were not accepting of LGBT+ identities, those who felt particularly isolated or did not have supportive family or friends, and victims of abuse. Asylum seekers were particularly likely to have attempted suicide (see Chapter 7). As discussed in the preceding chapter, gay and bisexual men gave second-hand accounts of men married to women who were also having sex with men, and these men were also at particular risk of suicide.

## Borderline Personality Disorder

A number of LGBT+ people said they had been diagnosed with Borderline Personality Disorder (BPD). Some service providers expressed concern that one of the criteria for diagnosis of

BPD is an unstable sense of self, but that perhaps LGBT+ identities were being used inappropriately as a diagnostic criteria.

*"While (LGBT+ people) are exploring their identity and coming to an understanding of who they are, professionals pathologise that as an unstable sense of self and use that to diagnose a personality disorder, when all that's happening is they've been socialised to be straight and they have to explore the options and see what identity fits them".*

Service provider

However, none of those who had been diagnosed with BPD indicated that they felt the diagnosis had been inappropriate. Indeed, some felt that they had to 'fight for a diagnosis' in order to access appropriate medication.

Where the diagnosis of BPD preceded seeking medical gender transition, some people felt that BPD could be masking genuine gender dysphoria:

*"When I came out as trans to my GP he said you're probably not trans, it's probably just your BPD acting up. I had to argue and argue, and they still sometimes doubt me".*

Non-binary

One trans masculine interviewee had Dissociative Identity Disorder (DID), and in a similar way to those with BPD, there were issues with professionals conflating the symptoms of DID and gender dysphoria.

## What helps mental health?

Having supportive family and friends was seen as one of the most important factors contributing to good mental health. Support from the LGBT+ community and having LGBT+ friends ("finding my tribe") was also seen as crucial by some, and this made a huge difference to the mental health of those who had previously felt depressed, anxious and/or isolated.

Some had struggled for some time to work out how they identified, and a key facilitator of improved mental health was the point at which they were able to identify and name the sexual and/or gender identity which described them ("finding my label"):

*"I think getting to a point of being able to identify as asexual rather than a weird straight person helped a lot. Actually being able to say this is the thing that I am was really helpful, having the word. That other people feel like this and it's got a word, this is what I am".*

Asexual woman

Although there were huge frustrations at the long waiting times for mental health services and concerns about the appropriateness of some mental health services (see Chapter 6), appropriate counselling and medication were also felt to be very beneficial for improved mental health for many people.

## Autism, ADHD and Learning Differences

The literature review pointed to evidence of a higher prevalence of learning, development and behavioural differences among LGBT+ people compared to cis gender/heterosexual people. These included Autistic Spectrum Disorder (ASD)/Asperger's, Attention Deficit Hyperactivity Disorder (ADHD) and dyslexia. Indeed, many of those who engaged in the research had been diagnosed with at least one of these conditions, and more also acknowledged they had autistic traits but had not been diagnosed.

Having these conditions, particularly ASD, made it difficult for LGBT+ people to meet people and socialise. This was compounded by the fact that many queer spaces (gay clubs etc) are too noisy, busy and over-stimulating, meaning they are often not accessible to those with ASD. Therefore autistic LGBT+ people were often particularly isolated, having few opportunities to engage with the LGBT+ community or meet potential partners.

As noted in the preceding chapter, those with autism and other developmental or learning differences appeared to be particularly vulnerable to abusive or unhealthy relationships.

ASD also made it difficult for some to work out their sexuality or gender identity:

*"I think my autism impacted my sexuality at a young age, because I was trying to imitate everyone else- to work out what I needed to do to be like them, which is the autism. I knew I felt different in terms of sexuality, but I also felt different in lots of other ways. And in TV shows I didn't see anything different either- it was always male and female couples, even if the characters were animals and I thought, ok- this is how it works. I understood that I was different and I didn't want to be. So I buried down anything that seemed different to other people. If there was a boy I was friends with or talked to, I decided that must mean I was in love with him and stuff like that".*

Gay/lesbian woman

Trans and non-binary people with ASD and other conditions which affected their socialisation and communication, often found it difficult to articulate their feelings around their gender dysphoria or how they identified or wanted to present. This caused difficulties when accessing the GIC, and on the part of the GIC, it made it difficult to diagnose dysphoria or identify appropriate interventions.

Not only could ASD or other conditions make gender dysphoria diagnosis difficult, this could also work in reverse, with the identification of autism being made more complex for trans people:

*"Autism diagnosis can be tricky when you're transgender. Whether you're trans or have autism obviously you're going to feel different from most people. So when you're getting a diagnosis they have to make sure that you feel different because of autism, and not because of your gender or your identity or whatever. When you're in an assessment for autism, they basically have to rule out everything. Like is it your trans status that's having an impact on how you socialise or is it autistic traits? You're likely to be kind of isolated because of your identity and it can give you anxiety. So it can make diagnosis harder, and I think it takes longer. I think it's more likely to go missed if your trans".*

Trans masculine

For those with any kind of learning, behavioural or developmental differences, there was a common expression of the difficulties of being “doubly different” relating to both their condition and their LGBT+ identity, making it particularly difficult for them to feel that they fit in:

*“A huge problem for women with ADHD is self-worth because of all the ways you fail all the time. And I think being bi as well. The year I came out I was depressed with the stress of it and the feeling of not fitting in, and the stigma of it. You have to constantly build your own sense of self-worth about being bi and then quite a big crossover with being ADHD because it highlights another way you’ve failed to be normal or achieve normal things”.*

Bisexual woman

### Summary of Key Differentiated Findings for Mental Health

LGBT+	Depression and anxiety very common Poor mental health associated with other people’s reactions/attitudes; Period of working out identity associated with poorer mental health- mental health often improved once identity was reconciled Some reported hypervigilance Diagnosis of conditions such as BPD/autism could be masked by LGBT+ identity (or vice versa)
Gay and bisexual men/MSM	There could be a high suicide risk where men in relationships with women were secretly having sex with men
Transgender men and women and non-binary	Often a particular struggle to work out identity/attempts to deny identity; Moods could be affected by hormone treatment; Experiences of self-harm, eating disorders and suicidal thoughts highest for this group



## 4. Behaviours Impacting Wellbeing

### Smoking

The literature review showed many sources which showed that smoking rates were higher for LGBT+ people. Many of those who engaged with the research were smokers. Some linked this to mental health (e.g. using smoking as stress relief), and it was felt that depression and other mental health problems were not conducive to a successful attempt to stop smoking. Many felt that smoking cessation was not a top priority for them when they had other problems to deal with such as mental health problems, relationships with family or partners, etc.

### Alcohol

The literature review cited numerous sources which show that LGBT+ people are more likely to drink alcohol at high or problematic levels. This was substantiated by the research, with many interviews and group discussions involving much discussion around alcohol as an issue for many LGBT+ people. Some used alcohol at problematic levels, and some had a history of addiction to alcohol.

One of the common reasons for using alcohol excessively was 'self medication' and as a coping mechanism to deal with depression, anxiety and stress. One non-binary person described how they used alcohol not only to cope with depression but also to facilitate self-harm:

*"I drink to drown my sorrows. I don't have non-binary friends that I can go to, to hang out with – I don't have that social connection, so I drink on my own, and self-harm comes into it, because alcohol numbs the skin for when you go to self-harm – it makes it easier".*

Non-binary

As mentioned in Chapter 2, a common theme in groups discussions and interviews was the fact that the gay scene and other LGBT+ social spaces were almost exclusively focussed on alcohol or in places where alcohol was served. Some felt that the only way to socialise with other LGBT+ people or to meet potential partners was to go to bars and clubs and this could lead them to drink more alcohol than they would otherwise.

Alcohol was also used by many as a means of losing social and sexual inhibitions. Some LGBT+ people commonly said that they only felt able to be themselves and be out about their identity in social settings when they had drunk alcohol. Many also acknowledged that they were much more likely to have sex if they had been drinking alcohol and were also less likely to practice safe sex.

*"Because of social anxiety stuff, alcohol tends to calm that down because I'm just not thinking any more. I don't think I've ever come out to anyone sober, thinking about it, because the anxiety is just too much. When I realised alcohol reduced anxiety, I realised it was helpful".*

Non-binary



## Drugs

Use of illegal drugs and legal highs were not reported to the same extent as alcohol, but a significant proportion of LGBT+ people who engaged with the research spoke of using drugs either historically or currently. Use of drugs was often linked to mental health problems – both as a consequence and cause of mental health problems; while drugs were used to alleviate feelings of anxiety and depression, they were also seen as ultimately exacerbating these problems. The consequences of behaviours that occurred when under the influence of drugs could also be the cause of regret and lead to poorer mental health.

Among gay and bisexual men in particular, a recurrent theme in discussions was the prevalence and normalisation of drug use on the gay scene in both Edinburgh and Glasgow, with drugs readily available and drugs being consumed routinely by patrons in gay bars and clubs, and among social groups of gay men. Many different types of drugs were mentioned including Cannabis, MDMA, Ketamine, Cocaine and G (GHB/GBL).

There was a range of views about how people who took drugs felt about their drug use. Some were unconcerned about it, some felt addicted, but a more common position was having concerns about how they were using drugs and wanting to cut down or stop:

*"I'm using drugs when I want to, so I wouldn't say I'm compelled or addicted, but I think socialising on the gay scene makes using drugs kind of inevitable and predictable and I would say I am concerned a bit about my drug and alcohol intake. I think a lot of it is choosing who I socialise with. I need to sort of step back and just have a bit of a reality check and think is this the sort of behaviour I want to continue? I can already see how much hurt I've caused myself".*

Gay man

*"I have used alcohol and drugs to a point that is not great for my wellbeing. More importantly it drives more dangerous decisions when I use them. In the last few years I've tried to be on top of that and understand that reality. I have a lot of gay friends and it is just so normalized to be using drugs to the point of people passing out on floors and whatever else. It's just very recently that my head's kind of turned around a bit and realising that I don't feel like doing that anymore. I've had to step out of certain social spaces and certain social groups to avoid it because there's nothing else you're going to do with that group apart from drinking and drugs. That's been a bit sad when I've realised that's what's keeping us together".*

Bisexual man

Some LGBT+ people felt they relied on drugs to the point of being addicted, but like those addicted to nicotine, addressing their drug addiction was not necessarily a priority for them as they were dealing with other problems:

*"I definitely am addicted to weed. I tried a couple of weeks ago to go a full week without smoking weed and I couldn't. I feel like it's not a high priority for me – there are a lot bigger fish to fry in terms of what's making my life worse, so weed makes it easier in the short to mid-term. It will be a medical problem at some point probably, and it's obviously not great at improving my mental health. It maybe limits me in getting better, but it*

*also stops me from getting really bad. So it's a stabiliser almost. I just don't feel my addiction is that significant a problem next to everything else".*

Non-binary

Similarly, some felt that they used 'soft drugs' in place of other more harmful substances or behaviours and that this was a safer or healthier coping mechanism for them than other things they had tried or were tempted to try.

Some MSM also used drugs for chemsex, and this could be problematic as it was often associated with risky sex or men finding themselves in vulnerable situations. For some, chemsex was addictive and they felt that sex without drugs subsequently became unsatisfying.

Some people who suffered from physical ill health or disabilities also mentioned the use or misuse of prescription opioid pain medication and felt at risk of becoming addicted to these (see Chapter 7).

## Sex/Safe Sex

LGBT+ people of all identities decried the lack of appropriate Sexual Health and Relationship Education (SHRE) in schools and elsewhere which they felt failed to include, or adequately include, information on sex and relationships for people with LGBT+ identities. Some felt that, as result, they were ill equipped to make good choices about relationships or make informed choices around sexual health. Among NHS and other services, there was felt to be a particular dearth of information, advice or health promotion messages on sexual health for lesbian and bisexual women or for trans and non-binary people, which contrasted with a lot of information relating to MSM.

Many LGB men and women reported periods of engaging in frequent, casual and/or risky sex, and there were a number of factors which influenced this:

- **Drug and alcohol use:** Many pointed to the use of alcohol and drugs leading to risky sexual behaviour, (including chemsex)

*"My first boyfriend gave me a spliff. It was amazing and we had great sex. And then we had poppers. But it wasn't until I was dumped by the love of my life boyfriend and I was feeling so (bad) about myself and about life, when someone said 'here, have a line of this'. And I thought why not, my life's (bad) anyway and no one will find out. Just to get out my head for a bit. And that was kind of it, and I went deeper and deeper. It was very tied in with the very risky and excessive sex; I'd maybe be having sex with five or six guys a night, sometimes at a time, you know Chemsex. And you have to come back from that".*

Gay man

- **Risky sex as a result of poor mental health/low self-esteem:** Some indicated that having risky sex was due to their poor mental health and low self-esteem – either from feeling worthless, or not having the confidence to ask a partner to use protection.

*"I went through that stage of having unprotected sex. It was to do with my mental health because I felt I wasn't accepted in my community, so why should I respect myself".*

Gay man

*"It's clear people make poor sexual health decisions due to their mental health. From working in the sauna, I saw that so many times. People that were afraid to go and get a condom in case their trade ran away. So they would just be like 'I'll do it now because it will never happen again'"*

Gay man

- **Sex as a coping mechanism/release or self-harm:** Some, particularly gay and bisexual men, pointed to their use of sex, particularly risky sex, as a coping mechanism in the same way they may use drugs or alcohol, or as a form of self-harm:

*"I know all the information about safe sex, but yet since I stopped drinking, when I'm under stress and anxious I've noticed the amount of sex I'm having has massively increased, and I'm having unprotected sex a lot. I used to advocate using a condom all the time because it made absolutely no sense not to, but here I am doing it constantly and going back to (sexual health clinic) for another thing and another thing. Because I can't drink any more I feel that I'm using that as a coping mechanism".*

Gay men

*"I've got mental health problems and I used to use Grindr as a form of self-harm. I'd sleep with people, unprotected, as self-harm".*

Gay man

- **Risky sex and frequent casual sex following coming out:** Some described a period of high levels of sexual activity, including risky sex, immediately following their coming out. This could be more pronounced where gay/lesbian men or women had tried to suppress or fought against their sexuality for a long time:

*"I was married for 27 years and then thought I just can't do this anymore. I now feel totally liberated. Now I lead my life – my life at the moment is back in my teenage years that I never had. When I came out I went mental - I was out there having sex night and day, unprotected, and absolutely loving it. I got HIV but I don't blame anybody else – it was down to me because I was living the life I never had".*

Gay man

*"When I first came out I was a bit like a kid in a sweetie shop. Safe sex wasn't on my agenda in the first five/six years of coming out. I was a bad girl! I didn't hit the lesbian scene till I was about 21, so when I did finally do something about sexuality, I wanted adventure and I had a big appetite for a number of years".*

Gay/lesbian woman

- **Risky sex/frequent casual sex following an abusive relationship:** A further catalyst for a period of high levels of casual sex and risky sex was leaving an abusive relationship. A number of LGBT+ people (usually women) spoke about such periods either as a coping mechanism to deal with their traumatic experiences, or as rebellion against an abusive period.

*"After I got out of an abusive relationship, I was in a bad place and I had a really promiscuous year. I ended up having an abortion – my mental health was so poor that the abortion was the right thing to do at the time".*

Bisexual woman

*"I had a period of promiscuity that was a direct result of coming out of an abusive relationship. The guy was so controlling and possessive. That was the first thing I could think of to rebel".*

Bisexual woman

- **PrEP leading to complacency:** Gay and bisexual men frequently talked about how the availability of PrEP has had a hugely positive effect in reducing the risk of contracting or passing on HIV, but a downside was that many MSM had become complacent about using protection to prevent other STIs.

Some gay and bisexual men were satisfied with, and preferred, brief sexual encounters, but others indicated that they felt somewhat frustrated with this lifestyle and would prefer longer-term relationships but felt ill equipped to deal with an emotional relationship with a partner.

*"I think it's to do with not being sure how to have 'normal' relationships and rather than seeking long-term relationships, I'm having these short encounters".*

Gay man

Some pointed to negative impacts of frequent and risky sex including contracting STIs, unwanted pregnancy, being tired during the day and impacting work or study, and regrets and self-loathing following some sexual encounters.

## Physical Activity

There was a large degree of variation in the extent to which people were physically active, ranging from those who were completely inactive to those for whom sport/physical activity was an important part of their daily lives. A number of people pointed to a clear link between physical activity and mental health, noting that when they were depressed they did not feel like being active, but also when they were active that it boosted their mental wellbeing.

Discussions highlighted a number of barriers to participation in sport and exercise for LGBT+ people. These are discussed below.

Gay men in particular felt excluded from the 'laddish culture' in many sports. Their feelings of exclusion from sport often stemmed from school years, but prevailed in later years with the perception of endemic homophobia in some sports, particularly team sports. Some also spoke about anxieties around communal changing and showering with straight men in sports facilities. However, many pointed to the prevalence of gay men working out in gyms, which could be linked to the high importance of physical appearance among large sections of gay

men. Some felt that using gyms and working out to try to achieve 'physical perfection' were often focussed more on aesthetics than health and that many other parts of their lifestyle could be unhealthy. The importance of physical appearance for many gay men, also led to some reporting that they felt too self-conscious or too unhappy about their body to use gyms.

Trans and non-binary people had particular practical and emotional barriers to participation in sports and physical activity. These included communal or gender-segregated changing rooms at gyms and other sports venues which caused high levels of anxiety or were deemed completely inappropriate for trans and non-binary people. There were also very practical considerations around what to wear for sports and exercise, particularly for those who had not surgically transitioned, and many trans people said they would feel too self-conscious exercising in any way with other people around. Many trans and non-binary people spoke about doing exercises such as yoga alone at home rather than in a class setting because they did not feel they could participate with others. One trans woman described how she went to the gym at 2am because the gym was almost empty at that time and she was also able to use the disabled changing cubicle. A trans man said he could only use the gym if he changed at home.

Some trans people spoke about sports they felt that they had had to give up after transition. For example, some trans men and trans women had given up swimming due to not feeling comfortable presenting in a swimming costume. Some trans women spoke about having given up football or rugby, which they had previously enjoyed, but they did not feel these sports were in keeping with her new feminine identity or that there were appropriate opportunities to continue participating. Gender segregation in sports and strict rules around gender were also barriers to trans and non-binary people who were interested in participating competitively. A trans woman spoke about giving up a particular niche form of running she was previously good at because she was afraid of being challenged about previously having entered races as a man.

GIC staff spoke about incidences where trans patients needed to lose weight before surgery but the barriers around changing and self-consciousness in gyms made it difficult to formulate effective exercise plans. They tended to advocate solo activities such walking and cycling.

Bisexual and lesbian women varied in the extent to which they were active, but on the most part did not appear to face particular barriers to participation in regard to their sexual identity. Among those who participated in sport and activity, lesbian and bisexual women found sports clubs and facilities inclusive and they did not face discrimination, although some were not out in sports settings because it was not seen as relevant in any way. However, one lesbian woman mentioned issues with 'heterocentric' exercise classes where she felt uncomfortable.

There were, however, some examples of good practice and inclusivity including a number of LGBT+ sports clubs and teams. Most of these were felt to be inclusive of all LGBT+ identities, and for those interested in the sports, these clubs offered a much sought-after opportunity to connect and socialise with other LGBT+ people away from 'the scene'. Roller derby was also mentioned several times as an inclusive mainstream sport.

## Online Activity

### **Online Gaming**

Some trans and particularly non-binary people often used online gaming as a means of interacting in a non-gendered way, or trying out genders in a virtual environment. Among those who did this, this was largely felt to be positive on their mental health. Online gaming allowed people to experiment playing as characters of different genders, characters with no gender, or adopt avatars that presented in ways they identified (before beginning their own transition). Online gaming was also felt to be an activity which could relieve stress and was seen as a much more positive alternative to destructive options such as drug use or self-harming. However, it was recognised that gaming could become addictive or people could be compelled to spend longer on these types of activities than they felt they should. As a result, some had taken action to try to limit their online gaming activity.

Among GIC professionals, there was some concern that people were accessing the service who spent much of their time online gaming and that they had not spent sufficient time socialising in the real world in their preferred gender.

### **Social Media**

Social media was largely viewed as a very good way for people to connect to other LGBT+ people, particularly those in more rural areas and those with minority identities. Social media was used to connect to people, make friends, access online groups and online support. Social media and digital dating apps were also used to connect to potential partners.

However, it was also recognised that social media could be very detrimental to mental health and self-confidence where negative messages and attitudes relating to LGBT+ people were prevalent. There was much discussion from all LGBT+ groups about the current discourse on social media against trans people, particularly trans women.

Some LGBT+ people took action to ensure they were not too exposed to negative online content, including blocking people, limiting the time they spent on social media and ensuring they only linked to their friends on some platforms rather than having sight of wider activity.

Social media was also felt by some to have a negative effect on mental health because of people posting and promoting distorted images and messages of their 'perfect lives', leaving people feeling inadequate. For gay men in particular, social media and dating apps were felt to perpetuate the unrealistic pressures on gay men regarding their appearance.

## Summary of Key Differentiated Findings for Behaviours Impacting Wellbeing

LGBT+	Common use of smoking, alcohol and drugs – often as a cause or consequence of poor mental health; some addictions Social media could reduce isolation but could be damaging to mental health
LGB Men and Women	Periods of frequent casual and/or risky sex associated with drug use, poor mental health, coming out, and abusive relationships
Gay men	The 'laddish' culture and homophobia in sport was a barrier to participation
Gay and bisexual men/MSM	Prevalence and normalisation of alcohol and drugs on the gay scene Use of drugs for chemsex; PrEP had caused some to be complacent about sexual health
Trans men and women and non-binary	Many barriers to participation in sports and physical activity including self-consciousness, changing rooms/facilities, gender rules in sports
Non-binary	Online gaming was common, with both positive and negative effects on wellbeing
Disabled	Risk of addiction to opioid medication

## 5. Financial Wellbeing and Homelessness

### Financial Impacts

Although the topic guides for the interviews and focus groups did not specifically raise financial wellbeing as a topic for discussion, many of the dialogues revealed significant financial impacts which were directly or indirectly related to LGBT+ identities.

Due to either lack of access or long waiting times for NHS treatment, many LGBT+ people felt forced or compelled to access private treatment, particularly for counselling. Some gay/lesbian women indicated they had sought private fertility treatment after finding NHS fertility services inadequate. Trans men and women had often not only accessed private counselling but also paid for treatments related to their transition including hormone treatment (through private doctors or buying hormones online), electrolysis, wigs and, in one case, private gender reassignment surgery (GRS).

*"I'm still on the waiting list for the (GIC). I've still not got a date for my initial appointment and I've waited 22 months, so I'm temporarily seeing a private specialist and got my diagnosis of gender dysphoria and prescribed hormones. That is having a huge financial impact, and that's been one of my biggest worries. I had some savings and they've been depleted to zero. I think I can continue to have the private treatment until the end of the year, but if I haven't transferred to the NHS by then I'll have to sell my flat".*

Trans woman

One young trans woman spoke of an extended wait for the GIC and resorted to self medicating with hormones bought from the internet, and without parental support (she appeared to have been aged under 16 at the time), she resorted to sex work to pay for the hormones. At the time of contributing to the research she had waited 18 months but had not been seen by the GIC and she was arranging a large loan to pay for private surgery.

Also, all NHS GRS is performed in England and although travel expenses are reimbursed, they have to be paid upfront by patients and this caused financial difficulties for some.

As discussed in Chapter 3, some young people did not feel able to come out to parents until the point they were leaving or had left the parental home. In some cases, this led to young people moving out of the parental home before they may be otherwise ready either emotionally or financially, and they could struggle to meet living costs. In one case, a young trans woman described leaving full time education to get a job and become financially independent so that she could move out of the parental home and begin transitioning, because she had not felt able to open about her trans identity with her parents.

The difficulties faced by LGBT+ people living in rural areas and small towns (see Chapter 7) compelled LGBT+ people to migrate to cities where living costs could be higher and where they did not have financial support from family. Also, as discussed in Chapter 2, moving to a new city (e.g. as a student) often represented a 'new beginning' for LGBT+ people where they lived openly in their identity for the first time, but this also meant they were less likely to return to their family home or place of origin to live after their studies, and this could also have a financial impact.



The cost of travel to use health services, third sector support services and LGBT+ social groups was a financial burden for those in rural or outlying areas.

There was also a significant financial impact of addictions or use of drugs, alcohol and cigarettes (see Chapter 4). One gay man also described a gambling addiction, though which he had accumulated huge debts, and this had resulted in bankruptcy and homelessness.

An issue for gay men who had lived through the HIV epidemic of the 1980s was that some had not expected to live to old age, in particular those with HIV prior to the advances in HIV medication. This meant they were less likely to have made financial provision for their old age:

*"When I first came out, I remember a teacher at school saying I wasn't going to see old age. For a lot of gay men, we weren't expecting to get old, so things like pensions are not in place. People living with HIV were thinking, I'm not going to be around, so there's no use thinking about a pension and all that".*

Gay man

## Homelessness

The literature review pointed to a disproportionately high number of homeless people having LGBT+ identities. A number of those who engaged with the research had experienced homelessness, and reasons included:

- Breakdown of family relationships after coming out, forcing young people away from the parental home, or preventing return in times of hardship
- Escaping an abusive relationship
- Migration from rural areas to cities, where people would sofa-surf
- Addictions including alcoholism and gambling addiction which led to eviction

### Summary of Key Differentiated Findings for Financial Wellbeing and homelessness

LGBT+	Financial impacts of seeking private counselling, addictions Cost of travel for rural LGBT+ people to access services and social support Financial impacts of leaving parental home in order to come out; difficulties returning to place of origin after living openly at university Homelessness with various causes including breakdown of relationships, urban migration and addiction
Gay men	Some older gay men (especially with HIV) may not have made sufficient financial planning for retirement
Transgender men and women	High financial costs of seeking private hormone treatment or surgery, other services for transition (e.g. wigs) and travel to use the GIC and surgical services in England

## 6. Experience of Health Services and Other Services

Many reported overall positive experiences of accessing and using health services. However, the nature of the discussions meant that the focus was often on elements which were less satisfactory.

### Heteronormative Assumptions and Heterocentric Services

A common theme was frustration at the heteronormative assumptions made in healthcare services. Many felt that the default was to assume that patients were cis and straight and interactions would proceed on the basis of this assumption until or unless the patient made the choice to correct their assumption and disclose their identity. Many felt that much more could be done to ask open questions which were not rooted in the assumption that all patients were cis and heterosexual and that the onus should not be on the patient to challenge assumptions or to actively disclose their identity:

*"It's just so awkward unnecessarily when people just assume (you're straight). It doesn't make for the best start when you're trying to have a therapeutic relationship with a health provider – it makes it awkward at the outset when one of the first things you have to do is correct their assumptions and out yourself. You think, are they judging me? I always end up saying 'no sorry, I'm a lesbian' – and then I think, why am I apologising? It's all awkward. That could be avoided so easily by asking questions that are not presumptive".*

Gay/lesbian woman

For cis women in particular, heteronormative assumptions at cervical screening, fertility and gynaecology appointments were prevalent and made gay/lesbian and bisexual women uncomfortable.

*"I was at a gynae appointment last week and the consultant asked if I have a partner and then she asked me where I am in terms of deciding to have children. I said I'm not and she said "I'll put 'not planning at the moment' then" which is a whole other set of assumptions. Then she went on to talk about how sex can be painful with endometriosis and that it can be difficult to conceive 'the natural way'. I didn't come out to her in the end. I thought 'I'm only going to see her once' and my regular team know. But again, it was in my notes that I have a same sex partner. So I had 10 minutes of her talking about fertility and male partners and sperm clinics. They're supposed to ask if you have a partner and what gender they are, but she didn't. You'd think a gynaecologist should be the best at asking! They just hear 'partner' and head off on a set of heteronormative assumptions".*

Bisexual woman

Some group discussions involved debate regarding whether it would be appropriate for GPs and other healthcare providers to routinely ask about sexual identity during appointments. Some questioned whether this would be either necessary or relevant in most healthcare settings/circumstances. However, others felt that it was important for healthcare providers to know information about the individual and that there were numerous ways in which sexual identity or associated lifestyles may impact health and healthcare. There was an example of

a gay man who was critically ill in hospital, but whose next of kin (and companion at hospital) was his wife. He was close to death and his diagnosis of HIV was only made after a chance conversation a doctor when his sexual identity was discussed. He felt that if he had been asked about his sexual identity on admission to hospital, the doctors would have thought to do an HIV test sooner.

Some women pointed to the standard practice of performing pregnancy tests before many procedures and felt that they were not believed when they said they were in an exclusive relationship with another women and were offended when pregnancy tests were conducted anyway. For bisexual women in particular, they felt that the insistence to perform pregnancy tests confirmed that healthcare staff held a stereotypical view that bisexual women were promiscuous.

Non-binary people felt that data collection and forms in healthcare settings very often did not allow them to express their gender identity, which made them feel excluded, invalidated and anxious about speaking to healthcare professionals about how they identify.

*"In my doctors they used to have this thing that when you signed in it was on a screen and you had to select in front of everyone in the waiting room whether you were male or female. Even that half a second just breaks my brain every time and I'm like, I kind of don't want to go to this appointment now".*

Non-binary

Some trans patients also spoke about encountering forms in healthcare settings about gender identity in which gender and trans status were mutually exclusive options on a list, so they were unable to express their identity:

*"When I first went to get my blood test for HRT sorted – this was in the GIC – they gave me a form that said pick one – male, female, transgender and other. I had to only tick one of those – it didn't make sense – I'm female and trans".*

Trans woman

## LGBT+ Identities Affecting Healthcare Professionals' Diagnosis and Treatment of Unrelated Conditions

A number of LGBT+ people spoke about incidences where they felt that their diagnosis or treatment of unrelated medical conditions was negatively affected by their sexual or gender identity.

For gay and bisexual men, one of the most common examples was healthcare professionals making assumptions about HIV risks based solely on sexual orientation (rather than sexual behaviour), offering or suggesting sexual health screening when the patient presented for treatment for unrelated conditions, or attributing symptoms as possible indicators of HIV even where there was no risk:

*"I went to see the doctor about my memory and she said, 'we'll do blood tests on you for this, this and this and we'll do one for HIV'. I said, 'I'm sorry, hello? What's that got to do with memory'. And she said 'oh it can be to do with memory'. I don't know about this – but it kind of took away my confidence...I would just want to know if she would do the same tests*

*for a married 40 year old straight man as she would for me as a married 40 year old gay man”.*

Gay man

*“I was really ill and struggled to my GP who sent me home with paracetamol – I went back the next day and let slip that my partner was waiting outside for me so I could get to hospital. And she said ‘oh you’re gay!’ - then she proceeded to write this letter in front of me and said I had to give it to the consultant at A&E. I opened it and it said, like, this guy is gay and probably has AIDS and said he’s got pneumonia for the second time. She just jumped to conclusions without properly speaking to me - I was really angry. I’d been with my partner forever and been completely faithful. It was so sloppy, upsetting and unnecessary. I got an apology in the end but I stopped seeing that doctor”.*

Gay man

For trans men and women, the most common examples were healthcare professionals inappropriately attributing medical ailments to the effects of hormone therapy, and therefore misdiagnosing causes and conditions. Often trans people felt they were immediately diverted from general practice to gender services for conditions unrelated to their trans status or their use of hormones.

*“I’d gone to the GP with back pain I’d had for a few weeks. The GP was like, ‘I see you’re on hormones so it’s probably that, so I’m not going to do anything – the (GIC) should be taking over your healthcare’. Firstly, I’m on the waiting list for the GIC but won’t be seen for ages; secondly, they don’t see you for back pain! I persisted with the back pain and then went back and saw a better GP who has referred me to physiotherapy”.*

Trans woman

*“Whenever you go to the GP about anything, the GP is always like, ‘it’s your hormones’. They say that for everything. I went to the doctor because my eyebrow was falling out in patches. He said it might be because of testosterone – no, my eyebrow doesn’t fall out because of testosterone! I had alopecia, and it did grow back – but they could try looking into things instead of automatically assuming everything is due to hormones”.*

Trans masculine

## Confidentiality in Healthcare Settings

LGBT+ patients were not always clear about whether or how information is shared about their identity between different healthcare providers and staff within practices, and this could affect what they disclosed to practitioners.

Some group discussions involved debate about whether information about sexual orientation or gender identity should be held on health records and shared between medical professionals. One trans woman expressed concern that her records were ‘stamped’ with her trans status and this could be widely shared:

*"One thing I did note that I was a bit concerned about – I spoke to my GP at my previous practice and said that I was getting cervical screening letters just so you know, and when I got to my new practice I did notice when they brought up my patient records there was a big red box appeared over the notes that said 'this person is transgender'. I thought, how widely are these notes being shared? It's fine for the doctor to have it, because I'm constantly bouncing between doctors, but I wouldn't necessarily want everyone who is checking my notes to know".*

Trans woman

However, others recognised that it may be important for medical professionals to know about trans histories in various circumstances:

*"It's a balance where confidentiality is concerned – because if you were to pitch up with symptoms that could be prostate cancer but your GP didn't know you had a prostate...it's a balance between letting enough people know, without it being blazoned all over the place".*

Trans woman

One trans woman had experience of being a hospital inpatient when her medical notes had information about her GRS clearly visible on the front, and these were left in view of other patients, much to her distress.

Young people were concerned that consultations such as those with mental health practitioners at CAMHS were not kept confidential from their parents, noting that young people could attend CHAMS on their own, but that letters were sent to parents detailing information about the consultations.

## Treatment of Same Sex Partners in Healthcare

Most people with same sex partners felt that healthcare providers were respectful of their partner and included them appropriately as next-of-kin or supporters when using healthcare. However, there were a few examples where people felt their same-sex partner had not been treated in the same way, or given the same status as those in heterosexual relationships.

*"I've had some difficulties with mental health assessment services- not always taking my partners input, and not always giving space to that. Last time I was up there, they wouldn't let him into the room where I was being interviewed. I couldn't work out what that was about, but I think it was homophobia. The person I saw didn't see him as my family. He was really weird about it, and I didn't feel in a strong enough place to say 'actually, he's coming in', which is what I wanted to say. So that was really poor".*

Trans gay man

## Holistic Service Provision

There were examples in the third sector of services working well to provide a holistic service – being able to consider LGBT+ people's needs together and work towards addressing these. However, by contrast, the NHS was largely seen as being much less effective in taking a

holistic approach. In particular, the services did not appear to acknowledge and address the relationship between mental and physical health. A disabled person said:

*"What's ignored is that everything links up. If you feel isolated in the LGBT community and you're also disabled and you also have mental health issues, all these things are going to interact. If you're depressed, you don't do your exercises so you have more impairment. If you're isolated, you don't go out, so you're going to get more depressed. On the NHS you're treated as one case by every service...one part trying to treat your depression, one part treating your knees...They tried to treat my depression without giving me a lightweight wheelchair so I couldn't leave the house, so of course I'm going to be depressed".*

Bisexual man

Some also felt that healthcare providers failed to recognise the effect that some conditions could have on the lifestyles of some LGBT+ people, particularly around gay men's sex life. An example was a gay man who suffered from anal fissures. Although he had repeatedly tried to explain to his GP that this was not just a physical health issue but also about his sexual health as a gay man, he felt that the limitations on his sex life had never been taken seriously and that alternative treatment methods had not been explored. Another gay man who works supporting MSM also said that diagnosis and treatment of prostate cancer also often failed to take into account the sensitivities of how this could affect gay men's sex lives.

## GP Services

A majority of people who engaged with the research were, overall, happy with the care they received from their GP and most of those who were out to their GP had positive experiences.

However, many of the points made above about general experiences in healthcare applied to experiences in GP surgeries. This includes issues around heteronormative assumptions, examples of GPs misdiagnosing people through assumptions made about their sexuality or gender identity and concerns around confidentiality.

Many LGBT+ people said that they were not out to their GP. Reasons for not being out included fear of discrimination or negative attitudes (often based on past experience of accessing other services or the experiences of others), embarrassment/shame, or the fact that many people did not see their identity as relevant to their care.

Despite most experiences of GPs services being largely positive, some negative experiences recounted were:

- Difficulties caused by not seeing the same GP each time, making it difficult to establish a relationship of trust or having to come out at every appointment
- Patients (particularly trans and non-binary) feeling they had to educate their GP
- Inadequate advice, information and testing for gay and bisexual men's sexual health
- Lack of awareness and knowledge of trans issues and inconsistent experiences for trans patients (e.g. some GPs were willing to share care and prescribe hormones; others were not)
- Inappropriate advice to gay and bisexual women to 'get a boyfriend' to improve their mental health. There were similar accounts by several women.

*"When I went to the doctor a few months ago because I was having a bad time and not sleeping, one of his suggestions was 'Why don't you get a boyfriend?'. It was just ignorance, but I had waited until my mood was really low and then made the appointment which was a few weeks down the line, so by the time I got there I was just...I didn't even correct him, I couldn't deal with it".*

Gay/lesbian woman

*"I had a really bad experience when I went to talk to my GP about my depression. I'd hit a low point and said I would like to get counselling or get on medication and he turned round to me and said, 'Do you know, all you need is a wee boyfriend'".*

Bisexual woman

- Mental health problems in relation to the breakdown of same-sex relationships being trivialised or not taken as seriously as heterosexual relationships.

*"I went to the GP when I was at the point of having a mini nervous breakdown and I was sharing details about my relationship woes. Nothing was overt, but I sensed that this man would have taken the story I was telling him a lot more seriously had it been about an opposite sex couple. I was told there are no magic pills to cheer you up, my advice is move back to Glasgow (from Renfrewshire) and stay single for a year or too. Then I rang up week or so later – I was getting worse and worse. I basically said I wanted to see any other doctor. I went in and told her the exact same story and left having been taken seriously, feeling that my situation had been given some credulity, and most importantly a prescription for SSRIs which is what I needed at that point to take the edge off to allow me to pull myself together".*

Gay man

## Screening Appointments

Most lesbian and bisexual women who were within the age range to have routine cervical screening said that they did attend, but many felt that the screening protocols were not appropriate for them and found the heteronormative questions off-putting.

*"As a woman going for a smear test etc. they always ask are you sexually active, and then they say are you using contraception, and if you say no they look like you're the devil, so then I have to explain that I'm in a long term relationship with a woman. It's just a lazy presumption".*

Gay/lesbian woman

*"The last several times I've been for my smear test the practice nurse has always used it as a chance to talk about contraceptive needs. You find yourself in the situation of saying 'no, I don't use contraception' and she says 'are you not sexually active' and I have to say 'yes, but I'm married to a woman'...and then you have to get your smear done. It's all a bit embarrassing".*

Gay/lesbian woman



For all transgender people who engaged with the research, it was very important to them that their CHI number and gender marker was changed on their NHS records. However, this meant that NHS systems automatically sent them invitations to attend screening appointments based on their gender identity but not their anatomy (e.g. trans women being invited for cervical screening). Moreover, trans men and women were not automatically being invited to attend screening appropriate to their anatomy, and the onus was on the patient to remember to specifically ask for it. Trans men and women recognised the importance of having screening tests, but were concerned they would not remember to ask for them, and also had anxiety about having tests/procedures which were discordant to their gender identity.

*"Having smears is always a bit stressful. I have them at my GP surgery- the nurse practitioner does them. I have to remember when I last had one, because I don't get screening letters anymore because of being registered as male. It's easy to forget. They've always been good about it and done their best to make sure it's ok. But I'm very self-conscious about my genitals being different, and I wonder what they think really".*

Trans masculine

*"I'm not at the age of getting prostate exams, but I do worry how that will be. Will I be sitting in a clinic with a group of men in the waiting room".*

Trans woman

## Sexual Health Clinics

A common theme in discussions with gay/lesbian and bisexual women was the lack of dedicated sexual health services for WSW. When using sexual health services, gay/lesbian women sometimes felt that health professionals saw them as a low risk and were reluctant to refused to do full STI screening.

*"There was one time when I went to (sexual health clinic) and she was asking me stuff like what I did, and she asked me if there was any chance I was pregnant and I said there's no chance of that and she said why not, and I said I was gay. She asked if I'd ever been with a man and I said no I haven't, but I want to get a full sexual health screening - I just wanted it done so I knew. I was trying to explain to her that I've not been with a man but I've been with girls who have, and I just wanted to make sure I'm clear for when I next go into a relationship. She only did the chlamydia and something else, she said there was no point in doing the other ones because lesbians have a really, really low chance of getting an STD. I was starting to argue with her - like if it's a low chance, it's still a chance. But she was adamant, and I didn't get it done".*

Gay/lesbian woman

Some bisexual women felt that staff in sexual health clinics exhibited biphobic assumptions that bisexual women were promiscuous and engaged in risky sex.

*"I've had biphobic reactions at (sexual health) testing. As soon as you say you're bi, you get 'oh so probably unsafe sex or unprotected sex then' because there's an assumption that you're risky and have a huge number of partners. And if you have a negative reaction when you do come out, why would you then volunteer that information?"*

Bisexual woman



Gay and bisexual men often expressed praise for dedicated sexual health services for MSM which they felt offered a good service where they got good information, advice and treatment and where they were treated respectfully and non-judgementally.

*"I like the way that the NHS, especially for sexual health screenings, ask about drug use in a very neutral way, with no judging and it's clearly about just having the right information for the provision of the service. The non-judgemental way of asking is really helpful. The same with them asking about how many sexual partners you've had recently. They just want to be able to provide the most appropriate service and it does feel like that".*

Gay man

However, there was concern among gay and bisexual men that waiting times for sexual health screenings were becoming longer and there was a perception that cut-backs had reduced outreach sexual health testing teams on the gay scene.

Trans men and women and non-binary people often expressed confusion about which sexual health services they would use, and felt that generally there was not enough information and advice around trans sexual health.

## Transgender People as Hospital Inpatients

A number of trans men and women and non-binary people had experience of being inpatients in hospitals and often recounted problems with hospitals knowing which ward to place them on where wards were gender segregated, and some of those who had not been hospitalised expressed anxiety about the thought of being in an inpatient for this reason. In most cases, trans patients said that they had not been consulted at all about what ward may be most appropriate for them. Some examples where trans people had encountered difficulties with hospitalisation were

- A trans woman who was placed in a private room 'for her own comfort' when she would have preferred to be on a ward with other women, but she was sure she had been treated differently in case other women were concerned or complained about her being on the ward
- A trans man who was given a private room in the gynaecology ward (which he was happy with), but who was consistently misgendered by some of the staff who explained that they were used to women on the ward and were unapologetic
- A trans woman who was admitted in an emergency situation with no wig (with male pattern baldness) or makeup and staff were confused that her presentation did not match her medical records and CHI number and therefore spent a lot of time trying to resolve this, causing the patient some distress
- A trans non-binary person who spent 12 hours in A&E because 'they didn't know where to put me' and was eventually moved to a private ward in Intensive Care because the hospital was unable to place them in a ward more appropriate for their condition.

## HIV Stigma

Some of those living with HIV felt that they had been stigmatised and discriminated against on the basis of their HIV status. The only example in NHS services was dental services, with

one person saying that their dentist had insisted on only treating him at the last appointment of the day. Other examples were being refused a tattoo, and a private hospital charging extra for an operation because they had to book out the theatre for the whole afternoon to prevent contamination.

Service providers (and also one gay man who spoke about his experience as a care home worker) spoke about the concern they had for how older people living with HIV were treated in care homes, and felt there was discriminatory practice or lack of understanding among care home staff regarding HIV.

## Mental Health Services

Across all LGBT+ groups, there was huge frustration at the long waiting lists of mental health services, with waiting times themselves seen as hugely detrimental to mental health. The lack of early-intervention services for mental health was also decried.

Across all LGBT+ groups there was much reliance on third sector providers for counselling and support, many of which were dedicated LGBT+ services. Also, many had used private mental health services.

Some people spoke about accessing mental health services, but not being out to their mental health practitioners, even where they recognised that their LGBT+ identity was relevant to their mental health. In other cases, it took a number of sessions with a practitioner before patients felt able to be open about their identity. Some felt that their LGBT+ identity was not understood by mental health practitioners.

An LGBT+ service provider spoke about the shortcomings of mainstream mental health service provision for LGBT+ people:

*"What people tell us – there is a huge desire for specialist services, not because people particularly want to focus on their LGBT identity, but they want that to be understood. What people tell us is that when they go to mainstream services that often one of two things happen– either the service provider will really focus in on their LGBT identity as somehow being the cause of their mental health issues (that's particularly true for trans people, but not only so), or there will be an attitude of 'this is not an issue for this service' and they'll skirt over it rather than saying ok, you're LGBT what does that mean for your relationships with your family, what does that mean for your intimate relationships, what does that mean for your employment, your relationship with your neighbours, are you the victim of hate crime – all of these things that we absolutely talk about daily and understand within the LGBT context".*

Service provider

Some LGBT+ service providers spoke of recurrent experiences where they referred people to mental health services, but patients were referred back to the LGBT+ organisation because their issues were deemed to stem from their LGBT identity.

There was discussion in many of the groups and interviews regarding whether mental health services should be provided for LGBT+ people through specialist services or mainstream services. Overall, it was felt that mainstream services should have more awareness and

understanding of LGBT+ people, but that specialist services should also be available as this was often very beneficial to LGBT+ people. Many extolled the benefits of having a counsellor who identifies as LGBT+ themselves. There were examples of LGBT+ people who had used counselling services and only felt able to come out to their counsellor when the counsellor said they were LGBT+.

## Drug and Alcohol Services

A few of those who engaged with the research had successfully used drug and alcohol services to treat addictions. Two people had tried addiction services such as AA, but felt that these programmes were too aligned to faith/religion which could be off-putting. Some addiction services (particularly those outside of Glasgow or Edinburgh) were often viewed as not being LGBT+ friendly and, as with referrals to mental health services, LGBT+ service providers reported referrals to addiction services often resulted in people simply being referred back to the LGBT+ organisation.

## Gender Identity Clinics

There was huge frustration and dissatisfaction with the GIC in both Glasgow and Edinburgh. Current waiting times for an initial appointment are around 18 months. For those who had made the decision to transition, this was a long and difficult wait during which they largely felt unsupported. Many opted to seek private treatment for hormones or buy hormones on the internet. As discussed in the previous chapter, this had a very significant financial impact. Some who had bought hormones themselves on the internet had had problems relating to taking the wrong dosage – when they had subsequently accessed the GIC, they had had to be referred to an endocrinologist to correct this:

*"I cheated – I got hormones from Portugal where there was no prescription limitations on hormones or antiandrogens. I was stupidly on far too high a dose of estrogen so when I did eventually see the GIC I was posted off to the endocrinologist. However, I still don't regret doing that – it was still better than waiting a year to get an appointment. I just cracked on".*

Trans woman

GIC staff also spoke about the problems caused by demand for their service greatly exceeding their capacity, and also their awareness of the lack of provision of services to support those on their waiting list<sup>2</sup>. Provision of services at the GIC was further constrained by a lack of specialists in gender dysphoria meaning that if any member of staff left or was on extended leave for any reason, there was a significant impact.

The waiting time for specialist counselling service at the GIC was even longer than the wait for an initial appointment, and this too caused considerable distress and many trans people sought private counselling.

Not only was there a long waiting time for initial consultation, but also additional frustration and distress caused by:

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<sup>2</sup> LGBT Health and Wellbeing report that they now have funding from NHS Lothian and in the last year were able to provide counselling to 51 trans people in Lothian, many referred to the service by the GIC in Edinburgh. Waiting times for the LGBT Health and Wellbeing counselling service average six weeks for the initial assessment and 14 weeks from the initial assessment to start counselling.

- Very long waits between appointments
- Long waits for appointments notes to be transcribed and letters sent
- Long waits for referrals, or referrals not being made
- Correspondence being addressed to previous name/gender identity, even after repeated corrections
- Being given inaccurate information/expectations of waiting times
- Various other clerical inefficiencies and errors

For those who had accessed the GIC, there were often accounts of trans people hiding relevant information for fear that it would prevent access to hormone therapy and/or surgery. Most commonly, this included mental health problems, including depression, anxiety, self-harming and suicidal thoughts or attempts. Not only did trans people hide mental health problems from professionals at the GIC, they often did not seek help elsewhere because they expected or feared that the information would be shared with the GIC.

*"I got diagnosed with an anxiety disorder, but I was seeing a uni therapist and he said that if I got diagnosed with depression or something like that, then that would mess up my transition because then the NHS could turn round and say that you're not in your right mind to be able to decide to go through the process. So even people I know who really need help, they don't reach out for it in case they get a diagnosis and then later on the gender clinic says you can't go through the process because of the diagnosis, and then you'll wait years and years longer again, to try and prove that you are trans."*

Trans masculine

*"Two of my three near misses with suicide occurred when I was under the care of the gender clinic. These are not things you can tell the gender clinic. I was terrified if I mentioned it they would refuse surgery".*

Non-binary

Some had experience of having their GRS denied or postponed on mental health grounds, but it was felt that having surgery denied was itself of huge detriment to their mental health. Some felt that gender dysphoria as a cause of mental health problems was not appreciated enough and that often the most effective treatment was to proceed with medical and surgical transition.

*"I was basically denied surgery because of my mental health –I was just told I wasn't mentally stable enough for surgery. I thought – in what way is withholding necessary healthcare going to improve anybody's mental health ever?"*

Non-binary

Non-binary people who had accessed the GIC also hid their non-binary identity. The GIC service has stated that they are accepting of, and will facilitate transitions for, people with non-binary identities, but the perception of non-binary people themselves was that they had to present as if wishing to fully transition to another gender.

*"I have never said anything about being anything other than a binary trans woman to the GIC or to anyone else in the NHS. I've been seeing a non-*

*NHS therapist and I wouldn't say anything to her either. It's just the paranoia of it getting back to the (GIC). It's easier to pretend I'm binary".*  
Non-binary

Some trans women were dissatisfied with the extent to which the GIC was able to provide services such as hair removal and wigs. It was felt that the courses of electrolysis available on the NHS were insufficient, and many had supplemented these with private treatment. A further complaint was that consultations for electrolysis involved having to go the clinic to be photographed with several days hair growth on their face, forcing some to be housebound for a period as they would not be seen in public with facial hair, and also causing considerable anxiety having to go to the clinic. Trans women felt that they should be able to submit their own photographs for this purpose. Some trans women also felt that it was unfair that wigs were not available on the NHS for those who had male pattern baldness:

*"I enquired about getting a wig from the NHS and the doctor was like yes, absolutely – other women with hair loss would get one. A letter came back that said this is for natal females only. I have challenged that. It's another thing I have to self-fund. A colleague of mine who has hair loss – she gets it – but I don't. That's discrimination. But if I try to do something about that – I use the NHS for so many other things, you don't like to make too much of a fuss and don't want to be seen as a troublemaker when I'm so dependent on the gatekeeping of the GIC for everything else".*

Trans women

A further issue of concern which was raised by service providers as well as trans people was the perception that rules around Body Mass Index (BMI) imposed by the GIC were unfair and unnecessary, where the GIC would prevent GRS if BMI was above a certain threshold. There was a suspicion that this was 'gatekeeping' and a means of cutting down the number of GRS patients. One trans man said that he had seen a private surgeon who had said he had no concerns about performing the surgery privately, but acknowledged that the NHS would refuse him on the basis of BMI, which was used as a way to reduce the number of people eligible for surgery.

Geographical constraints of GIC services were also an issue, with those living in rural areas having to travel large distances to use the GIC. There was a perception of inequality in service provision between Glasgow and Edinburgh, with those in Edinburgh feeling that the GIC in Glasgow offered a wider range of services. The lack of any GRS in Scotland meant that trans people had to travel to England not only for surgery but also for pre- and post-operative consultations.

*"There are only two top surgeons in Manchester and they've obviously got the whole trans male community in Scotland to deal with. You have to go all the way down for them to look and say 'yeah, we'll give you surgery', and then you go all the way back down to get bloods and swabs taken. And then you go back down for your surgery. And then you go back two weeks later and they say 'yeah, it looks fine'. Surely some of that can be done locally even if the surgery is in Manchester".*

Trans masculine

## Fertility and Pregnancy Services

A few of the bisexual and gay/lesbian women who engaged with the research had experience of accessing fertility and pregnancy services. Experiences were mixed. Some felt that the process of accessing fertility services was lengthy and complicated but they did not feel they were discriminated in any way on the basis of their sexual identity. Others pointed to procedures, forms and questions being inappropriate for same-sex couples:

*"My partner and I went through a few rounds of IVF. All the encounters we had with people were really positive – it's not that unusual for same-sex female couples to be seeking IVF. But still the paperwork – I'm having to sign away that they can use my sperm for testing! It's just not applicable. Surely it can't be that difficult to come up with a separate set of paperwork".*

Gay/lesbian woman

Some felt that the fertility process was more complicated for same-sex couples on the NHS and sought private treatment instead. One woman who did so also encountered heterocentric protocols in the private clinic:

*"I did IVF with my female partner about five years ago. At that time, I couldn't access NHS treatment in the way my sister (who was in a relationship with a man) could. It was a more complicated process, so we went through a private clinic. The problem with that was all their paperwork was designed for straight couples".*

Bisexual woman

Another gay/lesbian woman described enquiring about fertility treatment at her GP surgery (in a more rural area outside of Lothian or GGC). They were referred to a clinic and had three appointments where they had to complete forms around infertility, answer questions about how long they had been trying to conceive or whether they had been abstaining from sex, before being referred to the hospital service (after nearly a year) where they learned they should have been sent in the first place – the initial clinic having only been appropriate for heterosexual couples. They were then put on a waiting list where they would have to wait a further 12 months to be seen. The frustration and disappointment forced them to seek private treatment.

## Fostering/Adoption

The literature review pointed to evidence from a survey which showed that many LGBT people thought they would face discrimination if they were looking to foster or adopt children. However, several of those who engaged with the research had experience of fostering, adoption or kinship care, or were in the process of exploring or applying for adoption and experiences were very positive. All services were felt to be inclusive and welcoming of LGBT+ parents.

## Personal Care and Elderly Care Provision

Several people expressed concern about their future as they aged and may need care. This was particularly likely to be mentioned by people in their 50s and older, and was the cause of real anxiety for some. Many spoke about hearing stories of gay, lesbian and bisexual

people going back into the closet in their old age, not feeling able to be open about their identity to carers.

*"In my experience, when you get to a certain age it is assumed that your gender, sexual orientation or queer identity doesn't matter – you're just a pensioner now. You're either a male pensioner or a female pensioner and that's what room you get in the care home. There is a lack of understanding that this is part of your identity when you go into care".*  
Gay/lesbian woman

*"My real concern is that the gay population is aging and most of the NHS budget is going into people who are aging. The problems of being older and needing care and being gay are not really being looked at yet. You see these articles about the arc of coming out and growing confidence and then isolation and going back into the closet again. If you end up needing care from people, you probably don't want to let them know you're gay – particularly if the service providers in social care come from different religious faith backgrounds. You're going to lie and you're going to feel isolated, and your mental health is going to suffer. I think it's important that care givers recognise the potential for you to be gay – it's up to you whether you choose to come out".*  
Gay man

Service providers also expressed concern about the prevalence of older people going back in the closet when they needed care. One gave an example of a gay man he supported who went into residential care and did not admit that his long-term partner who lived with was his partner and introduced him as his friend, and his daughter (who lived hundreds of miles away) was listed as next of kin.

One disabled wheelchair user who had support at home did not feel able to be out to her support workers, despite being out in all other areas of her life:

*"The only area where I'm not out is - there are support workers who come to help me with housework or things in the home and I'm not necessarily out to them because their chat about other things makes me think they might not be open minded. That's somebody who's in your home, so it's quite a vulnerable position. You don't want to open yourself up to the possibility of a hostile reaction".*  
Gay/lesbian woman

## Housing

Housing services were mentioned by only a few of those who engaged in the research.

One non-binary person had become homeless due to being evicted from their family home after coming out about their identity. This person was housed in emergency accommodation which was a women's shelter which they felt was very inappropriate:

*"I'm living in a women's refuge. It's hell. There are 15 women there – they were all like, are you female? I had to try to explain to them why I was there. I don't identify as female or male, but I dress more like a man and I have female parts. The housing service said that because I have*

*female parts they were going to put me in a female hostel. I said, 'but I'm not either or'. They wouldn't take that into consideration".*

Non-binary

A gay man who with mental health problems and a history of addiction who had been homeless, described how he was offered inappropriate accommodation which did not take into account his identity or his addictions:

*"In housing and homelessness services you become invisible in the system. And that's irrespective of gender identity or sexual orientation, but it must be complicated by prejudices. I was on the housing list for a year and then they offered me a practically burnt out flat with no furniture in an area where I had used to get drugs from and also had been abused for being gay at a bus stop. I refused it, but you can't do that many times".*

Gay man

In the group discussions with asylum seekers, the issue of housing was raised, and many were concerned that housing decisions, including who people shared with, were based only on gender and did not take account of sexual orientation. This was a particular concern where there was risk that gay or bisexual asylum seekers could be housed with straight asylum seekers from cultures where LGBT+ identities were not tolerated.



## Summary of Differentiated Findings for Health and Other Services

LGBT+	<p>Concerns about confidentiality in healthcare settings</p> <p>Perceived need for holistic service provision</p> <p>Many not out to GP</p> <p>Much concern about mental health service waiting times and lack of appropriate services</p> <p>Concern about lack of LGBT+ inclusiveness in elderly care</p> <p>Experiences of fostering/adoption positive</p>
LGB	<p>Wide experiences of heteronormative assumptions in healthcare settings</p> <p>Some concern about how sex same partners were treated (as visitors/next of kin)</p>
Gay/lesbian and bisexual women	<p>Particular problems with heteronormative assumptions in cervical screening, gynaecology and fertility services</p> <p>Lack of sexual health services and sexual health information for WSW</p>
Gay and bisexual men/MSM	<p>Concern about healthcare professionals making inappropriate assumptions about HIV risk based on identity alone</p> <p>High levels of satisfaction with sexual health services for MSM, but some concern about increased waiting times</p> <p>Some living with HIV had experiences stigmatisation using services</p>
Transgender men and women	<p>Common experiences of healthcare professionals inappropriately attributing symptoms to hormones</p> <p>NHS protocols meant trans people were not automatically invited to appropriate screening appointments</p> <p>Lack of provision/information for trans sexual health</p> <p>High level of dissatisfaction with GIC, particularly waiting times and inefficiencies</p>
Transgender men and women and non-binary	<p>Problems associated with hospital inpatients being placed in inappropriate wards and mis-gendered</p>
Non-binary	<p>Forms and recording systems often prevented non-binary people's gender being expressed/recorded accurately</p>

## 7. Intersections

### People of Faith

#### **Muslims**

Three people from Muslim backgrounds in Glasgow contributed to the research (this does not include a number of Muslim asylum seekers, who are covered in the Asylum Seekers section below).

Muslim LGBT+ people stressed the very strong family relationships and ties to the wider Muslim community. Both family relationships and relationships with the wider community were very important to them, but the Muslim community was said to be intolerant of LGBT+ people. Two of those who engaged with the research were not out to anyone in their family or their community; one had left home was out to her mother but no-one else in her family.

Early realisation of having a gay identity in the context of a traditional Muslim family was a very difficult and isolating experience and was associated with significant mental health problems:

*"When I was younger and started to realise about my sexuality while living in a traditional Muslim family, it had a huge effect on my mental health. I was scared to accept myself. I didn't want to know myself. I got very depressed and I had suicidal thoughts for a long time. I didn't talk to anyone about it".*

Gay/lesbian Muslim woman

Some of the complexities of living as a gay man in a traditional Muslim community were summarised by a gay Muslim man:

*"I was born and brought up in an area of Glasgow which is a predominantly Muslim Pakistani community. Growing up I had a lovely community around me who were very supportive in terms of my cultural background. When it comes to my sexual identity, it is a nightmare situation because I can't come out to anybody in my family or my community—it's a very tightknit community and if you fall out with this community the effect is you're left isolated. I honestly don't care what people think of me, but what I do care about is how my mum and dad are perceived, and I wouldn't want someone to discriminate against my mum and dad for my sexual identity. As a result, I've had to keep my identity hidden for years. Living a double life for that length of time – it's mentally draining. So the community is like a double-edged sword – there are people I know in the community who I can turn to if I have problems with my car, or if anything happens financially, there are people I can approach and I know for a fact they'll support me. But in terms of me coming out as a gay man – that would never be accepted. The dialogue hasn't even begun. I'm hoping that inclusive education might mean the next generation are more accepting".*

Gay Muslim man

Within the Muslim community, there was a culture of families living together, and there was an expectation that single people in particular would live with their families until they got married. For a gay man living with his extended family, this caused additional problems of living with people he was unable to be open about his identity with, being unable to bring partners home, being unable to stay with, or move in with, partners. He had relationships with previous boyfriends breakdown because he was unable to introduce them to his parents or move the relationship to the next level by moving in together.

All Muslim people who engaged with the research said that there were elements of Islamophobia or racism in the LGBT community, citing experienced such as having abusive comments made in gay bars. Many of the wider groups and interviews highlighted many LGBT+ people's dismay at LGBT+ social spaces almost always being centred on the consumption of alcohol, and for Muslim people who do not drink alcohol, this was particularly exclusionary.

There were no trans Muslims who engaged in the research, but comment was made by other Muslims about the difference in how trans people were viewed by the Muslim community in Scotland compared to Muslim countries. The perception was that the Quran acknowledges Third Gender, and trans and non-gender conforming people are accepted in countries such as Pakistan and Iran, but the culture which has developed among the Muslim community in Scotland is not accepting of trans identities. Those who were members of the support group Hidayah related accounts of Muslim trans people in the group who faced discrimination, hatred and isolation.

Hidayah was used as a means of LGBT+ Muslims coming together, mostly by means of on-line chats to share experiences and offer mutual support. This volunteer-led organisation was seen as a lifeline and helped them feel less isolated. Some of the asylum-seeking Muslims who engaged with the research had also used this group and found it very helpful. Other than Hidayah, there was felt to be no other organisations who could understand or help with the unique set of pressures felt by LGBT+ Muslims:

*"I was in a bad place and feeling suicidal and I contacted (a mental health charity). But when I contacted them they put me through to an LGBT counselling service and the person I spoke to was lovely – however they couldn't really understand my predicament or give me an reassurance that everything would be ok if I was to come out to my family because they didn't understand my cultural background. I knew it was difficult for them to empathise with me because my lived experience is very specific. I didn't contact them again or any other charity, because I knew there was no one who would understand".*

Gay Muslim man

Some had turned their back on their faith or were practicing their faith 'for show'. However, one gay Muslim man remained devout in his faith, studied the scriptures and had not found anything which he felt negated his validity as a gay Muslim. His faith was a central part of his life and important for his wellbeing.

### **Christians**

Some of the LGBT+ people who engaged in the research had experienced the breakdown of family relationships or negative reactions to coming out which were grounded in Christian faiths/beliefs. There was also a perception that much of the negative dialogue on social media

about LGBT+ people had a Christian (or distorted Christian) basis. These types of attitudes caused many LGBT+ people to have a dislike or wariness of Christian organisations and churches and people of Christian faith.

Some of those who engaged in the research had a Christian faith. Some said they had a strong faith but did not feel comfortable attending a church because they feared a negative reaction, particularly if they moved to a new place:

*"I was going to an evangelical church (in England) for 20 years and although the leadership knew my sexuality, it was never an issue, but it was never something I could openly discuss. The interesting thing is since I moved up here I've never been to church – I've had so many church friends from (England) come up to visit and they say have you not found a church yet? I say the reason I haven't found a church is I don't want to be judged as soon as I walk through the door and everyone will start whispering there's a new person, he's single, I wonder what way he swings".*

Gay Christian man

Some who had a Christian faith or a Christian upbringing found it difficult to reconcile their faith and their LGBT+ identity, at least at first, or found it difficult to be out at church:

*"When I was younger I was doing research into Christianity and finding all this hate, and the hate being the thing that's publicised – all the news stories about Christians and LGBT people are negative. So I was like, most Christian people don't like me, so I can't be out with my church. For quite a long time I wasn't out with the rest of my church. There's an assumption in the LGBT community that they're not welcome in Christian spaces, and so there was a bit of a disconnect when I was younger that you can't be Christian and LGBT – you have to choose one or the other because Christians hate us. That was difficult to navigate, being able to have that Christianity and that spiritual life, but also maintain my identity as a gay woman".*

Gay/lesbian Christian woman

Some were part of affirming, supportive Christian churches where they did not feel judged and felt able to be open about their identity. However, even where Christians had a supportive church environment and strong faith, they could find it difficult being out in the wider Christian community or with Christians they did not know:

*"There is that thing even though I'm Christian, if I find out someone else is Christian I'm far less likely to come out to them because I don't know what side of the fence they're going to be on.... I remember talking to a friend who works in mental health. She was saying that she wasn't allowed to wear a cross at work. I think she was expecting me to say you should be able to, but I was like, even as someone who is Christian, if I came across someone who was wearing a cross I wouldn't come out to them, I wouldn't be able to be open with them because I would be so worried it would influence their treatment of me".*

Gay/lesbian Christian woman

Some Christian LGBT+ people spoke about being the target of anti-Christian discrimination from within the LGBT community. An example was negative comments and verbal abuse when walking with a church group at Pride.

Those who had a Christian faith felt that their faith was very important for their wellbeing, and this was sustained even when relationships with some churches had been difficult:

*"My faith and spirituality is very important to me. My faith is something that really sustains me in difficult times. I've had negative experiences of churches in the past. When I came out, I got kicked out of church which was traumatic. But since then I found (an affirming church) which is great".*

Trans masculine Christian

*"I don't have an issue with my sexuality and my faith and my love for God. I still worship and love God at home and listen to worship music. My issues are with judgement within the church, and that's very unhealthy – especially if you're going back to the core value which, if you have faith, is love. Nothing is bigger than love".*

Gay Christian man

## Disabled People

Disabled people who engaged in the research had a wide range of specific needs and experiences.

Many disabled LGBT+ people felt that it was very difficult for them to be out at work, feeling that their main battle at work was for their disability to be accommodated, and therefore LGBT+ inclusiveness would be another battle for them.

*"In my previous workplace I was out to only one or two people. There was a lot of homophobia around. And that thing if you're disabled and LGBT, you're fighting for getting access needs met, so adding to anything on top of that would just have been...well pick which one I want to fight for. It's just easier not to be out".*

Gay/lesbian disabled woman

*"It's bad enough having a visual impairment and not having information accessible and not getting the right assistive equipment. As far as being LGBT, I've heard too much negativity around it; people are so judgemental and speaking about people at work who are transitioning – you become the subject of gossip. Instead of seeing a person as a person, you become this label, or speculation. So I've never mentioned I'm bisexual – it's bad enough having an impairment. It's been one battle after another to get anything for my visual impairment, so why would I add something else into the mix?"*

Bisexual disabled woman

The LGBT+ community was overall seen as not being inclusive for disabled people because:

- LGBT+ service provision and social spaces are not accessible
- LGBT+ social spaces focus on alcohol, and many disabled people can not drink alcohol due to medication or factors relating to their disability
- Disabled people frequently encountered negative attitudes towards disabled people among other LGBT+ people
- Disabled people were often disregarded as potential partners by many in the LGBT+ community.

Many of the disabled LGBT+ people who engaged with the research felt that they were often 'desexualised', with people often assuming they did not have a sex life or could not have a sexual identity. Also, they said that when they were open about their sexual identity or alluded to having a sex life, they were often asked inappropriate, invasive questions about the details of their sex lives. The tendency to be desexualised meant that where LGBT+ disabled people had a partner, the partner was often not recognised or legitimised:

*"When you do have a partner, it's not even recognised as a real relationship. You must just be pals. If you're trying to access services together, support each other, advocate for each other accessing health services, they can't get their heads round that this is a real relationship. Quite often you find yourself having to out yourself repeatedly to the same person until they get it".*

Gay/lesbian disabled woman

As well as being desexualised, some disabled people felt they were vulnerable to being fetishized by some people in the LGBT+ community.

As noted in Chapter 2, disabled LGBT+ people could be particularly vulnerable to abusive or unhealthy relationships.

While the lack of appropriate SHRE in schools was mentioned by many LGBT+ people, some disabled LGBT+ people said that sex education was even less likely to be given to disabled young people.

*"The whole desexualisation of disabled people starts at school. You don't even get sex education in a lot of special schools. A lot of disabled people aren't getting sex ed because it's assumed we won't be having sex".*

Bisexual disabled women

*"Even if you do get sexual health booklets, even the LGBT inclusive ones, there's never any reference to disability. There's never any reference to disability. There's all this information going out that we as a community aren't included in".*

Gay/lesbian disabled woman

As noted in Chapter 4, disabled people coping with physical pain could be susceptible to dependency to opioid pain relief. Some alluded to using them, or being tempted to use them for emotional relief:

*"I only take prescribed drugs, but there are times when I've used prescribed painkillers that border on addictive - times when I've taken painkillers not to not feel pain, but to not feel anything. That's a dangerous place to be, because there's no-one I can talk to about that - if I go to the doctor and say I'm experiencing addictive behaviour with my pain meds, they'll just take the pain meds away and then I'll be left with the pain. So there's nowhere I can address this problem - I just have to manage it on my own".*

Disabled bisexual man

Overall, disabled LGBT+ people felt the effects of 'double discrimination', feeling they were discriminated against on the basis of both their disability and their LGBT+ identity, and feeling they did not usually fit in with either LGBT+ or disability support or social groups. This was also a problem with finding opportunities for sport and physical activities, with disabled sports not necessarily being LGBT+ inclusive, and LGBT+ sports clubs not catering for disabled participants.

## Asylum Seekers

Asylum seekers who engaged with the research came from various Asian, Middle Eastern, African and Caribbean countries. Those from Asian, Middle Eastern and some African countries came from Muslim backgrounds and those from other African countries and the Caribbean had Christian backgrounds.

All asylum seekers described very traumatic experiences in their home countries and often included serious physical assault, death threats and risk of imprisonment or death penalty. All had experienced the rejection of family, friends and their church/faith group. Some had given up lucrative or rewarding careers and arrived in Scotland with nothing.

There were some asylum seekers who had links with the African community in Scotland, but within this, they were not out about their identity.

*"I am connected to people from (African country) here, but even here, they talk openly about how they hate gay people, so I can't be open with them. I still feel that I need people to talk to with my native language and speak about home, and I get support from them - we meet up for lunch and they help me out with things, like someone gave me a TV - they would never have done that if they'd known I was gay. Of course it's not as bad as back home - I know, at the end of the day, they can't do anything to harm me, but I would lose that social connection if they knew my true self".*

Asylum-seeking gay man

Others said that they deliberately avoided people from their home country because they would not be accepted and would be seen as a 'curse'. One person talked about moving to Glasgow from London in order to move away from a cultural group from his own country in order to be able to live freely as a gay man.

Some asylum seekers retained a strong Muslim or Christian faith, but found it difficult to find a safe place to worship where they could be open about their identity.

*"I am a Christian. Back home I couldn't be out. When I went to church I was there physically, but mentally I was somewhere else. They preached against being gay. When I moved to Glasgow I heard about (an affirming church) but I haven't been there. They must preach a different thing, not judge you – but it's hard going into a church when I'm so used to being judged".*

Asylum-seeking gay man

*"I'm a Christian, but in my church (African church in Glasgow) they condemn homosexuality. They say if you are involved in it, you need to leave us. I don't say anything, I just sit there and listen. They try to drive out the evil spirits causing homosexuality".*

Asylum-seeking gay/lesbian woman

*"Unlike Christians, In the Muslim community there are no churches that accept gays. If you even have a sign that you might be gay, you can not enter the mosque. The only thing I can do is connect to other gay Muslims through Hidayah online. That's the only support we get as Muslims who want to practice our faith".*

Asylum-seeking gay man

All viewed Scotland as a welcoming and inclusive country.

Most of the asylum seekers, having grown up in cultures where LGBT+ identities were not tolerated, retained an ingrained sense of shame regarding their identities and were very reticent to discuss this openly. This sometimes included a failure to disclose their identity at their initial Home Office interview and this could jeopardise their asylum claim. Most were not out to their GP or other service providers for the same reason.

Mental health was a very significant problem for all the asylum seekers who engaged in the research, the majority having attempted suicide, many on multiple occasions. Suicide was seen as a very likely outcome of failed asylum claims. Mental anguish was caused by:

- Past traumatic experiences in their home country (and in some cases, traumatic journeys to reach Scotland)
- Separation from their family and culture
- An unknown future, huge fear of being sent back to their country of origin where they are persecuted for their identity
- The asylum seeking process with long, traumatic and invasive interviews

*"You're an asylum seeker so you're running away from something, and you're LGBT which you never wanted, and then you have the Home Office that are putting pressure on you, and how can you prove to them who you are? Asylum seekers go through a lot, and when you're in the LGBT community, that's double pressure".*

Asylum-seeking gay/lesbian woman



*"Every single one of us who are asylum seekers have mental health problems, worrying how our case is going to go. When they ask me to go for an interview, I lose sleep for a week, and then they call the interview off. I have to take medication to be able to sleep. I've attempted suicide three times".*

Asylum-seeking gay man

*"My mental health started to deteriorate because of constant calls from the Home Office and constantly having to say to them to please contact my solicitor. Going to do my interview was the most harrowing, most degrading moment. The questions that were being asked – I felt naked, I felt raped, again. I felt degraded, that my dignity had been stripped from me. My privacy was invaded. My confidence was taken from me. After the interview I attempted suicide three times".*

Bisexual female refugee

*"The uncertainty of whether I can stay here is what gives me depression and anxiety. I know what will happen to me if I go back – I have death threats from my family. I've been through appeals and now I'm going for a judicial review. I am in a constant state..every time I hear a car outside, I'm alert. You never know when someone is coming to get you. I have insomnia – I sleep one hour out of every 24. I feel trapped. No wonder people are killing themselves. I've been told I can't stay here and I've been told I'll be killed if I go home. I've attempted suicide six times. In a week I'm going to the Home Office, but I don't have an active case – I could well be detained and sent back".*

Asylum-seeking gay man

Those whose claim was rejected were told they could no longer access any services, including the NHS. There was therefore no support or treatment available to them when suicide risk was the highest. However, some had been told by their GP that they would continue to treat them<sup>3</sup>.

The LGBT asylum seekers group in Glasgow is volunteer-led, with LGBT+ asylum seekers connecting and supporting one another. This was very positive for them, and there was much reliance on one another for support. Some Muslim asylum seekers also found it helpful to connect to Hidayah. However, asylum seekers did not tend to access any wider LGBT+ support services or groups<sup>4</sup>.

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<sup>3</sup> The understanding of the asylum seekers who contributed to the research was that they were not entitled to use services, including the NHS, once their asylum claim had been denied, and the perception was that doctors who continued to treat them were doing so as a favour. However, in Scotland, the NHS will provide free care to all – this was not something that appeared to be known.

<sup>4</sup> The LGBT asylum seekers group in Glasgow is supported by LGBT Health Scotland (they provide venue hire and promote the group), and LGBT Health Scotland also report providing mental health and other support to individual asylum seekers.

## Rural/Urban Differences

Many pointed to the differences in experiences of LGBT+ people in rural areas or small towns compared to large cities like Glasgow and Edinburgh. It was considered much harder to be an LGBT+ person in a rural area for many reasons:

- LGBT+ people said that generally, people in rural areas and small towns were more likely to have negative attitudes towards people with LGBT+ identities
- There was a lack of visibility and understanding of LGBT+ issues in rural areas
- LGBT+ people felt 'exposed' in rural areas and small towns, and often craved the anonymity of living in a large city. The cliché of being 'the only gay in the village' was often referred to, but was a stark and very uncomfortable reality for some.
- There was a lack of services for LGBT+ people and a lack of an LGBT community in rural areas
- GPs and other health services in rural areas may be less knowledgeable about LGBT+ issues, are more likely to be known to family members (therefore heightening concerns about confidentiality), and there is less choice in GP practices, meaning LGBT+ people were unable to transfer to another practice if they were unhappy with the attitude or level of knowledge of their GP
- Transgender people in rural parts of Scotland had to travel significant distances to attend GICs in cities.

*"I've dealt with isolation, loneliness, discrimination, exclusion and hate crime – all of that due to growing up in a village. With me being the only gay in the village it got quite difficult. I moved away and came back and it was just as bad – people crossing the road so they didn't have to walk by me, shouting stuff, etc. Small villages are a tough crowd".*

Gay/lesbian woman

Often, LGBT+ people had moved from rural areas to Edinburgh or Glasgow where they were able to connect with an LGBT+ community, the gay scene and LGBT+ service provision.

Conversely, a few of those who engaged in the research had moved from cities to smaller towns and villages in Lothian and GGC and they had concerns about how they would be received. However, their experiences were largely positive.

*"When we moved here (to a village in East Dunbartonshire) we were a bit unsure.. it's a small place and we didn't know how we'd be received. At the back of our minds we had plans to start a family and we weren't sure how that would be perceived, two men raising a child. But actually, there are other same-sex couples and a couple of same-sex parents, and really, times have moved on and people don't care. I'm cautiously optimistic that everything will be fine".*

Gay man

*"I was very concerned before we just recently moved (to a village in Midlothian). I don't know the area at all. My partner works for an LGBT Helpline and he hears the stories of small rural Scotland. I wouldn't say*

*we're scared, but it's something you take into account. We were joking after the first week, 'no bricks through the window yet!'*

Gay man

## Experiences Relating to Perceptions of Social Class

Many pointed to differences relating to social class. It was felt that people in more deprived areas were generally less open-minded or accepting of LGBT+ people. A number pointed to the difficulties of growing up in a 'working class' area or family, or going to school in a deprived area where they perceived bullying of LGBT+ people to be more prevalent. In describing their background as 'working class', it was evident that this term had connotations of 'traditional', with stronger expectations relating to gender roles and sexual orientation:

*"I was bullied quite a lot at school for being gay. It was in a working class part of Glasgow. I think if you were a girl you wanted to be a hairdresser, if you were a guy you wanted to be a footballer – that was the two career choices. I had no interest in sport whatsoever. I was bullied for being gay – they seemed to know before I did".*

Gay man

Some spoke about a more deprived background as having a very negative effect on them in terms of their inability to be out about the identity, internalised homophobia/trans phobia and experiences or being bullied at school. This was also recognised from those who grew up in less deprived areas - some pointed to not feeling comfortable or safe being visibly LGBT+ in deprived areas or around 'working class' people. One young trans woman described how she was supported by one side of her family but estranged from the other side, which she at least partly attributed to their working class background fostering traditional views:

*"When I wanted to transition, (my dad) wasn't supportive of that and I haven't spoken to him since. So I'm not in contact with my dad or his side of his family...his side are more traditional and conservative, and more working class than my mum's side of the family. Not that that's a black and white thing, but I do think in some communities there's less visibility, or less opportunity for LGBT to gain visibility within working class communities. I don't know how much that played into it, but that may have had an impact on their opinions. Before I came out, I did know there was a fair probability there would be an issue there, just because my (paternal grandfather) was quite vocally homophobic when it comes to those issues. That might be through the social situation and the area they're in. Exposure in day to day life is less common than in economically privileged areas".*

Trans woman

A further related theme was that those coming from more deprived background or those with lower educational attainment felt less equipped to deal with or challenge discrimination. This was something that was more commonly referred to by people who recognised that they were in a position to be able to emotionally handle discriminatory attitudes or vocalise their complaints of unfair treatment, but felt that others may not be able to. Those who felt they were from more privileged backgrounds sometimes asserted that they had a better resilience and confidence and could feel a sense of responsibility to be out or to stand up for their rights, as others may not feel able to do so.

*"I know I'm lucky - I had a good upbringing in a liberal household and always felt accepted...I think it's important to me to be out about how I identify and stand up and say something when I hear people saying anything inappropriate about LGBT people. There are people who are struggling with confidence and don't need to be exposed to that".*

Gay/lesbian woman

*"Heteronormative behaviour is so prevalent and it really takes you back. I work in this field, and I experience it, and every so often I go - that was a bit of an assumption. From opening a door to the guy who's come to fix the broadband saying 'is your husband in?'. Really? Obviously at my stage of life I get pissed off about it but ultimately you can laugh it off - but I do that from a position of privilege - I'm really comfortable with who I am. That's where it's the intersection of the poor mental health, economic deprivation, whether you've experienced childhood trauma have a negative effect on your life - you put LGBT identity in the mixture and it's a further disadvantage. That resilience is not easy to build".*

Service provider

## 8. Wish List and Discussion

The research has highlighted many issues relating to the causes and consequences of health inequalities for LGBT+ people particularly within the themes of social health, mental health, behaviours influencing wellbeing and access and use of health services. Of course, as a qualitative piece of research, the findings evidence the experiences of those who participated, but not the extent to which such experiences are replicated across the wider LGBT+ population in Lothian and GGC. The forthcoming national survey of LGBT+ will be valuable in quantifying many of these issues.

### Positives

The nature of the research meant that there was more time spent discussing negative than positives features of health and wellbeing, and this is reflected in the content of the findings presented here. Nonetheless, it is important to stress that many LGBT+ people who engaged with the research spoke about positive developments within the last few years which has seen LGBT+ people becoming more visible and more accepted, and less likely to face issues such as discrimination. Young LGBT+ people in particular appear to be more confident in coming out, and coming out generally appears to be a more positive experience now than it was in previous decades.

Although there were issues raised about availability of some health services and some incidents of practice in healthcare which was perceived as discriminatory, on the most part LGBT+ people felt supported by GPs and other health professionals and by third sector service providers.

### Wish List

Those who engaged with the research were asked for their 'wish list' of what they would like to see that would improve life for LGBT+ people. The most commonly expressed ideas are presented here, in approximate order of how often they were mentioned, together with a discussion of how these relate to the findings presented in the earlier chapters.

#### **1. LGBT+ Spaces for Socialising without a Focus on Alcohol**

The provision of LGBT+ social spaces was a priority across all LGBT+ identities. Many in Glasgow lamented the loss of the LGBT Centre which closed in 2009. This was felt to have been a hugely valuable, inclusive and safe space which gave LGBT+ people an opportunity to come together away from the alcohol-focused alternative places. Informants to the research said the centre was accessible for disabled people and inclusive of all LGBT+ identities and age groups. Across Lothian and GGC, there was a great appetite for a similar venue to be provided.

#### *Discussion*

The research highlighted the importance, for many people, of the LGBT+ community. It was vital for many to be able to connect to others in the LGBT+ community and develop friend groups with similar people. Those who were unable to do so felt particularly isolated; having LGBT+ friend groups and being part of the community was felt to contribute to improved

mental health. A key priority for many people across all LGBT+ identities was having appropriate, accessible social spaces to come together with other LGBT+ people away from the gay scene.

There were pockets of good practice and some niche LGBT+ clubs and groups focusing on specific interests (e.g. sports and singing). The community based groups supported by LGBT Health and Wellbeing were also helpful for some. However, the apparent unmet need was for a safe social space for LGBT+ people, or groups of friends to meet and socialise more organically and without specific agendas, but without alcohol or drugs.

Such venues may contribute not only to reduced isolation and improved mental health but also less engagement with behaviours such as excessive alcohol, drug use and risky sexual behaviour.

## **2. LGBT+ Education in Schools**

A further priority mentioned by many people across all LGBT+ identities was education about LGBT+ issues in schools. A very common complaint across all LGBT+ groups (including young people still in, or having recently completed, school) was that they had not received SHRE in schools which adequately related to their LGBT+ identity, leaving them without the required information about forming relationships and safe sex, and it was suggested by many that SHRE should be more inclusive of all identities. Moreover, many felt that education about LGBT+ identities in schools was needed to ensure that all people are aware of LGBT+ issues in order to ensure that LGBT+ issues are normalised/destigmatised, which, it would be hoped, would increase understanding and reduce discrimination.

### *Discussion*

LGBT+ education in schools was advocated by many people, and this would seem an appropriate area to develop, as suitable LGBT+ education may be effective in:

- normalising LGBT+ identities, improving acceptance and understanding among the general population;
- helping young LGBT+ people struggling with their identities to understand how they may be identifying;
- allowing young LGBT+ people in schools to feel included and accepted;
- alleviating any shame or internalised homophobia on the part of LGBT+ young people;
- providing LGBT+ with the information they need about making choices relating to healthy relationships and safe sex.

These measures may therefore be instrumental in improving many of the aspects of social and mental health highlighted by the research.

## **3. Training for Health and Other Staff**

Many suggested that there was a clear need to train staff, particularly in NHS services, in order to provide awareness of LGBT+ identities and ensure that service provision was inclusive, non-judgemental and appropriate. Some pointed out that training should be essential for receptionists and administrative staff who had contact with patients as well as nurses, doctors and counsellors. Some stressed the importance of such training to be

mandatory rather than optional, and some felt that such training should be embedded into medicine and nursing courses.

### *Discussion*

The research suggests that a key aim of NHS staff training should be to ensure that heteronormative assumptions, prevalent across all healthcare settings could be replaced with open and inclusive conversations and protocols. Healthcare providers could make significant steps to offering a more comfortable and inclusive experience for LGBT+ patients when their language, forms and protocols did not make presumptions about gender identity or sexual orientation.

Some other areas for improvements in healthcare may include:

- a better awareness and understanding of trans and non-binary issues in primary health care
- more information and provision around sexual health services for gay and bisexual women, transgender and non-binary people
- a more holistic approach to healthcare including the consideration of the relationship between physical health, mental health, and engagement with harmful behaviours; also more awareness and consideration of how certain conditions can specifically impact the lifestyles of LGBT+ people.

## **4. Mental Health Waiting Lists and Appropriate Services**

The long waiting lists and lack of availability of appropriate mental health services meant that improvements to mental health provision was a key priority suggested by many LGBT+ people. The importance of early-intervention mental health services was stressed by many, and generally cutting down the excessive waiting times for mental health services was seen as essential. It was recognised that all mainstream mental health services should be LGBT+ inclusive, and counsellors and other mental health practitioners should have adequate training on LGBT issues. However, it was also felt that specialist services for LGBT+ people, particularly the availability of LGBT+ counsellors would best meet the needs for many LGBT+ people. For trans people, mental health support while they were waiting to transition was also a key priority.

### *Discussion*

The research has shown that mental health problems are prevalent among all LGBT+ identities, but that service provision is inadequate to support and treat those with mental health problems. The research suggests that appropriate improvements to mental health service provision may include:

- General investment in mental health services to ensure shorter waiting lists for counselling and other therapies;
- Training for mainstream mental health professional to ensure they have the awareness, knowledge and skills to treat LGBT+ people appropriately;
- Provision of specialist LGBT+ mental health services, ideally with LGBT+ counsellors;
- Provision of dedicated mental health support for those waiting to transition;
- Provision of dedicated mental health support for LGBT+ asylum seekers, including emergency support for those whose claim is rejected.

## 5. Improvements to the GIC

Among trans men and women, improvements to the GIC service were the most frequently mentioned priority. The types of improvement desired were:

- Shorter waiting times for initial appointments
- Shorter times between appointments
- Improvements to efficiencies in, for example, dictating notes, issuing letters and making referrals
- Support for those on the waiting list
- More opportunities for shared care with GPs, which would relieve pressure on the GIC
- More access to services to assist transition including wigs and hair removal
- Provision of GIC services in areas other than Edinburgh and Glasgow
- Access to GRS in Scotland, or more pre- or post- op care available in Scotland.

### *Discussion*

Demand for the GIC service in Edinburgh and Glasgow clearly outstrips capacity and the evidence suggests that the long waiting times and inefficiencies of the service are hugely frustrating to the trans men, trans women and non-binary people who use them. A further issue was patients not disclosing all relevant information to the GIC for fear that it would prevent or delay their transition. Some of the impacts of the waiting times, inefficiencies and mistrust of the GIC were:

- detriment to mental health while waiting to be seen, prolonging the period of dysphoria without access to treatment for transition
- significant financial impact of private treatment
- dangers or damage caused by buying hormones without prescription
- risk of suicide or other impacts from not seeking mental health treatment or disclosing mental health problems.

The findings suggest are that investment is needed in the GIC to improve capacity and service provision. The experience of trans men and women varied with regard to the degree to which GPs were involved in their care, but training GPs regarding trans care and having more universal protocols for shared care and prescription of hormones would be a way of alleviating the pressures on the GIC and also providing more a more convenient service for trans people.

## 6. More Services being Visibly LGBT+ Inclusive

Many suggested that a key development would be more services, including health services, being *visibly* LGBT+ inclusive, and many pointed to rainbow lanyards, badges and flags worn or displayed by staff in workplaces as a very positive development, meaning that LGBT+ people felt more comfortable and welcome using services and felt they would be more confident being out about their identity and less likely to fear discrimination. However, some stressed that where services and staff used these types of branding, it would be vital to ensure that this was backed up by appropriate equality and diversity training. There were mixed opinions regarding formal accreditation such as the LGBT Charter mark. Some LGBT+ people felt that this was useful in knowing that services had a real commitment to inclusivity, and some LGBT+ service providers felt that if a service had the LGBT Charter mark they could



refer people there with confidence. However, some LGBT+ people felt that the amount of work required to achieve accreditation could be off-putting and could foster resentment among some people.

#### *Discussion*

The evidence from the research suggests that visible signs of LGBT+ inclusivity in services such as posters, rainbow lanyards/branding etc may help to inspire confidence in LGBT+ people in accessing and using services and being open about their identity. It would, of course, be important that visible signs of inclusivity were backed up by appropriate staff training to ensure that LGBT+ service users did indeed receive the level of service the branding suggested. The LGBT Charter mark or similar schemes may be valuable particularly for third sector services having confidence when referring LGBT+ people to services.

### **7. Support for LGBT+ Victims of Domestic Abuse and Sexual Violence**

Across LGBT+ groups, several people suggested that there needs to be provision of services to support people from the LGBT+ community who had been victims of domestic abuse and/or sexual violence, including services to support those who had been the victims within same-sex relationships.

#### *Discussion*

Many of the research informants had been the victim of domestic abuse and/or sexual violence, but there was a perceived lack of services to support or advise victims, leaving them further isolated and vulnerable. There was also a lack of understanding and awareness among service providers and the general public that sexual violence and domestic abuse can occur outside of scenarios involving male perpetrators and female victims. This could also mean that LGBT+ victims did not always recognise that their experience constituted abuse.

It is noted that at the time of interview (June 2019), funding was being sought for a service, led by Rape Crisis and LGBT Health and Wellbeing to support LGBT+ victims of sexual violence. The research suggests that this is a much needed service, and, once available, it would be important that this was widely advertised to ensure that LGBT+ victims were aware of it. A more general campaign raising awareness of domestic abuse and sexual violence in LGBT+ relationships may help victims to recognise incidents and seek help, and also boost awareness among the general population.

### **8. Provision of Inclusive Facilities and Opportunities for Sport and Physical Activity**

Many, particularly trans men and women and non-binary people, suggested that they would be able to be more physically active if there were affordable (e.g. council-run) sports facilities which provided gender neutral changing facilities with private cubicles. Some suggested more LGBT+ inclusive sports clubs and facilities. Some said they would be interested in taking part in dedicated sessions for trans people (e.g. yoga or swimming sessions), while others were against this and felt it would be more important to make regular sessions more inclusive.

### *Discussion*

While some trans and non-binary people indicated that they participated in sports and physical activity, descriptions of their activities were very often solo activities, and often behind closed doors – at home, or in one case during the night at a 24-hour gym.

Improving the provision of appropriate community sports venues with non-gendered changing rooms and offering inclusive sports sessions are likely to increase participation in sports and physical activity for trans and non-binary people and are may have impacts such as:

- Improving overall equality of access
- Reducing isolation
- Improving physical wellbeing, encouraging healthy weight
- Improving mental wellbeing

## **9. Provision for Asylum Seekers**

For asylum seekers, the key priorities were:

- Provide dedicated counselling services for LGBT+ asylum claimants, and have emergency services available to those whose claims are initially rejected
- Employ LGBT+ people to conduct Home Office interviews for asylum claimants as they would have a better understanding of the issues faced by LGBT+ claimants

### *Discussion*

The mental health needs of asylum seekers were particularly acute. These were often the result of very traumatic experiences in their home countries, separation from family and culture, internalised homophobia/shame, and the huge anxieties associated with going through their asylum claim and not knowing whether they will be returned to the country from which they had fled.

The research suggests that a dedicated mental health service for LGBT+ asylum seekers, offering support from a service which understands the unique set of pressures and issues faced by LGBT+ asylum seekers would be of great benefit. Moreover, it would appear that work is needed to ensure that asylum seekers are aware of any and all relevant existing services and, critically, that they are aware that they can access NHS services after an asylum claim is denied. Asylum seekers appear to be at particular risk of suicide and the point at which claimants are denied refugee status is potentially the most perilous. It is therefore most important that appropriate emergency mental health services are available.

## 9. Concluding Comments

We are indebted to all the LGBT+ organisations, service providers and employers who helped with the research – participating in the engagement events, contributing as interviewees, advertising the research, facilitating the recruitment of LGBT+ people and providing venues for group discussions. We are particularly grateful to all the LGBT+ people who gave their time to contribute and who spoke so eloquently and candidly about their experiences.

One aspect identified in the research which merits more in-depth qualitative exploration is the experience of LGBT+ elderly people who require care. The research highlighted that a common fear among LGBT+ people was that they may not be able to be open about their LGBT+ identity in their old age with those caring for them or in a residential care home. There were also some concerns about how those living with HIV would be treated in a care setting. Future research may be able to identify whether these fears are justified and represent the actual experiences of LGBT+ people receiving elderly care. The research included relatively few older LGBT+ people, and further research would be important to explore their wider needs.

The full health needs assessment will consider the findings from the literature review (published separately), the qualitative research findings presented here and the findings from the forthcoming quantitative survey. Together, these should provide a comprehensive assessment of the nature and extent of the health inequalities and needs of LGBT+ people and will inform future equality work, policy development, health promotion activities and service development.

## Appendix A: Methodology

### Literature Review

In March-April 2019, a literature review was conducted of relevant research in the last 10 years in the UK with a particular emphasis on Scotland. The review encompassed studies which include health and wellbeing components, including those conducted with LGBT+ populations and those with wider populations with sufficient sample size and details of LGBT+ status to allow an examination of differentiated results. The review includes measures of health and wellbeing outcomes, determinants of health and wellbeing, and experiences of engaging with health services. A separate report was produced with the findings from the literature review.

### Engagement Events

Two engagement events were conducted in May 2019 – one in Glasgow and one in Edinburgh. These events brought together staff and volunteers from health and other statutory organisations, third sector organisations supporting or campaigning for LGBT+ people, academics and other interested parties. The engagement events provided an opportunity to:

- Share the draft findings from the literature review, inviting comments regarding the extent to which findings were surprising or confirmed what was already known, identifying gaps
- Set out the plans for the qualitative engagement and invite comment about the composition (groups to engage with) and content (topics to explore)
- Invite interest in being involved in the qualitative engagement – being involved in the interviews with LGBT+ service providers and/or assisting in reaching LGBT+ to engage with the research.

### Qualitative Engagement with Staff Involved in Providing Services for LGBT+ People

Between 4<sup>th</sup> June and 1<sup>st</sup> July 2019, interviews were conducted with staff and volunteers at statutory and third sector organisations. Most organisations had a particular focus on LGBT+ people or subgroups of LGBT+ people, and some were selected because they represented a service sector which the literature review identified as a particular need for LGBT+ people.

The interviews were loosely structured, guided by a topic guide (see Appendix). The interviews ascertained information about each organisation (including the type of work/services offered, clientele and reach), and the perceived experiences and needs of the LGBT+ people they work with. The interviews also included discussions about the engagement with LGBT+ people for the next stage of the research including enlisting the help of organisations to advertise the research and/or recruit participants.

Interviews were conducted with the following organisations (two were conducted by telephone; the remainder were conducted face-to-face)

- **LGBT Youth Scotland**, a national organisation with a network of staff and volunteers supporting young people aged 13-25, including regional support groups and digital support. They also work on policy and influencing, support schools and other

organisations on LGBT inclusivity and run the LGBT Charter scheme to accredit inclusive institutions and organisations.

- **LGBT Health & Wellbeing**, provides support programmes for LGBT adults in Edinburgh and Glasgow, as well as the national LGBT Helpline Scotland. Their programmes have a primary focus on mental/emotional health and combatting social isolation. They run a range of social and support groups, offer specialist mental health services, one-to-one support and counselling, as well as supporting a range of volunteer-led community social groups. They involve volunteers in the delivery of many of their groups and support programmes.
- **Stonewall Scotland** is an LGBT charity who focus on policy work (changing laws), changing hearts and minds (public campaigns) and transforming institutions, including a diversity champions programme in workplaces.
- **WOW Network (Women Out at Work)** who support gay/lesbian, bisexual and transgender women in the workplace, aiming to support, guide and connect.
- **Waverley Care S-X Project (Edinburgh)** which promotes sexual health for MSM but also provides a holistic approach to addressing needs including mental health discussions, drug and alcohol use, etc. They provide testing, one-to-one support, referral and partnership working with other organisations, outreach and campaigns.
- **Terence Higgins Trust** – An HIV and sexual health charity, predominantly working with MSM. This includes a weekly clinic in Glasgow and peer support work for people infected with HIV.
- **Sandyford Gender Identity Clinic**
- **Chalmers Gender Identity Clinic**
- **Rape Crisis Glasgow** who are primarily a women-only service for those aged 13+ who have experienced sexual violence at any point, offering one-to-one, structured emotional support and providing advocacy through the criminal justice system. At the time of interview, they were developing a specialist programme for LGBT survivors of sexual violence in partnership with LGBT Health and Wellbeing and were hoping to secure funding for this.
- **Cyrenians** a homelessness charity who's work includes a mediation support service to support young people at risk of homelessness including relationships breaking down with parents/carers
- **Metropolitan Community Church (MCC)**, an affirming Christian church for LGBT people.
- **Y-Sort It, Clydebank**, a youth organisation with a wide-reaching remit who previously delivered a LGBT+ youth group and continues to support LGBT+ young people in West Dunbartonshire
- **Scottish Bi+ Network**, a volunteer-led organisation who campaign for bi-visibility and provide social events and online support/virtual meet-ups for bisexual/pansexual people in Scotland.
- **Glasgow Council on Alcohol** who are delivering ABIs with LGBT people, including in gay bars and exploring ways in which to make addiction services more inclusive
- **NHS Lothian LGBT+ Staff Network** who provide networking, support and social events for staff within the organisation and who are invited to give views on organisational policies etc.
- **Police Scotland** who have a Scottish LGBT+ Police Association and a network of LGBT allies in the workplace who challenge inappropriate conversations/behaviours, signpost people to where they can get help, etc.

- **Edinburgh Trans Women’s Support Group**, a group for trans women supported by LGBT Health and Wellbeing
- **NHSGGC Health Improvement Team for Sexual Health**

In addition, in the subsequent phase of interviews with LGBT+ people, interviewees were identified who were also involved with LGBT+ organisations and were able to speak from an organisational perspective as well as a personal one. Additional organisations were:

- Out on Sundays (walking group for gay men in Glasgow)
- Unscene Edinburgh (social group for gay and bisexual men in Edinburgh)
- Hidayah (support group and campaign for visibility of LGBT+ Muslims)
- LGBT Unity (support and social group for LGBT asylum seekers in Glasgow, supported by LGBT Health and Wellbeing)

## Qualitative Engagement with LGBT+ People

### Timescale

Qualitative engagement with LGBT+ people was conducted between 1<sup>st</sup> July and 15<sup>th</sup> August 2019.

### Advertising and Recruitment

Multiple methods were used to advertise the research and recruit participants. These included:

- Development of a flyer (identical paper and e-flyers were produced)
- Attending Pride Edinburgh on 22<sup>nd</sup> June to hand-out flyers, speak to attendees and invite people to complete an engagement form if they were interested in taking part
- Social media campaign on Twitter, launched by Traci Leven Research and shared by many LGBT organisations and individuals. Several hundred thousand views were achieved
- Many organisations shared information on their websites, Facebook Pages, newsletters and mailing lists
- Direct recruitment by LGBT+ organisations

An online engagement form was used for LGBT+ people to express interest in taking part in the research. The form collected contact details, information about gender, trans and sexual identities, preferred means of engaging and some demographic details.

### Sample Size and Profile

A total of 209 people completed the online engagement form, and further LGBT+ people were directly recruited to some group discussions by organisations. Approaches were made to all LGBT+ people who completed the form, with the exception of approximately 15 gay men (being the only LGBT+ subgroup which was over-subscribed). However, a significant proportion chose not to engage or did not respond when invited to take part.

LGBT+ people engaged via:

- 16 (physical) discussion groups in Greater Glasgow & Clyde and Edinburgh
- 2 online discussion groups
- 28 face-to-face interviews

- 10 online interviews (a mix of video, voice and text interviews)
- 13 phone interviews

Discussion groups were composed of people with similar LGBT+ identities, or a mix of LGBT+ people in thematic groups. The composition of each of the 18 groups is shown below:

<b>Group</b>	<b>Location</b>	<b>Recruitment Method</b>
Gay men	Glasgow	Volunteered via engagement form
Gay/lesbian women	Glasgow	Volunteered via engagement form
Bisexual women	Glasgow	Volunteered via engagement form
Non-binary	Glasgow	Volunteered via engagement form
Men living with HIV (comprised gay men and bisexual men)	Glasgow	Existing support group in third sector
Young LGBT+ people in West Dunbartonshire (comprised lesbian women and trans masculine)	Clydebank	Recruited by youth organisation
Disabled LGBT+ people (comprised bisexual women, bisexual men, gay men, lesbian women, non-binary)	Glasgow	Recruited by disability support group
Asylum seekers (comprised gay men, bisexual women, lesbian women)	Glasgow	Researcher visited LGBT+ asylum seeker social event to meet and invite people, obtain contact details
Asylum seekers (comprised gay men, lesbian women)	Glasgow	Researcher visited LGBT+ asylum seeker social event to meet and invite people, obtain contact details
Gay men	Edinburgh	Volunteered via engagement form (augmented by some recruited by a third sector organisation)
Bisexual women	Edinburgh	Volunteered via engagement form
Bisexual men	Edinburgh	Volunteered via engagement form (augmented by some

		recruited by a third sector organisation)
Trans women	Edinburgh	Volunteered via engagement form
Young trans and non-binary people aged up to 25 (comprised trans masculine, trans women and non-binary)	Edinburgh	Recruited by LGBT+ youth organisation
Young LGBT people plus LGBT support workers (comprised gay/lesbian women, gay men, trans masculine, non-binary)	Edinburgh	Existing group in third sector
Non-binary	Edinburgh	Existing social group
Gay/lesbian women	Online	Volunteered via engagement form
Gay/lesbian women	Online	Volunteered via engagement form

In total, 175 people participated in the research. The breakdown by identity is shown below:

	<b>Focus group participants (across groups) 18</b>	<b>Interviews</b>	<b>Total</b>
Lesbian/gay women	23	7	30
Gay men	33	14	47
Bisexual women	17	2	19
Bisexual men	8	4	12
Trans women	9	8	17
Trans masculine	10	8	18
Non-binary	23	6	29
Others (asexual, queer)	1	2	3
<b>Total</b>	124	51	175

All participants are only counted once, with gender identity taking precedence over sexual identity for the purposes of classification. A majority of trans men, trans women and non-binary people who engaged also identified as gay, lesbian, bisexual or pansexual.

The breakdown by health board is shown in the following table:



## Breakdown of Participants by Health Board

	<b>GGC</b>	<b>Lothian</b>	<b>Total</b>
Lesbian/gay women	21	9	30
Gay men	27	20	47
Bisexual women	11	8	19
Bisexual men	8	4	12
Trans women	4	13	17
Trans men/trans masculine	6	12	18
Non-binary	11	18	29
Others (asexual, queer)	3	0	3
<b>Total</b>	<b>91</b>	<b>84</b>	<b>175</b>

Most of those who engaged lived in Glasgow or Edinburgh, although attempts were made to reach as many people as possible in other local authority areas in GGC and Lothian. Of the 91 people from GGC who engaged, 16 were from areas other than Glasgow (East Dunbartonshire, West Dunbartonshire, Renfrewshire, East Renfrewshire and Inverclyde and two who lived outside of GGC but used services there). Of the 84 people in Lothian, 10 were from areas other than Edinburgh (East Lothian, Midlothian and West Lothian). Many of those who engaged had experience of living elsewhere in Scotland prior to living in GGC and Lothian, and there were also people who had moved to Scotland from abroad – indeed, there were participants from every continent.

The age breakdown is shown below:

<b>Age group</b>	
16-21	27
22-29	56
30-39	36
40-49	33
50-59	17
60+	6
<b>Total</b>	<b>175</b>

## Group Discussion and Interview Conduct

A topic guide was developed for the group discussions, together with visual prompts on each of four topics:

- Social health
- Mental health
- Health behaviours
- Health (and other) services

The topic guide and visual prompts can be found in Appendix B. The purpose of the topic guide and visual prompts was to introduce the broad themes of focus to the study, but participants were free to identify and discuss the issues most relevant/important to them within each theme.

Group discussions were recorded (with consent from all participants) and subsequently transcribed.

The same topic guides and visuals were used for one-to-one interviews. The visuals could not be used for the telephone interviews, and in these cases the interviewer described in more detail the key sub-themes that the interviewee may wish to discuss.

Online groups and interviews were conducted using secure private online meeting rooms through Adobe Connect. The interviewer/group moderator presented by video, and the visual prompts were displayed on the screen. Interviewees/participants responded by video, voice or text (or a mix of these). Where interviewees responded by text only, a full written account was generated in the course of the interview; where they responded verbally, these were recorded and subsequently transcribed.

Interviews and groups varied considerably in length, but on average, interviews took around 50 minutes and groups were around 90 minutes.

### **Incentives**

Incentives were offered for participation. Each group participant received a £20 high street voucher and they were offered reimbursement of travel expenses (although travel expenses were not offered where groups were conducted within a meeting/group they usually attended). Those who took part in interviews were entered into a prize draw for a £50 high street voucher.

### **Standards and Compliance**

All research was conducted in accordance with the Market Research Society Code of Conduct<sup>5</sup>, and was compliant with data protection regulation.

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<sup>5</sup> <https://www.mrs.org.uk/standards/code-of-conduct>

Appendix B : Topic Guides and Visuals

## **Topic to Cover in Engagement with LGBT+ Organisations/Service Providers**

1. Details of organisation: services provided, populations targeted, size, reach, geographical coverage, etc.
2. Views on the issues/health needs of LGBT+ people, particularly the populations within the scope of the organisation

Reference topics covered in the literature review/feedback on literature review findings

3. Views on existing service provision for LGBT+ people
  - To what extent are services available, accessible, appropriate, inclusive?
  - What are the barriers to access/engagement for LGBT+?
  - Are there examples of good practice/what works well and why?
  - What changes should be made to health service provision/other suggestions to better improve health and wellbeing for LGBT+ people
  - Public health and health improvement approaches?

4. Advice and arrangements for reaching and recruiting LGBT+ people for the research

Advice around general approach and wording on engagement forms/adverts

Practical ways organisation can help:

- Publicising
- Recruiting
- Hosting

# **LGBT+ Health Needs Assessment**

## **Topic Guide for Focus Groups**

### **Introduction**

I am \_\_\_\_\_ (name and pronoun). I am an independent researcher commissioned by NHS Greater Glasgow & Clyde and NHS Lothian to conduct a series of group discussions and interviews with LGBT+ people on the topic of health and wellbeing. The purpose is to understand more about the health needs of LGBT+ people so that the NHS are able to develop services which better meet these needs.

In a moment, I'm going to ask you to introduce yourselves with whatever name you'd like us to use today (it doesn't have to be your real name) and the pronoun you use.

Everything you say is anonymous. We will produce a report on the research findings, bringing together the findings from lots of groups and interviews. No names or other identifying information will be attached to anything you say. Please respect the confidentiality of what others in the group say.

If everyone is okay with this, I am going to record the discussion. This is just so I have an accurate record of what is said. I am the only one who will have access to the recording – I will just listen to it once to write up what was said (without any names), and then I'll permanently delete it. (Check everyone consents to recording).

ASK EVERYONE TO INTRODUCE THEMSELVES (names and pronouns)

I'm going to introduce five broad topics for discussion. I want you to feel able to raise the topics within these that are most important to you, and you might want to share your views and experiences. Please don't feel you have to answer every question or to talk about anything you don't feel comfortable with.

### **1. Social Health**

**(Visual 1):** The first broad topic is around what we might call social health – how the people around us and our environment affect our feelings and wellbeing.

This sheet shows some of the positive and negative things that can affect our wellbeing.

(Invite comment, experiences, views on these topics).

Prompts:

- How does being out/not being out regarding your identity affect how you feel in different situations?
- Have these issues changed over the last few years? In what way?

### **2. Mental Health**

**(Visual 2):** The next topic is mental health. Most people have times when they have good mental health and times when they have poor mental health.

Would you like to share any experiences of good or poor mental health you have had?

What contributes to good mental health or poor mental health?

What are the consequences of good mental health or poor mental health?

Are there ways your physical health or disability affect your mental health or becoming affected by your mental health?

### **3. Health Behaviours**

**(Visual 3):** We're now looking at things we do that affect our health or wellbeing. There are six things here relating to lifestyle and behaviours. Are there things here you can share about your past or current behaviour?

Prompts:

What influences your choices?

Sports/physical activity – does anything prevent you from participating in sport/physical activity?

Sex/safe sex – do you feel that you have enough information to be able to make informed choices around safe sex?

(particularly for trans/non-binary) – ask about online activity (e.g. gaming)

Links between behaviours and mental health and social health.

Links between behaviours and cultural norms (for general population/ for LGBT+ community)

### **4. Using Health Services and Other Services**

**(Visual 4):** We're interested in hearing about your experiences of using health services and other services. Here are some services you might have used, but you can tell us about other services too.

Can you give examples of good experiences and bad experiences of using services?

Prompts:

What puts you off or stops you using services?

Are you out with healthcare providers? Why/why not?

To what extent are services appropriate for you, and meet your needs?

To what extent do services understand issues around your LGBT+ identity?

To what extent are services inclusive or discriminatory?

Issues around heterocentric norms

Are services improving or declining in terms of how they meet the needs of LGBT+ people?

## **5. Wish List**

What is your wish list? What would improve the health and wellbeing for LGBT+ people?

Prompt:

Service provision

Policies

Health promotion messages

### **Close:**



Thank you for all your input. We should have a report on the findings from this stage of the research by September. It is hoped that this will inform a nationwide survey. The findings from both these will be used to look at how health services are provided.

Issue thank you leaflets/support leaflets and vouchers.

# How the people around us and our environment affect our feelings and wellbeing

**Family, friends, partner, colleagues, others:**

- Support
- Encouragement
- Feeling valued
- Feeling included





**Getting involved:**


- Volunteering
- Activism





Being "out" about your identity



Feeling safe or unsafe



Being a carer







Isolation, loneliness

Hate crime, abuse

Bullying

Discrimination

Exclusion

Faith/spirituality

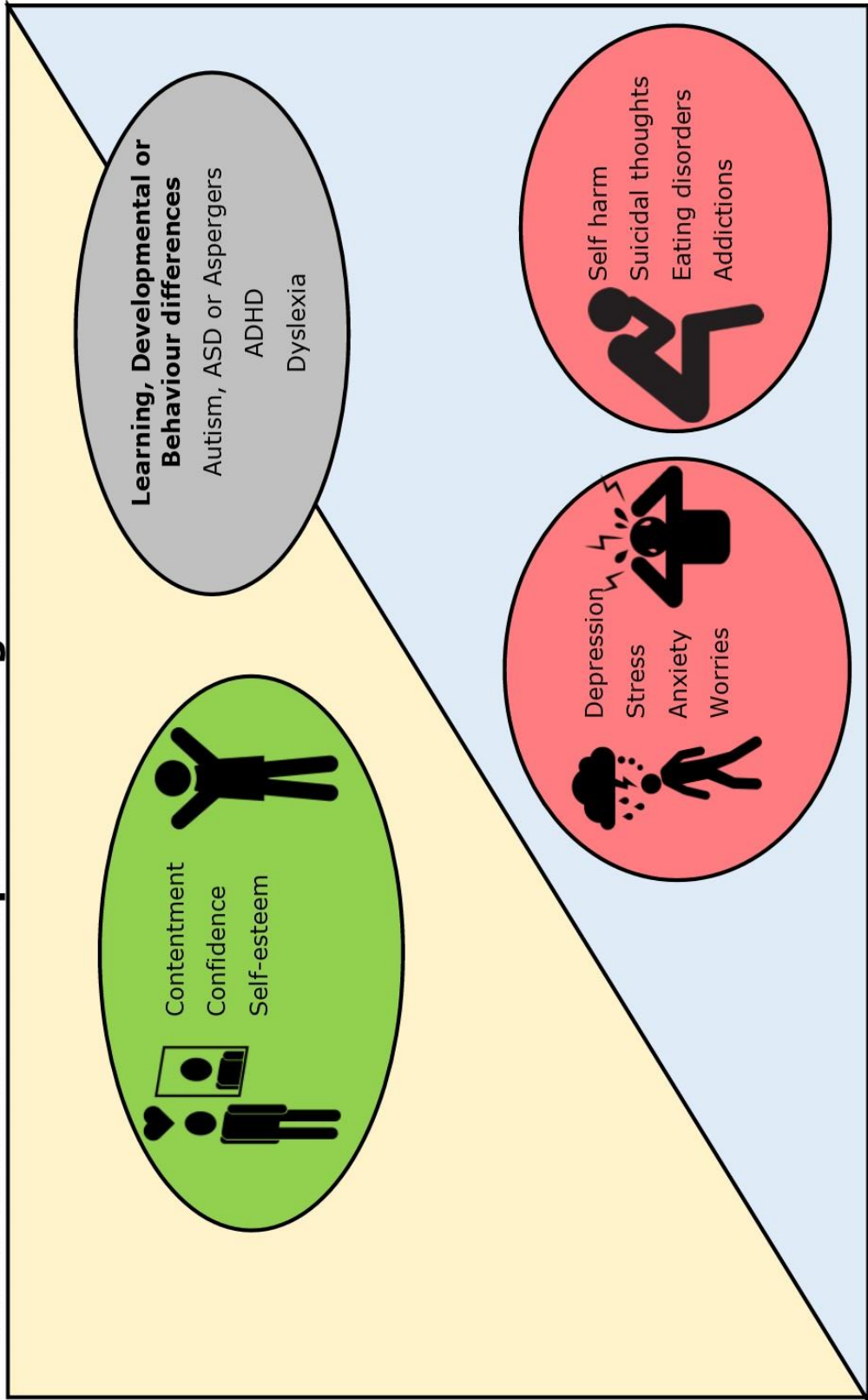




## Mental Health

**What are the causes of good or bad mental health?**

**What are the consequences of good or bad mental health?**



## Using Health Services and Other Services

