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

## Executive Summary




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

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This research was commissioned by
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UNIVERSITY OF LEICESTER

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

University of Brighton
Centre for Transforming Sexuality and Gender

## Introduction

This research was commissioned in late 2017 by NHS Nottingham City Clinical Commissioning Group (CCG), which has since merged with five other CCGs to become NHS Nottingham and Nottinghamshire CCG. Improving mental health outcomes and reducing inequalities were strategic priorities for NHS Nottingham City CCG. Engagement work with Nottingham's population commissioned by the CCG in 2016 found the need for improved cultural competence amongst healthcare professionals, with a focus on general practitioners (GPs), to enable them to better understand, identify and respond to specific communities, including lesbian, gay, bisexual and/or transgender (LGBT) people. This was reinforced by research conducted about LGBT+ people's experiences of health services by Healthwatch Nottingham and Nottinghamshire in 2017, who similarly made recommendations about improving cultural competence, including avoiding labelling and language errors and appropriately addressing transgender people. A number of these considerations are captured in *Nottingham City's Mental Health and Wellbeing Strategy 2019-2023* which explicitly identifies the need to reduce stigma and discrimination and improve the mental health outcomes of LGBT people, including via this study.

As the full report details, this local focus on LGBT+ mental health runs alongside a parallel national picture where increasing research evidence points to the higher prevalence of mental ill-health amongst LGBT+ people, and yet higher rates of dissatisfaction with primary care and mental health services. Following the Government's National LGBT Survey (Government Equalities Office 2018a), the Government developed *the LGBT Action Plan* (Government Equalities Office 2018b), the commitments within which include appointing a national LGBT health adviser to offer leadership on reducing health inequalities. Further, the NHS (2019) *Long Term Plan* acknowledges that LGBT+ children and youth are likely to experience additional mental health needs, and early intervention for children and young people is prioritised. Our research in Nottingham City is therefore timely and reflects the growing recognition of the need to address mental health disparities for LGBT+ people and improve the patient experience.

The current study was commissioned to inform decisions about the future commissioning of mental health services in Nottingham City to meet LGBT people's needs. In our research we use the acronym LGBT+ to include other sexual and gender identities which have become more visible in recent years, such as pansexual, non-binary and genderqueer. The aims of this research, as set out in the commissioning brief, were:

- to increase understanding of how to prevent mental ill-health
- to facilitate early diagnosis; and
- to promote self-care amongst Nottingham City's LGBT+ population.

The services that are in the scope of the research are primary care services – that is, the general practices within Nottingham City – and community mental health services commissioned by NHS Nottingham City CCG. A full list of these services can be found in the full report (p.5).

## Methodology

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

1. A rapid evidence assessment which reviewed existing literature about LGBT+ mental health and healthcare.

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

3. A creative, participatory stall at Nottinghamshire Pride 2018 which engaged visitors through a graffiti wall, craft activity and comments cards.

4. Focus groups with 10 LGBT+ people about what helps and hinders them in maintaining good mental health and their views about mental healthcare for LGBT+ people in Nottingham City.

5. Semi-structured interviews with 20 LGBT+ people who have sought mental healthcare from NHS general practices and community mental health services.

6. Semi-structured interviews with five commissioners of mental health services, mostly in Nottingham and Nottinghamshire.

7. Semi-structured interviews with 11 frontline practitioners and service managers in community mental health services.

8. Semi-structured interviews with two General Practitioners and an online survey of general practice healthcare professionals (n=8).

Three volunteer LGBT+ community researchers were recruited and trained, and were involved in running the Nottinghamshire Pride stall, analysing the Pride stall data, reviewing research materials, recruiting focus group participants and co-facilitating the focus groups.

The research has been guided by a steering group comprising representatives from NHS Nottingham City CCG and Nottingham City Council. The steering group has offered critical input on key decisions throughout the research process, as well as being an important communication mechanism for sharing updates with the research team about the local context[1].

Ethical approval for all aspects of the research was received from the University of Leicester Ethics Sub-Committee of Criminology and School of Education, and approval from the Health Research Authority was received for the fieldwork components involving NHS health professionals[2]. We extend our huge thanks to all of the health professionals and commissioners who participated in this research and who helped to facilitate this research. Our greatest thanks go to the members of Nottingham's LGBT+ population who shared their valuable insights and often very painful experiences with us.

[1] To make direct contact with the research team for further information or to receive a copy of the full report, please email Rebecca Barnes at rb358@leicester.ac.uk

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

## Key findings and recommendations

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

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

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

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

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

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

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

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

| Key findings | Recommendations | Recommendation for: |
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| 1. All of the data sources indicate considerable gaps in knowledge and awareness regarding LGBT+ people's mental health needs. This includes gaps in knowledge about LGBT+ lives, LGBT+ people's mental health, distinctions that may exist between L, G, B, T+ identities and healthcare needs, and the intersections between them and other aspects of identity.<br><br>Service users with less widely known-about sexualities or gender identities such as being transgender, pansexual, asexual or non-binary were more likely to report feeling misunderstood by health professionals. Previous research indicates that those who identify as bisexual, queer, pansexual and transgender report disproportionately poorer mental health.<br><br>Many service users felt that health professionals need more knowledge and understanding of mental health more generally, in addition to greater compassion and sensitivity. Some thought that receptionists, as key gatekeepers, require training too. | **1. Regular comprehensive training is needed about LGBT+ identities, health needs including mental health and trauma, and cultural competence in creating inclusive services.**<br>(i) Training needs to encompass the full spectrum of sexuality and gender identities, including those which are less well understood such as transgender, non-binary, pansexual and asexual identities.<br>(ii) Training needs to embrace intersectionality; that is, to recognise that, like everyone else, LGBT+ people's identities, needs and healthcare experiences are shaped by other aspects of their identity such as their gender, ethnicity, socio-economic status, faith and whether or not they have a disability.<br>(iii) Training should include engagement with lived experience e.g. a training package that has been co-produced with and, where possible, delivered by LGBT+ people.<br>(iv) Training needs to address unconscious bias, values and emotions, and is therefore best delivered face-to-face, or using interactive, discussion-based online platforms.<br>(v) Training needs to be provided to commissioners and health professionals.<br>(vi) Receptionists within primary care and community mental health services also need to participate in training, but a tiered approach is needed to tailor the intensity and depth of the training to different job roles.<br>(vii) Training should be standardised across the Integrated Care System (ICS)[3], and for GPs, it could be embedded within practice learning time. Training and equality and diversity leads across the ICS should be involved in the development and review of this training. | **All system partners working together** |

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

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| | (viii) Efforts need to be made to assess the impacts of training on attitudinal and/or behavioural change. | |
| 2. Despite the NHS Sexual Orientation Monitoring Standard having been launched in 2017, awareness and uptake of this amongst NHS health professionals appears to be limited. Amongst both service users and some health professionals, there was confusion about why this data might need to be collected.<br><br>Whilst some LGBT+ service users expressed concerns about how their sexual orientation data would be used and whether providing it would adversely impact their healthcare, others felt that being asked for this information would facilitate disclosure and provide health professionals with a more holistic understanding of their health needs.<br><br>Community mental health practitioners and commissioners felt that demographic data about sexual orientation was lacking and that being able to access this data would inform service delivery, review, improvement and commissioning.<br><br>The collection of gender identity data is not currently mandated. Whilst this is a gap in the data, there is some resistance to monitoring of gender identity because it can force people to disclose their (trans)gender history. | **2. Patient/service user data about sexual orientation (and where appropriate, gender identity) needs to be systematically collected, recorded, collated and shared.**<br>(i) Health professionals need to be aware of the reasons for collecting sexual orientation data but also trained about the sensitivities of doing so.<br>(ii) Patients/service users need to understand why it is important to collect sexual orientation data and how their data will be used.<br>(iii) More communication is needed about the NHS Sexual Orientation Monitoring Standard which, whilst not mandatory, promotes best practice in understanding the patient population and individual needs.<br>(iv) Develop a standardised template in F12[4] for GP clinical systems for sexual orientation monitoring, to comply with the NHS England standard.<br>(v) Health professionals and managers need to have access to collated anonymised sexual orientation (and where available, gender identity) monitoring data in order to inform service improvement and better understand who is and who is not accessing their service. Data review needs to be intersectional, rather than examining sexual orientation and/or gender identity in isolation from other protected characteristics.<br>(vi) Commissioners need to have access to and make use of collated, anonymised sexual orientation (and where available, gender identity) monitoring data to feed into the assessment of local needs, identify under-served groups and subsequently inform commissioning decisions. As noted above, data review needs to be intersectional in order to identify specific gaps and needs.<br>(vii) Progress towards increasing the collection of sexual orientation data needs to be considered alongside progress and challenges with collecting other equalities monitoring data e.g. in relation to ethnicity. | **CCG, Primary Care and Community Mental Health Service Providers** |

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

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

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

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

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

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| from being signposted to LGBT+ support groups and social activities.<br><br>Stronger relationships between health commissioners, health services and LGBT+ groups and organisations would lead to improved sharing of information and expertise. | Nottinghamshire LGBT+ Network is another potential key partner, but they currently do not have meeting space.<br>(iii) Using such locations could facilitate referrals and provide a safe space. Therapists working in these spaces should be openly LGBT+ or culturally competent allies.<br>(iv) It should be recognised that not all LGBT+ service users would feel comfortable accessing a space that was badged as an LGBT+ space. Therefore, maintaining a choice of settings for therapy – as is currently the case – is essential. | |