



An Ghíomhaireacht um Leanaí agus an Teaghlach  
*Child and Family Agency*



# The Rainbow Report

LGBTI Health Needs & Experiences and Health Sector Responses

by Niall Crowley



**The Rainbow** presents all the colours, cultures, & identities of humanity that equally contribute to the creation of beauty.

**The Rainbow Eye** symbolises the seeing of this beauty, of inclusively seeing & accommodating differences and of holding a vision for, & celebrating equality.

# **THE RAINBOW REPORT**

## **LGBTI Health Needs and Experiences and Health Sector Responses and Practices in the HSE South East Region**

**Niall Crowley**

**January 2015**

## Forward

As Chairperson of this Research Steering Group, it gives me great pleasure to publish the Rainbow Report - LGBTI Health Needs and Experiences and Health Sector Responses and Practices in the HSE South East Region.

LGBTI people, as with all members of our community, require access to appropriate, timely and professional health services.

The health requirements of LGBTI people are similar to those of our community as a whole in that they reflect a need to be and feel well physically, psychologically and socially. How society perceives and treats difference can impact upon the physical, psychological and social wellbeing of LGBTI people, and can create greater health risks associated with minority stress.

The HSE Southeast (CHO Area 5) commissioned this work to find out from LGBTI people what they identified as their specific health needs and how they found our service provision in meeting these needs. The research explored what worked well from a service user perspective and also looked at what we as service providers could improve upon in the future.

Health service providers across primary and secondary care were asked what they felt worked well in supporting the wellbeing of LGBTI people and what supports might enhance how we currently provide services.

There can be a tendency to group peoples health needs together without having properly established if this is appropriate. This research has contributed to establishing and acknowledging the need to look independently at the needs of each of the groups represented in the collective term LGBTI. Throughout this report it is apparent that the needs of each of these groups while in a sense similar, are different. You will see this reflected in the report where some research aspects look at challenges associated with sexuality while others aspect relate to issues with regard to accessing services concerning gender identity.

The feedback from users of our services is powerful. Where LGBTI people felt that they were treated with respect and professionalism by the services it was noted that staff were not working under a presumption of heterosexuality. For the most part this was how lesbian, gay and bisexual interviewees experienced our services. It was felt that society as a whole is beginning to embrace change and difference.

Responses from health professions included how in our role as service providers we strive to ensure that everyone is being treated the same. However, the research evidence suggests the need for services to be organised on the basis of promoting equality, this means acknowledging and accommodating difference rather than treating everyone the same.

The experiences of the health services as recounted by trans service users and by their families was predominantly negative. Their feedback from their experiences

highlighted for us the need for increased training and development of knowledge and skills within our services to ensure appropriate, timely and professional access and delivery of health services.

The health needs of intersex individuals is a relatively new area for me personally and also for many health professionals. Given that this area is still largely underdeveloped we look forward to working together to achieve the development of standards in this area of treatment.

A number of participants highlighted that using a welcoming sign, such as the rainbow, indicating that the service is aware of sexual & gender identity differences would enhance service accessibility. So, as part of the launch of this report we will also be launching a rainbow sticker for all health services to use.

43 LGBTI people participated in this report. I would like, on behalf of the steering group to thank them for their input. Their valuable insight into how we can improve what we do, based on their experiences will support us in enhancing the services we provide.

Health service professionals participated in this report from across a number of disciplines and from both primary care and hospital trust settings. I would like to thank them for the time they gave to feeding back on their experience in the provision of services to LGBTI people, as well as highlighting training needs they have, that if supported would enhance the way we provide services.

I would like to thank all members of the steering group, Thelma Blehein, Tara Hunt, Susan Murphy, Angela Joy, Suzanne Nolan and Kieran Donohue.

I would like to thank Tulsa Community Development for working with HSE primary care and social inclusion in the commissioning, development and launching of this report. Thank you to Thelma Blehein for her editorial work and for her design & layout of the cover, document, summary & stickers and to Angela Joy for the banner design.

In particular I would like to thank Niall Crowley for his knowledge, experience and professionalism throughout all the research and the development of this report.

I hope we have done justice to the collective knowledge, experiences and contributions that have made up this report and look forward to working with LGBTI service users, our colleagues in the HSE, hospital trusts and external agencies to implement the recommendations.

I am confident that this publication will prove to be of great benefit to both policy makers and practitioners and will play an important role in the ongoing quest to improve the health & well being of the LGBTI community and also the ongoing quest to improve on service delivery.

**Dr. Derval Howley**  
**Regional Manager Social Inclusion & Substance Misuse**  
**HSE Southeast (CHO Area 5)**

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- TransParenCi

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## Glossary

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*Sexual Orientation:* Who we feel attracted to, whether it is people of the same sex, another sex or both<sup>1</sup>.

*Sexual Identity:* The group or community we feel part of, based on our sexual orientation, either gay, lesbian, bisexual or heterosexual<sup>2</sup>.

*Gay:* Someone who is emotionally and sexually attracted to people of the same gender. Gay is usually used to refer to males, lesbian to refer to females<sup>3</sup>.

*Lesbian:* A girl/woman who is emotionally and sexually attracted to other girls/women<sup>4</sup>.

*Bisexual:* A person who is emotionally and sexually attracted to both males and females<sup>5</sup>.

*Bigender:* People who have two gender identities either simultaneously, at different times, or in different situations<sup>6</sup>.

*Trans Person:* Trans is used as shorthand for transgender. Transgender refers to a person whose gender identity and/or gender expression differs from the sex assigned to them at birth<sup>7</sup>. This term can include diverse gender identities such as: transsexual, transgender, cross dresser, drag performer, androgynous, gender queer, gender variant or differently gendered people.

*Intersex:* Intersex individuals are persons who cannot be classified according to the medical norms of so-called male and female bodies with regard to their chromosomal, gonadal or anatomical sex<sup>8</sup>. Their gender is legally and administratively non-existent due to the dominance of the gender binary.

*Equality:* Achieving equal outcomes between groups in society in relation to the distribution of resources, power and influence, status and standing, and respect.

*Diversity:* The range of groups in society that are distinguished on the basis of their identity including gender identity and sexual identity.

*Discrimination:* Direct discrimination is defined in the equality legislation as the treatment of a person in a less favourable way than another person is, has been or would be treated in a comparable situation on any of the nine grounds which: exists; existed; may exist in the future; or is imputed to the person concerned. Indirect discrimination happens where there is less favourable treatment in effect or by impact. It happens where people are, for example, refused employment or training not explicitly on account of a discriminatory reason but because of a provision, practice or requirement that they find hard to satisfy.

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<sup>1</sup> See BeLonGTo website: <http://www.belongto.org/resource.aspx?contentid=2244>

<sup>2</sup> See BeLonGTo website: <http://www.belongto.org/resource.aspx?contentid=2244>

<sup>3</sup> See BeLonGTo website: <http://www.belongto.org/resource.aspx?contentid=2244>

<sup>4</sup> See BeLonGTo website: <http://www.belongto.org/resource.aspx?contentid=2244>

<sup>5</sup> See BeLonGTo website: <http://www.belongto.org/resource.aspx?contentid=2244>

<sup>6</sup> See Nonbinary.org website: <http://nonbinary.org/>

<sup>7</sup> See Transgender Equality Network Ireland website: <http://www.teni.ie/page.aspx?contentid=139>

<sup>8</sup> Christian-Gattas D., Human Rights Between the Sexes, A preliminary study on the life situation of inter• individuals, Heinrich Boll Stiftung, Democracy Series, Volume 34, 2013

### 1.1 Project

The HSE South East Region Social Inclusion Unit commissioned this research project. The purpose behind the project was to better understand the experience of LGBTI people of the health services in the region and to better support health professionals in the region to respond effectively to the needs of LGBTI clients.

The HSE at a national level identified significant health inequalities for LGBT people in a 2009 report on 'LGBT Health: Towards Meeting the Health Care Needs of Lesbian, Gay, Bisexual and Transgender People'. The findings of this mapping exercise have been further explored in the work of LGBT Diversity South East Region and are reflected in the five year regional strategy developed by this group in 2012.

There is a body of international and national research work that has examined issues of equality and diversity for LGBTI people and the manner in which health services are geared up to respond to the practical implications of the diversity presented by LGBTI people. At a national level, the HSE and the Equality Authority published joint research work on 'Recognising LGB Sexual Identities in Health Services' in 2007. The Equality Authority published research in 2004 on 'Access to Health Services for Transsexual People' that identified specific issues for Trans people in accessing health services.

There has been no such research in the South-East region. There is also little research work done on the perspectives and experiences of health professionals with regard to LGBTI issues and clients. This research will fill these gaps and support further initiatives to enable LGBTI people's effective access to and benefit from health services.

The research project is designed to:

- Gather information on HSE Hospital (including STI clinics) policy and practice in responding to LGBTI health needs.
- Gather information on General Practitioner policy and practice in responding to LGBTI health needs.
- Engage with Primary Care Team Leads on the inclusion of LGBTI health needs, issues and experiences in their work.
- Establish the perspectives of the LGBTI community in the South East and identify current health issues and experiences of the health services for these communities.
- Make recommendations on foot of the above.

The research aims to raise the profile and awareness of LGBTI health needs within the health services of the HSE South East Region and to make recommendations to further progress this work in the HSE South East Region.

### 1.2 Methodology

The research methodology is based on frequent interaction with and support from a steering group established by the HSE South East Region for the project. These

interactions and this support have been central in making the project possible and in ensuring its quality and potential impact.

The first stage in the research was a literature review of relevant research and reports in Ireland and internationally on LGBTI health needs, experiences and issues. This literature review informed the approach developed for each research element pursued and forms part of this final report.

The project was granted full ethical approval by the Research Ethics Committee, HSE South East on 8<sup>th</sup> October 2014. This included approval of the Standard Application Form, Hospital Online Survey, G.P. Survey, Primary Care Team Survey, and Participant Interview Guide.

The second stage in the research was information gathering. This involved:

- A postal survey of General Practitioners in the region.
- A survey of Primary Care Teams in the region.
- Meetings with six selected Primary Care Teams in different parts of the region in both urban and rural settings.
- An online survey of hospital staff.
- Interviews with LGBTI people in all counties in the region.

The surveys focused on exploring practice in:

- Giving public profile to service provider commitment to LGBTI issues.
- Implementation of policies and procedures for inclusion of LGBTI people by service providers.
- Professional development opportunities for health professionals and administrative staff on LGBTI issues.
- Provision of specific programmes or services to address LGBTI issues by service providers.

The surveys also sought information on the supports that health professionals thought might be useful in achieving an LGBTI friendly services. The survey forms are included as appendices to this report.

The interviews and focus groups with Lesbian, Gay, Bisexual and Trans people focused on:

- Needs: What parts of the health services have you used? What parts of the health services are most used by LGBTI people generally?
- Experiences: What have been your experiences of health service provision – in particular hospital provision and general practice provision?
- Good Practice: In what parts of the health sector have you come across good practice in responding to LGBTI people and their health needs? What did this practice involve? What made it effective?
- Recommendations: What changes would you like to see in the policies, programmes, and/or practices of the health services in the South-East region to make them more LGBTI friendly?

The interview guide and consent form are included as appendices to this report.

The third stage in the research was the drafting of the research report. The draft report was discussed at the project steering group. A copy of draft conclusions and recommendations was circulated to key interlocutors from the information gathering work to get their feedback. This feedback was assessed and included in the final report as appropriate.

## 2.0 Literature Review

### 2.1 Introduction

This literature review is primarily concerned with the areas of health policy, the practice of health professionals, and the experience of LGBTI people of health service provision. It is principally focused on the Irish context but looks to the international context for material that could offer guidance for further developments in the Irish context.

The review first identifies international perspectives of relevance to these issues. It then explores the growing literature that has emerged in the national Irish context before looking to literature that relates to specific regional contexts in Ireland. It concludes by examining literature specific to the South East region.

At these three different levels the literature review identifies health policies, programmes or plans that have been developed that make specific mention of, or are targeted at, LGBTI people. It examines literature that has sought to shape health policy and practice by health professionals. It explores literature that seeks to establish the particular health needs and experiences of the health service of LGBTI people.

### 2.2 International Guidance

#### *Policies*

*Yogyakarta Principles: The Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity, 2006*

*Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Version 7, World Professional Association for Transgender Health, 2011*

The **Yogyakarta Principles**<sup>9</sup> were developed by an international gathering of human rights experts from around the world in Indonesia. They set out how international human rights law applies to sexual orientation and gender identity. They assert binding international legal standards with which Ireland is required to comply. A section on the rights to the highest attainable level of health is included.

This document sets out a number of requirements on States that have relevance for policy and practice in the provision of health services. These include to:

- Ensure that healthcare facilities, goods and services are designed to improve the health status of, and respond to the needs of, all persons without discrimination on the basis of, and taking into account, sexual orientation and gender identity, and that medical records in this respect are treated with confidentiality.

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<sup>9</sup> Yogyakarta Principles: The Application of International Human Rights Law in Relation to Sexual Orientation and Gender Identity, 2006

- Ensure that all sexual and reproductive health, education, prevention, care, and treatment programmes and services respect the diversity of sexual orientations and gender identities, and are equally available to all without discrimination.
- Facilitate access by those seeking body modifications related to gender reassignment to competent, non-discriminatory treatment and support.
- Ensure that all health service providers treat clients and their partners without discrimination on the basis of sexual orientation or gender identity, including with regard to recognition as next of kin.
- Adopt the policies, and programmes of education and training, necessary to enable persons working in the healthcare sector to deliver the highest attainable standard of healthcare to all persons, with full respect for each person's sexual orientation and gender identity.

The World Professional Association for Transgender Health published **Standards of Care for the Health of Transexual, Transgender, and Gender Nonconforming People, Version 7**<sup>10</sup> in 2011. This provides “clinical guidance for health professionals to assist transsexual, transgender and gender non-conforming people with safe and effective pathways to achieving lasting personal comfort with their gendered selves”. These standards are based on seven principles:

- Exhibit respect for patients with non-conforming gender identities.
- Provide care that affirms patient's gender identities and reduce the distress of gender dysphoria.
- Become knowledgeable about the healthcare needs of transsexual, transgender and gender non-conforming people.
- Match the treatment approach to the specific needs of the patient.
- Facilitate access to appropriate care.
- Seek patient's informed consent before providing treatment.
- Offer continuity of care.

The standards make particular reference to children and adolescents with gender dysphoria. This includes that mental health professionals should help families to have an accepting and nurturing response, that psychotherapy should focus on reducing the child's or adolescent's distress related to gender dysphoria, and that clients and their families should be supporting in making difficult decisions regarding the extent to which clients are allowed to express a gender role that is consistent with their gender identity.

The standards point out that transsexual, transgender and gender non-conforming people need health care throughout their lives from providers experienced in primary care and transgender health. Every transsexual, transgender, and gender non-conforming person should partner with a primary care provider for overall health care needs.

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<sup>10</sup> Standards of Care for the Health of Transexual, Transgender, and Gender Nonconforming People, Version 7, World Professional Association for Transgender Health, 2011

## *Shaping the Policy and Practice Agenda*

*Crowley N., Good Practice Exchange Seminar on Public Policies Combating Discrimination against and Promoting Equality for LGBT people, Netherlands, 2010*

*Crowley N., Good Practice Exchange Seminar on Discrimination on the Grounds of Sexual Orientation and Gender Identity - How to Overcome the Barriers to Public Policy Making, Estonia, 2011*

*Crowley N., Public Policies Combating Discrimination Against LGBT People, Good Practice Exchange Seminar, Belgium, 2013*

*Agius S. & Tobler C., Trans and Intersex People: Discrimination on the grounds of sex, gender identity and gender expression, European Network of Legal Experts in the Non-Discrimination Field, European Commission, 2011*

*Director of Public Health Annual Report 2013”, Public Health Agency, Belfast, 2014*

The **European Commission convened three good practice seminars** on public policies combating discrimination and promoting equality for LGBT people. These were hosted in the Netherlands in 2010, Estonia in 2011, and Belgium in 2013. They included a focus on health policies and provision.

At the **Netherlands event**<sup>11</sup> the theme of ‘Pink Competency’ was developed through the presentation of a Government funded project from Norway. Training is provided to health care professionals on LGBT issues to build the knowledge and competence of health professionals on LGBT issues. It is rooted in cooperation with the relevant professional organisations and networks of professionals. It is based on the assumption that the training is being provided to people who are committed to doing a good job and who require further knowledge and competence to enable them to do so. NGOs can take the first steps in building ‘Pink Competency’ in public sector bodies but, ultimately, the national authorities have to take over the training so that it can be extended to all workers in the health sector.

The theme of ‘Gay Straight Alliances’ was presented in relation to improving recognition and acceptance of older LGBT people. The Dutch Association for the Older People played a leading role in creating a gay straight alliance of older people. Visibility is promoted through participation of older people on gay pride events and in events targeting older people, and through media and exhibitions. Empowerment is promoted through ‘Pink Ambassadors’ who are trained to promote the interests of older LGBT people.

At the **Estonian event**<sup>12</sup> four types of barriers to making progress in public policy on LGBT issues were identified:

- Political barriers: Including political hostility, policy making that responds to public opinion rather than LGBT needs, lack of prioritisation of LGBT issues, and invisibility for and inaction on LGBT issues.

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<sup>11</sup> Crowley N., Good Practice Exchange Seminar on Public Policies Combating Discrimination against and Promoting Equality for LGBT people, Netherlands, 2010

<sup>12</sup> Crowley N., Good Practice Exchange Seminar on Discrimination on the Grounds of Sexual Orientation and Gender Identity - How to Overcome the Barriers to Public Policy Making, Estonia, 2011

- Societal barriers: Including physical and verbal abuse of LGBT people, and negative and judgmental attitudes in relation to LGBT people.
- Cultural barriers: Including values in relation to gender and gender roles and in relation to family, marriage and the raising of children. These cultural barriers can be exacerbated in situations of economic inequality.
- Administrative barriers: Including a lack of capacity of public institutions to engage with LGBT issues in a relevant, open and effective manner.

Effective strategies to enable policy making include legal requirements; funding and support from institutions outside the jurisdiction; awareness raising campaigns within society and within institutions; framing the issues within a broader message such as human rights, diversity or democracy; institutional systems of internal dialogue and partnership with other organisations; and internal learning processes, coordination between public bodies and mainstreaming of LGBT policy issues in all policy areas.

The report highlights that transgender people face particular barriers. They are a small but vulnerable group and reliable samples are difficult to get for survey work. A comprehensive approach involving cooperation between various Government bodies is needed. Innovative ways to connect with transgender people and build good relations must be found. The inclusion of transgender people needs to be monitored.

At the **Belgian event**<sup>13</sup> equality competence in operations was identified as key in achieving outcomes for LGBT people. Sound decision-making needs data for evidence-based decisions, engagement with civil society for participative decisions, and impact assessment to ensure equality outcomes from decisions. Equality competence in operations involves the organisation having an equality policy, providing equality training for staff, and implementing equality plans.

The report notes that the diversity of LGBT people presents challenges for effective policy making on LGBT issues. Lesbian and bisexual women and gay men and bisexual men present specific issues in different contexts. Young LGBT people and LGBT people on low incomes have particular needs. Transgender people require a specific focus and are still only emerging as a focus in policy making. A challenge is posed in the report to deepen understanding and knowledge of intersex people and open channels of communication with them.

The European Commission published '**Trans and Intersex People: Discrimination on the grounds of sex, gender identity and gender expression**' in 2011<sup>14</sup>. This defines Intersex people as holding a status that "relates to their biological makeup (genetic, hormonal and physical features) which is neither exclusively male nor exclusively female, but is typical of both at once or not clearly defined as either. These features can manifest themselves in secondary sexual characteristics such as muscle mass, hair distribution, breasts and stature; primary sexual characteristics such as reproductive organs and genitalia; and/or in chromosomal structures and hormones.

The report found "negative attitudes towards trans and intersex people are often directly correlated to the importance that a determinate society places on the binary

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<sup>13</sup> Crowley N., Public Policies Combating Discrimination Against LGBT People, Good Practice Exchange Seminar, Belgium, 2013

<sup>14</sup> Agius S. & Tobler C., Trans and Intersex People: Discrimination on the grounds of sex, gender identity and gender expression, European Network of Legal Experts in the Non-Discrimination Field, European Commission, 2011



gender model, as well as the levels of gender stereotypes, sexism and gender inequalities that exist within it". It concluded, "Intersex discrimination is a particularly complex form of sex discrimination. Notably, surgery on intersex people is not the same as gender reassignment. It often takes place early in life before the person concerned can participate in the decision-making process. For this reason, the key stakeholder groups often consist of the parents of intersex children, who do not wish to have their children associated in any way with sex ambiguity. However, many intersex adults are angry that surgery was performed upon them as young children without their consent. At the same time, they do not necessarily desire genital reconstruction, because of the severe impact it can have on sexual pleasure".

The **Director of Public Health Annual Report 2013**<sup>15</sup> takes the celebration of diversity as its theme. This includes a focus on LGBT people. It notes, "A deep association exists between diversity and our work in public health. It is well recognised that some people find it more difficult to enjoy their full health. It is also evident that minority groups experience poorer health outcomes and have significantly lower access to services". It suggests that it is "important that public health principles, core services, research and programmes take into account the diversity in communities and the population" and that diversity involves "recognising individual as well as group differences; treating people as individuals; placing positive value on differences in the community and population".

The report notes that there is limited information available on transgender health. It notes a survey conducted in the UK that reported "34% of transgender people attempted suicide and about 50% experienced discrimination at work". It notes the lack of robust data on the number of lesbian women, gay men and bisexuals in Northern Ireland but that, "research in the UK estimates that around 5–7% of the population is lesbian, gay, or bisexual (LGB)". It points to research findings that LGB people are at significantly higher risk of mental disorders, suicidal thoughts, substance misuse and deliberate self-harm and notes evidence from Northern Ireland that "individuals of alternate sexual orientation are over-represented among patients with sexually transmitted infections, including syphilis and HIV".

It identifies barriers to healthcare for LGB people, including: homophobia and heterosexism; misunderstandings and lack of knowledge; lack of appropriate protocols; poor adherence to confidentiality; and an absence of LGB-friendly resources.

### *LGBTI Experiences*

*EU LGBT Survey, European Union Lesbian, Gay, Bisexual, and Transgender Survey: Results at a Glance, European Union Fundamental Rights Agency, 2013*

*Equality Bodies Promoting Equality & Non-Discrimination for LGBTI People, Equinet, Brussels, 2013*

*Pinto N., "Consultations with ILGA-Europe's Members on the needs, priorities, challenges and good practices in the field of health", ILGA - Europe, 2014*

*Organisation Intersex International Website*

*Reed T., Family Matters: Families and Transsexualism a better understanding, Gender Identity and Research Society, UK, 2005*

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<sup>15</sup> "Director of Public Health Annual Report 2013", Public Health Agency, Belfast, 2014

In 2013 the **European Union Agency for Fundamental Rights<sup>16</sup>** published the **results of a survey of 93,079 people over the age of 18 who identified as LGBT** people from across the European Union. Overall, one in 10 of the respondents who had accessed healthcare services in the year preceding the survey reported that they had felt discriminated against by healthcare personnel in the last year. The level of discrimination was twice as high among transgender respondents.

The figures given for Ireland show that:

- 17% of transgender respondents reported discrimination in accessing health services in the previous year compared to an average of 19% for the European Union.
- 15% of Lesbian respondents reported discrimination in accessing health services in the previous year compared to an average of 12% for the European Union.
- 14% of Bisexual men respondents reported discrimination in accessing health services in the previous year compared to an average of 8% for the European Union.
- 13% of Bisexual women respondents reported discrimination in accessing health services in the previous year compared to an average of 10% for the European Union.
- 9% of gay men respondents reported discrimination in accessing health services in the previous year compared to an average of 9% for the European Union.

The European Union Agency for Fundamental Rights recommended that Member States would:

- Ensure that adequate training and awareness raising is offered to healthcare providers on the health needs of LGBT people in order to eliminate prejudices and improve services to LGBT people.
- Include specific measures to improve access to healthcare services and targeted policies to provide high quality healthcare to LGBT people, irrespective of sexual orientation and gender identity.
- Ensure that general and transgender specific healthcare services take account of the health needs of transgender people without discrimination and prejudice.
- Include a section on LGBT healthcare clients in their national health plans.
- Ensure that health surveys, training curricula and health policies take account of LGBT people and their needs.

Equinet, the European network of equality bodies, published "**Equality Bodies Promoting Equality and Non-Discrimination for LGBTI People**" in 2013<sup>17</sup>. This report was based on a survey of 24 equality bodies in 22 countries on their work on LGBTI issues. It includes a focus on intersex people. It found limited visibility for intersex people in the work of equality bodies.

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<sup>16</sup> "EU LGBT Survey, European Union Lesbian, Gay, Bisexual, and Transgender Survey: Results at a Glance", European Union Fundamental Rights Agency, 2013

<sup>17</sup> "Equality Bodies Promoting Equality & Non-Discrimination for LGBTI People", Equinet, Brussels, 2013

One equality body reported policy work to “express concern at early surgical interventions for intersex children without the child’s participation”. Some equality bodies reported addressing the issues of intersex people under the gender identity and disability grounds. However, intersex people had only made a small number of complaints. The report emphasises the “need to focus on, understand and respond to the particular situation of intersex people and their specific experience of discrimination as intersex people”.

In 2014 ILGA-Europe published<sup>18</sup> **“Consultations with ILGA-Europe’s Members on the needs, priorities, challenges and good practices in the field of health”**. The report identified eight main types of challenges and difficulties for LGBTI groups in getting involved in issues of health and health provision:

- Antagonism and lack of cooperation from health authorities, organisations and professionals, and from governmental agencies with responsibilities in this field;
- Lack of resources;
- Interrelation with the work of other actors on health;
- Diversity of issues within LGBTI health, and specificities of different groups;
- The broad scope of LGBTI health;
- Lack of know-how and expertise on health;
- Lack of involvement of LGBTI communities in health activities and difficulties in reaching out to specific subgroups within LGBTI people;
- Antagonism and hostility to LGBTI activism from the general population.

**Organisation Intersex International (OII) Europe**<sup>19</sup> has put forward a set of demands agreed at the 2<sup>nd</sup> International Intersex Forum in 2012. These include:

- “Put an end to mutilating and ‘normalising’ practices such as genital surgeries, psychological and other medical treatments including infanticide and selective abortion (on the grounds of intersex);
- Ensure personal, free, prior and fully informed consent of the intersex individuals as a requirement in all medical practices and protocols;
- Create and facilitate supportive, safe and celebratory environments for intersex people, their families and surroundings;
- In view of ensuring the bodily integrity and health of the intersex child, psycho-social support and non-pathologising peer support should be provided to parents and/or care providers and the child’s immediate family instead of surgical or other medical treatment unless such interventions are life-saving;
- Provision of all human rights and citizenship rights to intersex people;
- The provision of access to one’s own medical records and any documentation, and the affirmation of the intersex person’s right to truth;

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<sup>18</sup> Pinto N., “Consultations with ILGA-Europe’s Members on the needs, priorities, challenges and good practices in the field of health”, ILGA - Europe, 2014

<sup>19</sup> See: <http://oii-europe.org/category/library-en/presentations/>

- Acknowledgement and redress of past suffering and injustice caused.

**Family Matters**<sup>20</sup> is a paper by Terry Reed of the Gender Identity Research and Education Society in the UK. It calls for a better understanding of families and transsexualism. It notes, “for many, acceptance within the family setting is an important ingredient in the successful rehabilitation of the individual in the new gender role. Engagement with the family should, therefore, be considered as part of the care package offered to trans individuals, and undertaken with their consent” and that “support and education for families may help to mitigate the pain and loss associated with the transition process, and may often prevent deterioration of, or lead to significant improvements in, ongoing relationships”.

It identifies the impact on siblings and parents in terms of ‘families, on the other hand, having lived, usually in total ignorance of the real situation, are shocked at what appears to them to be a sudden and disastrous decision, and they want the process of change to slow down, preferably to a complete standstill. From the family’s perspective, the trans person may seem oblivious to the need for time for the family members to adjust to the changed situation; families often experience disorientation, anger and grief’.

It identifies the impact on partners of Trans people in terms of “this keen sense of betrayal, of disintegration of the family unit, may reach a level of grief that transcends even the loss occasioned by the death of a partner”. It explores this further in that “the focus of their grief, the trans partner, is still alive and is, often, keen to remain a part of this unusual family group. Yet rejection and alienation are common and, sometimes a cloak of secrecy descends, leading to prolonged isolation of partners as well as of trans people themselves”.

## 2.3 National Strategy

### *Policy Foundations*

*A Plan for Women’s Health, Department of Health and Children, Dublin, 1997*

*The National Health Promotion Strategy 2000-2005, Department of Health and Children, Dublin, 2000*

*The National Health Promotion Strategy 2000-2005, Department of Health and Children, Dublin, 2000*

*Employment Equality Acts 1998 to 2012, Equal Status Acts 2000 to 2011, and Irish Human Rights and Equality Commission Act 2014*

Until recently there has been an invisibility for LGBT people in national health policy. The main focus for any mention of LGB people was in relation to HIV/AIDS. There have been notable exceptions to this in the naming of lesbian health issues in **“A Plan for Women’s Health”** in 1997<sup>21</sup> and an identification of the health needs of lesbians and

<sup>20</sup> Reed T., Family Matters: Families and Transsexualism a better understanding, Gender Identity and Research Society, UK, 2005

<sup>21</sup> “A Plan for Women’s Health”, Department of Health and Children, Dublin, 1997

gay men in **“The National Health Promotion Strategy 2000-2005”**<sup>22</sup>, both published by the Department of Health and Children.

“A Plan for Women’s Health” identifies the attitudes encountered by lesbians when seeking care from health services as the most serious health issue and recommended that health professionals be informed about lesbian health issues and respect the sexual orientation of lesbian women.

“The National Health Promotion Strategy 2000-2005” recommends that all environments be safe and supportive for young gay men and lesbians, that work to meet LGB people’s health needs be done in partnership with LGB people, and that health promotion programmes for lesbians and gay men be given priority.

The **Employment Equality Acts**, enacted in 1998, prohibit discrimination in employment on a range of grounds including gender (encompassing trans people) and sexual orientation. The **Equal Status Acts**, enacted in 2000, prohibit discrimination in the provision of goods and services on a range of grounds including gender (encompassing trans people) and sexual orientation. The **Irish Human Rights and Equality Commission Act 2014** includes a duty on public sector bodies to have regard to the need to eliminate discrimination, promote equality of opportunity and treatment, and protect human rights in the performance of their functions. This includes trans people and the ground of sexual orientation.

Public bodies, including health services, are required to make an assessment of the human rights and equality issues they believe to be relevant to the functions and purpose of their organisation and to set out the policies, plans and actions in place or proposed to be put in place to address those issues in their strategic plans. They are also required to report on developments and achievements in their annual reports.

### *Shaping the Policy Agenda*

*Implementing Equality for Lesbian, Gays and Bisexuals, Equality Authority, Dublin, 2002*

*Equality Policies for Lesbian, Gay and Bisexual People: Implementation Issues, National Economic and Social Forum, Report No.27, Dublin, 2003*

*Collins E. & Sheehan B., Access to Health Services for Transsexual People, Equality Authority, Dublin, 2004*

**“Implementing Equality for Lesbian, Gays and Bisexuals”**<sup>23</sup> was published in 2002 by the Equality Authority to set out an agenda for equality and non-discrimination for LGB people. An advisory committee that included LGB organisations was convened by the Equality Authority to assist with drafting this publication. It includes a chapter on health issues.

The diversity perspective developed in this report points to particular health needs of LGB people, the invisibility experienced by this group in the health services, and assumptions of heterosexuality as key issues. This leads to a difficult experience for LGB

<sup>22</sup> “The National Health Promotion Strategy 2000-2005”, Department of Health and Children, Dublin, 2000

<sup>23</sup> “Implementing Equality for Lesbian, Gays and Bisexuals”, Equality Authority, Dublin, 2002

people within health services and risks misdiagnosis and mistreatment. It identifies good practice in HIV/AIDS strategies targeting gay men for being partnership based and multi-dimensional.

The report recommends a mainstreaming approach where general services are assessed for their potential impact on LGB people and are adapted as necessary. It recommends a training strategy for health professionals on LGB issues and that health boards establish LGB health needs and develop responses to these. It makes particular recommendations for the inclusion of LGB people in mental health and women's health strategies. It recommends that health promotion would target specific information materials on LGB people and would address information materials on LGB issues to health professionals.

The report promotes a particular approach to breaking the invisibility surrounding LGB issues and to improving inclusion for LGB people. This '4Ps' approach is based on organisations giving 'public profile' to their commitment to LGBT issues, implementing 'policies and procedures' for inclusion of LGBT people, ensuring 'professional development' for their staff on LGBT issues, and ensuring 'programme development' to address LGBT issues.

The National Economic and Social Forum developed a policy implementation report in 2003 on foot of this work by the Equality Authority. **"Equality Policies for Lesbian, Gay and Bisexual People: Implementation Issues"**<sup>24</sup> takes a general perspective in recommending that "all Departments and State Agencies should take the necessary steps to ensure that they are aware of the needs of their LGB clients or service users, the extent to which their needs are currently met and how these needs are included in the planning and review of services, programmes and schemes" and "should put in place employment equality policies, equal status policies and anti-harassment policies that name LGB (people) as a target group". It also recommends "training and staff supports regarding equality generally and sexual orientation in particular should be built-in to all public services".

In relation to health services the report emphasises the importance of an increased visibility for LGB people's health needs and the need for these to be named in service plans. LGB people's health needs should be mainstreamed "into the design, delivery and impact assessment of services" and LGB interests should be "represented in all consultative fora and structures that inform policy and service development".

Key areas for attention are identified as primary healthcare, sexual health and HIV/AIDS, mental health; and next-of-kin issues. The lack of community infrastructure within the LGB community, at national and local level, is identified as an implementation barrier for policy.

The Equality Authority broke new ground in 2004 in developing a specific focus on the health needs of Trans people. **"Access to Health Services for Transsexual People"**<sup>25</sup> identifies the health services available to trans people and the perspectives of trans people on access to health services and makes recommendations in relation to access for trans people to health services that would meet their needs.

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<sup>24</sup> "Equality Policies for Lesbian, Gay and Bisexual People: Implementation Issues", National Economic and Social Forum, Report No.27, Dublin, 2003

<sup>25</sup> Collins E. & Sheehan B., "Access to Health Services for Transsexual People", Equality Authority, Dublin, 2004

Policy and practice in meeting the health needs of trans people was found to be underdeveloped. The predominant focus is on enabling access to gender reassignment surgery abroad rather than a necessary treatment path. Only a small number of specialist providers are identified and most health boards rely on general mental health and psychiatric health services.

The trans people interviewed identify significant barriers to accessing treatment in an Irish context. Initial support sought includes GPs and counsellors and many trans people report lack of knowledge and/or negative reactions from GPs and counsellors. Geographic accessibility, lack of information on their condition and on treatment options and service availability and lack of family services to support partners and family are identified as further barriers.

The report's recommendations include that the Department of Health and Children should develop a formal policy on transsexualism and develop standards of care and procedures for treatment. The Health Service Executive and health service providers should develop policies and practices to ensure no discrimination against and the promotion of equality for trans people. Health service providers should make accessible information available on treatment paths. Consultation and partnership with trans people should be central in developing policies and practices.

### *Building the Policy Portfolio*

*Reach Out: Irish National Strategy for Action on Suicide Prevention 2005-2014, Health Service Executive and Department of Health and Children, Dublin, 2005*

*A Vision for Change: Report of the Expert Group on Mental Health Policy, Department of Health and Children, Dublin, 2006*

*LGBT Health: Towards Meeting the Health Care Needs of Lesbian, Gay, Bisexual and Transgender People, Health Service Executive, Dublin, 2009*

*National Drugs Strategy (interim) 2009-2016, Department of Community, Rural and Gaeltacht Affairs, 2009*

*Better Outcomes Brighter Futures: National Policy Framework for Children and Young People 2014-2020, Department of Children and Youth Activities, 2014*

In 2005 the Health Service Executive published “**Reach Out: Irish National Strategy for Action on Suicide Prevention 2005-2014**”<sup>26</sup>. This strategy identifies LGBT people among what is referred to as ‘marginalised groups’ that experience discrimination and can be vulnerable to self-harming behaviour. It recommends specific research to determine the risks faced by these groups and to review the available services and support agencies for these groups. It further recommends the development of supports, services and education resources to improve mental health and wellbeing of these groups and to reduce any increased risk of suicidal behaviour. It emphasises the importance of consultation with these groups in developing these initiatives.

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<sup>26</sup> “Reach Out: Irish National Strategy for Action on Suicide Prevention 2005-2014”, Health Service Executive and Department of Health and Children, Dublin, 2005

**“A Vision for Change: Report of the Expert Group on Mental Health Policy”** was adopted by the Department of Health and Children as national policy in 2006<sup>27</sup>. This makes limited reference to LGBT people. It includes gay and lesbian people among those understood to have additional needs when they develop a mental health problem.

In 2009 the Health Service Executive published **“LGBT Health: Towards Meeting the Health Care Needs of Lesbian, Gay, Bisexual and Transgender People”**<sup>28</sup>. This report charts new territory as “the first report of its kind to map out existing health related services, supports, gaps, and actions for the Lesbian, Gay, Bisexual and Transgender (LGBT) community”. Its aim is to “provide a cohesive, unitary approach towards addressing the health related needs of the LGBT community across the HSE”.

The report highlights particular health issues experienced by LGBT people:

- General health: “Health impacts of higher levels of smoking, alcohol consumption, recreational drug use, and a higher incidence of obesity and eating disorders”.
- Mental health: “High incidence of depression, anxiety, substance misuse, self-harm and suicide”.
- LGBT young people: “Experience of isolation, fear, stigma, bullying and family rejection contributing to depression, anxiety, self-harm, suicide and substance misuse”.
- Lesbian and bisexual women: “Higher incidence of cardio-vascular disease, polycystic ovarian syndrome, ovarian cancer and possibly breast cancer. Lower use of gynaecological services. Low awareness of STIs spread by woman-to-woman sex. Barriers to accessing assisted human reproduction (AHR) services”.
- Gay, bisexual men and MSM: “Homophobic abuse and violence, stress, substance misuse, and sexual health risks (including HIV and syphilis)”.
- Transsexual people: “Lack of essential health services – surgeons, post-operative care, endocrinologists, psychiatrists, therapists, and a designated gender specialist. Isolation, fear, stigma, physical violence and family rejection contributing to depression, anxiety, self-harm, suicide and substance misuse”.
- Older LGBT people: “Invisibility, isolation and loneliness. Lack of recognition of partners. Difficulties expressing bereavement”.
- Ethnic and cultural minorities: “Health problems resulting from discrimination/persecution in their country of origin, and discrimination within their respective communities here. ‘Double discrimination’ as both immigrants and LGBT people”.
- Disability: “Mental and physical health consequences of ‘double discrimination’, lack of recognition of the disabled as sexual beings, access problems in relation to health services and participation in the LGBT community”.

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<sup>27</sup> “A Vision for Change: Report of the Expert Group on Mental Health Policy”, Department of Health and Children, Dublin, 2006

<sup>28</sup> “LGBT Health: Towards Meeting the Health Care Needs of Lesbian, Gay, Bisexual and Transgender People”, Health Service Executive, Dublin, 2009



- Parenting, fostering and adoption: “Difficulties in accessing health services for LGBT people and their children resulting from lack of social and legal recognition of their family unit. Difficulties accessing Assisted Human Reproduction (AHR) treatment. Psychological distress associated with systemic stigmatization of their families, and related risk of isolation and bullying of children with LGBT parents in schools”.
- Homelessness: “Health risks associated with homelessness including substance misuse, prostitution and homophobic attacks, and difficulties accessing health services”.

The key recommendations of the report include the need to name LGBT people as a target group in HSE policy and planning; to develop a HSE policy on funding and allocating resources to LGBT health related work; to ensure proper consultation with LGBT communities in planning and developing health and social services; to ensure that the development of Primary Care Teams and Networks reflect and address the needs of LGBT people; to develop training on LGBT issues for all HSE staff; and to promote ‘LGBT Good Practice Guidelines for Service Providers’.

These **‘LGBT Good Practice Guidelines for Service Providers’** are set out in the report:

- Don’t assume everyone is heterosexual;
- Be informed about health issues of LGBY people;
- Respond positively when people disclose their sexual orientation and/or gender identity;
- Ensure respect, confidentiality and privacy is shown to all LGBT people;
- Address issues of same-sex partners and next-of-kin in care settings in a sensitive manner;
- Ensure all paperwork uses language which is inclusive of LGBT people and their families;
- Where relevant all health related publications should include references to and images of LGBT people;
- Display contact details, posters and literature of local and national LGBT services in your waiting areas;
- Be familiar with local LGBT groups and services and develop working relationships with them;
- If you are unsure of appropriate language, ask LGBT person/group for guidance;
- Address unacceptable, offensive or discriminatory comments and/or actions relating to LGBT people;
- Promote inclusive practice for LGBT people through the development of local policies and provide appropriate training for service providers.

The **National Drugs Strategy (interim) 2009-2016**<sup>29</sup>, published by the Department of Community, Rural and Gaeltacht Affairs, includes a commitment to awareness

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<sup>29</sup> National Drugs Strategy (interim) 2009-2016, Department of Community, Rural and Gaeltacht Affairs, 2009

campaigns that specifically engage LGBT people. The strategy identifies the need to differentiate the needs of specific groups and tailor services accordingly and mentions LGBT people in this regard. Engagement with and provision of services for LGBT people is identified among the priorities in the strategy.

**Better Outcomes Brighter Futures, the National Policy Framework for Children and Young People 2014-2020**<sup>30</sup> makes specific reference to young LGBT people in relation to two of the outcomes sought. Under the goal of active and healthy, children and young people there is a commitment to “tackle inequalities in health outcomes for identified vulnerable groups, including young people identifying as lesbian, gay, bisexual and transgender”. Under the goal of ensuring children and young people are safe and protected from harm there is an acknowledgment that “groups who may be particularly vulnerable to bullying and discrimination include lesbian, gay, bisexual and transgendered (LGBT)” people and a commitment to reduce discrimination and intolerance.

### *Planning for LGBT Inclusion*

*Primary Care Division, Operational Plan 2014, Health Service Executive*

*Health Service Executive: National Service Plan 2015, HSE, 2014*

*Transgender Health: Proposed Model of Care, Consultation Paper 2014, Quality and Patient Safety Division, Health Service Executive, 2014*

The national level **Primary Care Division Operational Plan for 2014**<sup>31</sup> makes particular commitment to action in relation to trans people. Actions to develop “treatment pathways for Transgender service users” and support for the Transgender Equality Network Ireland to carry out action addressing mental health and suicide prevention are identified. Action on HIV/AIDS is identified in a separate section to “support health promotion in aspects of the European Joint Action on Quality Improvement in HIV/AIDS prevention”.

The **Health Service Executive National Service Plan 2015**<sup>32</sup> commits resources to social inclusion and identifies that “social inclusion plays a key role in supporting access to services and provides targeted interventions of minority groups” such as “lesbian, gay, bisexual and transgender services users”.

The Quality and Patient Safety Division of the HSE published **Transgender Health: Proposed Model of Care** in 2014<sup>33</sup>. This is a consultation paper and an important step in resolving the issue of there being “no agreed model of care, clinical guidelines or treatment pathway in place for transgender people (including children and adolescents)”. It sets out current treatment pathways, identifies key issues of concern

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<sup>30</sup> Better Outcomes Brighter Futures: National Policy Framework for Children and Young People 2014-2020, Department of Children and Youth Activities, 2014

<sup>31</sup> Primary Care Division, Operational Plan 2014, Health Service Executive

<sup>32</sup> Health Service Executive: National Service Plan 2015, HSE, 2014

<sup>33</sup> Transgender Health: Proposed Model of Care, Consultation Paper 2014, Quality and Patient Safety Division, Health Service Executive, 2014

and sets out a proposed model of care. Its main focus is on Trans people but it makes some reference to Intersex people.

### *Building the Practice Agenda*

*Lesbians, Gay and Bisexual People and their Sexual Health: Good Practice Guide for Healthcare Professionals, GLEN, 2012*

*Allen O., Lesbian, Gay and Bisexual Patients: The Issues for General Practice, GLEN & ICGP, Dublin, 2013*

*Lesbian, Gay, Bisexual and Transgender Service Users: Guidance for Staff Working in Mental Health Services, GLEN and the Mental Health Commission, 2013*

*Lesbian, Gay and Bisexual People: A Guide to Good Practice for Social Workers, GLEN and the Irish Association of Social Workers, 2011*

*Quiery M., Invisible Women: A review of the impact of discrimination and social exclusion on lesbian and bisexual women's health in Northern Ireland, Lesbian Advocacy Services Initiative, Northern Ireland, 2007*

**“Lesbians, Gay and Bisexual People and their Sexual Health: Good Practice Guide for Healthcare Professionals”<sup>34</sup>** was published by GLEN in 2012. This identifies a series of barriers faced by LGB people in accessing sexual health services. These include patients not being out to health professionals, minority stress and stigma, fear of anti-gay bias, negative experiences of dealing with health professionals, hetero-normativity, perceptions that health professionals do not understand LGBT issues, confidentiality issues in GUM clinics, lack of knowledge of services available, fear of HIV diagnosis, stigma associated with HIV, and the particular situation of LGBT people from minority ethnic groups.

Good practice recommendations are made for clinics and for clinicians. Clinics need to create a public profile by ensuring that they demonstrate to their patients that they are inclusive of LGB and MSM people. Clinics need to develop inclusive policies and procedures that address the needs of LGB and MSM people. These should include equality and diversity policies. They should have programmes that engage with LGBT communities and target the needs of MSM and LGB patients. These could include a specific targeting of LGB people and should involve relationship building with the LGB community. Staff in clinics should be equipped with the information they need to provide an inclusive service to LGB and MSM patients through guidance and training.

Clinicians need to stay informed on LGB health issues. They should not assume all patients are heterosexual and should respond positively when patients disclose they are lesbian, gay or bisexual. They should ensure the principles of confidentiality. Particular attention is needed to working effectively and positively with younger MSM and LGB patients.

GLEN and the Irish College of General Practitioners' Quality in Practice Committee developed guidance for General Practice in 2013. **“Lesbian, Gay and Bisexual**

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<sup>34</sup> “Lesbians, Gay and Bisexual People and their Sexual Health: Good Practice Guide for Healthcare Professionals”, GLEN, 2012

**Patients: The Issues for General Practice**<sup>35</sup> explores language and concepts to be used, the health issues of LGB people, and good practice in service provision for LGB patients.

It identifies five elements of good practice:

- Stay informed on LGB health issues;
- Don't assume patients are heterosexual;
- Acknowledge when patients disclose they are lesbian, gay or bisexual;
- Take a gay-affirmative approach and challenge bias;
- Demonstrate that your practice is LGB friendly.

It defines an inclusive general practice as applying “to all forms of diversity, including sexual orientation and it means that general practitioners: Recognise diversity among their patient population and respect this diversity; Understand the issues facing diverse patient groups (such as LGB patients) and are able to respond to their specific health needs; and Provide an accessible and appropriate service within their scope of practice and refer patients on to specialist or other services where necessary.

It emphasises that “there are a number of specific health issues which general practitioners should be aware of in relation to these patients. A good understanding of these issues is the foundation of providing an inclusive service to LGB patients. The issues can be grouped into three general areas: Mental health; Sexual health; and General health and screening.

GLEN and the Mental Health Commission published “**Lesbian, Gay, Bisexual and Transgender Service Users: Guidance for Staff Working in Mental Health Services**”<sup>36</sup>. This identifies the need for mental health professionals to give consideration to the additional issues for LGBT service users of a number of factors including minority stress (the mental health consequences of stigmatisation and harassment), coming out (discovery, acceptance, and disclosure of sexual orientation), homophobic and transphobic bullying, and transitioning (the process of changing the way someone's gender is lived publicly).

It outlines steps that could be taken by those working in and providing mental health services and structures these under the themes of the Mental Health Commission's Quality Framework for Mental Health Services. These steps include:

- Consider LGBT issues when developing policies and services.
- Engage with LGBT community groups.
- Provide training to build awareness of mental health care staff of LGBT issues and needs.
- Identify LGBT specific needs of service users.
- Respond supportively to disclosure of LGBT identity.
- Respect the rights of LGBT service users.

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<sup>35</sup> Allen O., “Lesbian, Gay and Bisexual Patients: The Issues for General Practice”, GLEN & ICGP, Dublin, 2013

<sup>36</sup> “Lesbian, Gay, Bisexual and Transgender Service Users: Guidance for Staff Working in Mental Health Services”, GLEN and the Mental Health Commission, 2013

- Use language that reflects openness and does not assume heterosexuality.
- Display LGBT information.
- Create a safe environment.
- Include LGBT people in the service ethos statement or equality policy.
- Provide information, advice and support to the partners of LGBT service users.
- Treat same-sex civil partnered or co-habiting couples in the same way as married or co-habiting heterosexual couples.

**“Lesbian, Gay and Bisexual People: A Guide to Good Practice for Social Workers”<sup>37</sup>**

was published by GLEN and the Irish Association of Social Workers in 2011. This emphasises the importance of being “aware of LGB social and emotional issues and LGB stressors”, not assuming all service users are heterosexual, responding supportively when someone discloses they are LGB, challenging “anti-gay bias and take a gay-affirmative approach” and demonstrating that their “practice is inclusive of LGB people”.

**Invisible Women: A review of the impact of discrimination and social exclusion on lesbian and bisexual women’s health in Northern Ireland<sup>38</sup>**, by Marie Quiery, found

that Lesbian and Bisexual women experience significant barriers to accessing health services. “They: are reluctant to disclose their sexual orientation for fear of discrimination by health professionals; lack awareness and knowledge of health risks; access health services less often than other women; delay treatment and follow-up; generally prefer a more holistic approach to healthcare; have a preference for female service providers; are at risk of psychological distress, damaged self-esteem and reluctance to access preventive care if they do not have access to an LGB community; have a high uptake of counselling services which could reflect the homophobic society within which lesbians have to live and/or the value lesbians place on internal and emotional well-being; are up to 2-3 times more likely to attempt suicide and have higher levels of self harm than their heterosexual counterparts; have a 1 in 2 chance of mental illness as diagnosed in the General Health Questionnaire”.

This research also explored the perspectives of health professionals and found that they: “are often misinformed or uninformed about lesbian health issues; have limited available research on the health status or long-term health outcomes for lesbians; have little or no training in lesbian health at undergraduate or postgraduate level in Northern Ireland; limit access to existing assisted reproduction services; do not facilitate official acknowledgement of lesbian family forms or provide adequate and appropriate care of lesbians and their children; can create negative experiences in relation to health care which can directly impact on women’s willingness to seek regular care”.

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<sup>37</sup> “Lesbian, Gay and Bisexual People: A Guide to Good Practice for Social Workers”, GLEN and the Irish Association of Social Workers, 2011

<sup>38</sup> Quiery M., Invisible Women: A review of the impact of discrimination and social exclusion on lesbian and bisexual women’s health in Northern Ireland, Lesbian Advocacy Services Initiative, Northern Ireland, 2007

## *LGBT Experiences*

*Maycock P., Bryan A., Carr N., & Kitching K., Supporting LGBT Lives: A Study of Mental Health and Wellbeing of Lesbian, Gay, Bisexual and Transgender People, GLEN and BeLonGTo, Dublin, 2009*

*McNeil J., Bailey L., Ellis S., & Regan M., Speaking from the Margins: Trans Mental Health and Wellbeing in Ireland, Transgender Equality Network Ireland, Dublin, 2013*

*National Action Plan for Social Inclusion 2007 – 2016, Government of Ireland, 2007*

*Higgins A., Sharek D., McCann E., Sheerin F., Glacken M., Breen M., & McCarron M., Visible Lives: Identifying the experience and needs of older lesbian, gay, bisexual and transgender people in Ireland, GLEN, 2011*

*Elliot I., Voices of Children, Marriage Equality, Dublin, 2010*

**“Supporting LGBT Lives: A Study of Mental Health and Wellbeing of Lesbian, Gay, Bisexual and Transgender People”<sup>39</sup>** was published by GLEN and BeLonGTo in 2009. This study sought to identify mental health risk and resilience factors for LGBT people and to identify and develop responses to the issue of suicide among LGBT people, especially young LGBT people.

Psychological distress experienced by LGBT people was found to be strongly associated with external stressors such as presumed heterosexuality, homophobia, prejudice and victimisation. Internal stressors are strongly related to the anxiety of coming out. Issues in relation to self-concealment in contexts such as school and the workplace are also identified. The stigma and discrimination encountered by LGBT people can result in an extremely negative perception of being LGBT which causes many to experience depression and a significant minority to engage in self-injurious behaviour and to experience, and in some cases act on, suicidal thoughts.

The study examines the experience of the LGBT people interviewed of the health services they had accessed. Many say that health care professionals needed to have more knowledge of and sensitivity to LGBT issues. Many did not reveal their sexual identity to healthcare professionals they were attending for fear of a negative reaction. The presumption of heterosexuality by and the lack of cultural competence of healthcare professionals are identified as barriers. Trans people report particular difficulties in accessing necessary health services.

The recommendations made include the need for mental health and social services to be provided in a way that is accessible and appropriate for LGBT people, for mental health service standards to be developed that include a focus on care policies for LGBT people, and for suicide prevention and mental health promotion to be inclusive and appropriate to LGBT people. Training to develop the understanding and competence of health professionals in relation to LGBT issues is also recommended. Particular emphasis is placed on the need for LGBT specific services to respond to the particular causal factors for mental health issues within the LGBT community.

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<sup>39</sup> Maycock P., Bryan A., Carr N., & Kitching K., “Supporting LGBT Lives: A Study of Mental Health and Wellbeing of Lesbian, Gay, Bisexual and Transgender People”, GLEN and BeLonGTo, Dublin, 2009

**“Speaking from the Margins: Trans Mental Health and Wellbeing in Ireland”**<sup>40</sup> is the largest study on this issue to date in Ireland. It was commissioned by the Transgender Equality Network in Ireland and published in 2013. Participants were found to be at a much higher risk of negative mental health, self-harm and suicide over the course of their life than the general population. 78% of participants had considered suicide and 40% of these people had made at least one attempt. A key finding of the study is the significance of gender transition in improving mental health and wellbeing. Negative experiences in accessing health services are found to be widespread. 60% of those who had used a Gender Identity Clinic report at least one negative experience. 69% of those who had used a mental health service report at least one negative experience. 74% of those who had used a general health service report at least one negative experience.

The recommendations made on foot of this study focus on trans health and awareness training for health staff and management across general health care, mental health, and gender identity services; investment in research on mental health for trans people; enhanced collaboration between community organisations and mental health services in the area of trans support and outreach; investment in suicide prevention research, campaigns and interventions with the trans community; and exploration of alternative trans health care models focused on informed consent and patient flexibility.

The **National Action Plan on Social Inclusion 2007-2016**<sup>41</sup> establishes the lifecycle approach to policy making as underpinning policies and programmes to advance social inclusion. “The lifecycle approach places the individual at the centre of policy development and delivery by assessing the risks facing him or her and the supports available at key stages of the lifecycle. These key lifecycle groups are: Children, People of Working Age, Older People and People with Disabilities. The adoption of the lifecycle approach offers a comprehensive framework for implementing a streamlined, cross-cutting and visible approach to tackling poverty and social exclusion”.

**Visible Lives**<sup>42</sup> was published by GLEN in 2011 and is the first study of older LGBT people and their lives. The findings include that a major concern for older LGBT people is that older age services will not recognise and respect their LGBT identify. Mental health is a specific focus and 33% of respondents report having a mental health problem at one point in their lives, one in ten report currently taking prescribed medication for a mental health issue and only 2% report using mental health services. Only one in three respondents believe health care professionals have sufficient knowledge about LGBT issues.

Its recommendations include the need to engage with the HSE and HIQA to establish standards for the care of older LGBT people and to ensure that nursing homes and residential care services communicate a positive message of inclusiveness and respect for older people. It also recommends the need to engage with health and social care services to ensure that policies and practices are responsive to the needs of older LGBT people.

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<sup>40</sup> McNeil J., Bailey L., Ellis S., & Regan M., “Speaking from the Margins: Trans Mental Health and Wellbeing in Ireland”, Transgender Equality Network Ireland, Dublin, 2013

<sup>41</sup> National Action Plan for Social Inclusion 2007 – 2016, Government of Ireland, 2007

<sup>42</sup> Higgins A., Sharek D., McCann E., Sheerin F., Glacken M., Breen M., & McCarron M., “Visible Lives: Identifying the experience and needs of older lesbian, gay, bisexual and transgender people in Ireland, GLEN, 2011

**Voice of Children**<sup>43</sup> was published by Marriage Equality in 2010 and is the first study of children of LGBT parents in Ireland. This report identifies a number of negative experiences for these children in relation to the health system. These experiences revolve around the failure to recognise the family status of children and parents in LGBT families and the giving of privileged status to biological family members who could be distant, unaccepting or even homophobic. These experiences relate to situations of birth, serious illness and death.

## 2.4 Regional Situations

### *Building the Practice Agenda*

*Gibbons M., Manandhar M., Gleeson C., & Mullan J, Recognising LGB Sexual Identities in Health Services: The Experiences of Lesbian, Gay and Bisexual People with Health Services in North West Ireland, Equality Authority and Health Service Executive, Dublin, 2007*

The Equality Authority and the Health Service Executive published **“Recognising LGB Sexual Identities in Health Services: The Experiences of Lesbian, Gay and Bisexual People with Health Services in North West Ireland”** in 2007<sup>44</sup>. This research breaks new ground in addressing health services from a diversity perspective to examine how the practical implications of diverse sexual identities are being taken into account.

This study examines the experience of LGB people of the health services in HSE West and identifies good practices that might address this experience. Five key themes emerge from the study:

- Disclosure of sexual orientation: “Anxieties concerning confidentiality, homophobia, and heterosexism emerged across all services”.
- Recognition of partnership/next of kin: “Concerns with regard to partnership rights particularly in relation to hospitalization and GP services”.
- Parenthood: “Arose primarily for women in relation to GP and maternity services”.
- Mental health: “Primarily arose in relation to GP and other mental health professionals”.
- Sexual gynaecological health: “Arose mainly in relation to GPs and other sexual health professionals”.

A range of improvements is identified for the health services. These suggest that organisations in the health sector would:

- Emphasise a culture of ‘equal rights’ rather than ‘special treatment’;

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<sup>43</sup> Elliot I., “Voices of Children”, Marriage Equality, Dublin, 2010

<sup>44</sup> Gibbons M., Manandhar M., Gleeson C., & Mullan J, “Recognising LGB Sexual Identities in Health Services: The Experiences of Lesbian, Gay and Bisexual People with Health Services in North West Ireland”, Equality Authority and Health Service Executive, Dublin, 2007



- Provide training on LGB issues;
- Form partnerships with LGB organisations;
- Address issue of same-sex partners.

Individual health care providers would:

- Seek training on LGB issues;
- Avoid assumptions that clients are heterosexual;
- Be sensitive to the process of 'coming out'.

All health service settings would:

- Improve confidentiality;
- Disseminate appropriate literature for LGB people.

Sexual health services, mental health services and GPs would:

- Understand and meet the particular needs of LGB people.

LGB people themselves would:

- Take more responsibility for setting the context with the service provider.

### *LGBT Experiences*

*Gleeson C. & McCallion M., A Needs Analysis of the Lesbian, Gay, Bisexual and Transgender Population in Galway, Mayo, and Roscommon, GLEN/Gay HIV Strategies and LGBT West, 2008*

**A needs analysis of the LGBT Population in Galway, Mayo, and Roscommon**<sup>45</sup> was carried out for GLEN/Gay HIV Strategies and LGBT West in 2008. Four issues related to health and health services are identified:

- Half of respondents report having been assumed to be heterosexual by their family doctor. The need to give visibility to LGBT issues and to provide relevant information and leaflets in waiting rooms is identified. Good practice where health professionals treated respondents 'normally' while taking account of their sexual orientation when relevant is noted. However, a number of respondents describe how health professionals reacted negatively to disclosure.
- Sixty eight per cent of respondents consider themselves to have very or quite good mental health. This is lower than for the general population in the region. The need for counsellors and therapists to have LGBT awareness training is identified.
- Most (86%) respondents rate their sexual health as very or quite good. Concerns were raised about what is seen as an emerging complacency towards safe-sex practices amongst younger men. Respondents note their satisfaction with clinics with the exception of some waiting areas. A number of women say they were

<sup>45</sup> Gleeson C. & McCallion M., A Needs Analysis of the Lesbian, Gay, Bisexual and Transgender Population in Galway, Mayo, and Roscommon, GLEN/Gay HIV Strategies and LGBT West, 2008

misinformed by their GP who told them that they did not need smear tests because they were lesbian.

- Levels of smoking, alcohol and drugs use appear to be significantly higher in the LGBT population than national prevalence. It is suggested that future national prevalence studies should explicitly include sexual orientation.

Further research on prevalence, impact and causal factors for levels of smoking, alcohol and drug abuse is recommended. Specific health promotion initiatives are identified as being required for the LGBT population. Training in LGBT issues for health professionals is recommended. Research is recommended to identify the specific needs of transgender people in the region. Information on support services to transgender people and information on transgender issues for service providers are identified being required. The mainstreaming of LGBT issues across all areas of service provision is recommended.

## 2.5 South East Situation

### *Planning for LGBT Inclusion*

*Carlow, Kilkenny, South Tipperary ISA, Primary Care Division, Operational Plan 2014, Health Service Executive*

*Waterford/Wexford, Primary Care Division, Operational Plan 2014. Health Service Executive*

The **operational plans for Carlow, Kilkenny, South Tipperary<sup>46</sup> and for Waterford/Wexford<sup>47</sup>** make reference to LGBT people as a social inclusion priority. Actions for 2014 are set out in relation to primary care, social inclusion and national actions. Actions in relation to LGBT people are located in the social inclusion strand. Social inclusion is understood as playing “a key role in supporting equity of access to services and provides targeted interventions to improve the health outcomes of minority groups” including “lesbian, gay, bisexual and transgender service users”.

The actions indicated give particular priority to trans people and include the development of “treatment pathways for Transgender service users” and support for the Transgender Equality Network Ireland to carry out action addressing mental health and suicide prevention. Further actions include a review of LGBT service provision and engagement with the LGBT community to build capacity and engagement with health care services and supports. Action on HIV/AIDS is identified in a separate section to “support health promotion in aspects of the European Joint Action on Quality Improvement in HIV/AIDS prevention”.

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<sup>46</sup> Carlow, Kilkenny, South Tipperary ISA, Primary Care Division, Operational Plan 2014, Health Service Executive

<sup>47</sup> Waterford/Wexford, Primary Care Division, Operational Plan 2014. Health Service Executive.

## *Building the Practice Agenda*

*Smyth B., Building Strong and Inclusive Communities: A Regional Strategy for Lesbian, Gay, Bisexual and Transgender (LGBT) Inclusion and Support in the South East (Waterford, Wexford, Wicklow, Kildare, Kilkenny and Carlow), LGBT Diversity, Waterford, 2012*

A cohesive plan for the long-term development of supports for LGBT people in the South East was developed by the LGBT South East Regional Strategy Group in 2012. **“Building Strong and Inclusive Communities”**<sup>48</sup> was published to set out strategic priorities for the LGBT community in the South East. It is based on a vision that LGBT people are “equal, visible and active participants in all aspects of family, social, political, cultural and economic life in the South East”. Health and Safety is the fourth of the five themes identified with priority action areas including mental health, physical health, and sexual health. Transgender health is identified separately as the fifth of these themes.

Overall, in all areas of the health service, the plan recommends a strategy for the HSE of promoting LGBT inclusion and visibility in all health care settings and printed documents, providing awareness training on LGBT issues to all frontline health care staff, and promoting the supports that are available to LGBT community.

In relation to mental health the plan points to the particular needs of LGBT people when, quoting the 2009 HSE LGBT Health report, lesbians are 2.3 times more likely and gay men 6 times more likely to have mental health problems and, quoting the Supporting LGBT Lives report, over a quarter of those who identified as transgender indicated they had attempted suicide at least once.

The plan recommends that the needs of LGBT carers and of older LGBT people in care be researched, suicide prevention training be provided in the South East, supports be provided to older LGBT people in relation to bereavement and loneliness, and positive mental health initiatives be developed including free or pro-rated counselling services.

The plan recommends the provision of drugs awareness training, the promotion of prevention and screening programmes to the LGBT community, and the inclusion of LGBT data in National Drugs Task Force forms. It recommends a targeting of lesbian and bisexual women for STI screening and of gay and bisexual men for regular HIV and STI testing, the promotion of HIV and STI education in the region, and free sexual health clinics in the region.

The plan recommends the need for information on transgender issues to be communicated to all public and private clinics and a list of transgender supportive GPs and counselors in the region be compiled and distributed. There should be at least one GP in each county and at least one endocrinologist in the South East who is transgender aware and transgender friendly. Transgender awareness training should be funded. Transgender people should have access to counseling services that enable them to address self-esteem issues and sexual power dynamics and to develop their skills and confidence to negotiate and enjoy safer sex.

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<sup>48</sup> Smyth B., Building Strong and Inclusive Communities: A Regional Strategy for Lesbian, Gay, Bisexual and Transgender (LGBT) Inclusion and Support in the South East (Waterford, Wexford, Wicklow, Kildare, Kilkenny and Carlow), LGBT Diversity, Waterford, 2012

## 3.0 Health Provider Perspectives

### 3.1 General Practitioners

#### *Introduction*

A postal survey was sent to all General Practitioners in the South East Region. The survey focused on General Practitioners giving 'public profile' to their commitment to LGBTI issues, implementing 'policies and procedures' for inclusion of LGBTI people, ensuring 'professional development' for their staff on LGBTI issues, and ensuring 'programme development' to address LGBT issues. The survey also sought responses on the supports that General Practitioners thought might be useful in achieving an LGBTI friendly service.

Total number of completed responses	64
Total number of blank responses	7

A total of 64 General Practitioners responded to a postal survey questionnaire. Not all respondents identified their location. However, from the respondents that did, it is clear that the responses are geographically representative in coming from all counties in the region and from urban and rural settings.

Seven General Practitioners returned blank forms stating that they were not free or unable to participate. This could be a reflection of the pressure that General Practitioners are under. One respondent to the questionnaire pointed to the 'pressure of time and the competing demands on our time' as a 'huge factor'.

It could be a reflection of some hostility to the process. One of those not responding just wrote 'No Thanks'. Another took the time to refer the researcher to the practice policy on their website and suggest that the survey was 'nothing more than preaching in a disguised form'. The website of this large practice appeared to contain no such policy and no reference to LGBTI patients, no links to LGBTI groups and no mention of LGBTI issues or issues of equality and diversity. Another respondent also noted that they found 'this survey offensive. We do not discriminate or favour patients based on sexuality, gender, career, money etc.'

#### *Public Profile*

GPs taking steps on public profile	10
GPs not taking steps on public profile	54

Ten respondents stated that they had taken steps to communicate that their practice is open to the diverse gender identities and sexual identities of clients.

Few of these respondents reported practical steps in this area. Two respondents referred to the practice website as holding relevant information. Another respondent referred to hosting a meeting on the issues in the practice. Leadership emerged as a factor in communicating an LGBTI friendly profile. Two respondents from the one practice referred to the practice including an 'openly gay' doctor and the patients being aware of this. Another respondent referred to their 'well known liberal stance' in this regard. Another respondent suggested that their 'staff knew better than to' discriminate against any patient.

Reputation also emerged as important, particularly in smaller rural areas. One respondent noted that they had a patient 'diagnosed with gender identity disorder and she attends the practice and is very welcome' and went on to point out 'our practice is in a small rural area where people like to talk but nobody has ever made any comment on this patient'. Another respondent noted that they used 'direct communication with LGBTI patients' and have 'patients who have been referred by friends'. Another stated that they had 'open positive attitudes to those expressing LGBTI sexuality'.

Fifty four respondents reported that they had taken no steps to communicate that their practice was open to the diverse gender identities and sexual identities of clients.

Most respondents felt this was not necessary as their practice was open to all and treated all people the same. Some respondents suggested that such steps were not needed. One respondent pointed out that their 'practice profile reflects diversity'. Another respondents stated that 'we have a very diverse practice'.

There appeared to be some reluctance to make particular provision in relation to a specific group. One respondent stated there are 'no favourites, no exceptions'. Another respondent asked 'why should such communication be necessary? Patients are patients are patients'. Another respondent stated that there was a 'non-judgmental practice policy' though the practice reported no such policy in the later questions.

Fear of negative reaction also emerged. One respondent cited the staff and existing patients of the practice as a barrier to taking steps to profile LGBTI issues in the practice.

*Policies and Procedures*

GPs with policies and procedures	6
GPs without policies and procedures	58

Six respondents reported that they had some form of practice guidelines or policy in relation to equality and diversity for LGBTI patients.

One respondent highlighted a 'practice protocol written and agreed' and noted that practice meetings every two weeks were use to discuss issues and to update guidelines and protocols. Another respondent also mentioned 'frequent reiteration that all we do

must have the interests and the wellbeing of the patient at their centre' and that they 'listen to and thoroughly assess each complaint and problem'. Another respondent referred to a practice policy given to staff when they take up a post.

One respondent stated that they were currently developing a 'patient charter' that will apply to all service areas. They mentioned using 'regular meetings' to communicate about treating all clients equally.

One respondent referred to the ICGP 'guideline protocol' but noted that they did not need a 'practice guideline as I feel that this is a basic Christian value and has always been so in my practice'. Another respondent also state that they had no written policy but referred to 'medical ethics' as requiring equal treatment of patients.

Fifty eight respondents reported that they had no practice guidelines for equality and diversity in the treatment and care of LGBTI patients.

Most respondents felt this was not necessary in that they treat everyone the same, treat everyone equally, do not discriminate and/or treat everyone with dignity and respect. One respondent did point out that they had a bullying, dignity and harassment policy for the workplace. Two respondents pointed out that a policy or standards were not a priority in the current context of scarce time and scarce resources. Again, one respondent stated that such a policy would 'not be easily accepted' in the practice.

### *Professional Development*

GPs attended training	14
GPs did not attend training	50

Fourteen respondents reported that they had attended training on LGBTI issues. However, in most instances, this training formed a small part of training on other topics.

Two respondents reported that the GP south east scheme discussed LGBTI issues. One respondent reported attending meetings 'concerning LGBTI related issues within the Southern Gay Health umbrella'. One respondent reported using 'ICGP related training on their website'. Another respondent had qualified in Sexology and LGBTI issues fell under this.

Six respondents reported participation on STI training that included some reference to LGBTI issues. One respondent noted that the needs of minority groups were included in Continuing Medical Education. Another respondent pointed to a brief discussion of the issues as part of GP training. One respondent reported participating in numerous seminars on 'sexual assault, depression/anxiety related to sexual and gender issues'.

Fifty respondents reported that they had not participated in any training on LGBTI issues.

Most respondents reported no barriers to attending such training. Many respondents pointed to time pressures. Some suggested that there was no need for such training. One respondent reported that they relied on '37 years of practice'. Another stated that 'LGBTI patients are happy with us'. A few respondents stated that they were not aware of such training or that it was not available. There was some hostility to the idea of this

training. One respondent stated that 'likewise no training on heterosexual issues' had been attended.

### *Programme Development*

GPs reporting attendance as often	11
GPs reporting attendance as regular	37
GPs reporting attendance as rare	13
GPs do not know or no answer	3

Most respondents reported LGBTI clients as regularly attending their services. Eleven respondents reported LGBTI clients as often attending their services. Thirty seven respondents reported LGBTI clients as regular. Thirteen respondents reported LGBTI clients as rarely attending their services. One respondent stated that they did not know and two respondents did not answer this question.

GPs reporting attendance for same reasons as general population	35
GPs reporting attendance for sexual health	20
GPs reporting attendance for mental health	19
GPs reporting attendance of trans people	3
GPs reporting attendance for reproductive health	3
GPs reporting attendance for minority stress	1

Thirty five respondents noted that LGBTI patients attended for the same reasons as the general population. However, there was a significant focus on mental health issues and sexual health issues. Twenty respondents noted LGBTI patient attending for issues relating to sexual health and nineteen respondents noted LGBTI patients attending for issues relating to mental health.

Three respondents referred to patients attending in relation to trans issues. Three respondents reported patients attending in relation to reproductive health issues. One respondent noted a patient attending due to stress resulting from homophobic bullying.

A few respondents reported difficulties. Some of these are identified as common issues of delays and difficulties in referring patients. Others are more specific. Two respondents noted difficulties in discussing issues if patients have not identified as LGBTI. Three respondents noted difficulties in mental health referrals, one highlighting the lack of local back-up and the need to refer to Dublin, another highlighting the lack of specialised counseling services to refer to, and another stating there were difficulties in making mental health referrals.

GPs involved in outreach	1
GPs not involved in outreach	63

Only one respondent reported outreach activities. This respondent attended LGBTI meetings addressing gay men’s health issues.

### *Supports*

GPs interested in training	34
GPs open to disseminating LGBTI friendly literature	17
GPs interested in guidelines	7
GPs open to using LGBTI friendly leaflets and posters for display	4

There was significant interest among respondents in establishing supports for practice in relation to LGBTI issues.

Thirty four respondents were interested to receive **training** in relation to LGBTI issues. Some noted the need to provided this training locally, to ensure it is accessible and/or to make it part of Continuing Medical Education. Thirty respondents stated that they were not interested in training on LGBTI issues. Time constraints were the most frequent barrier noted in this regard.

Seventeen respondents stated that they would be happy to disseminate **LGBTI friendly literature** or make it available in their practice. Most reflected the need to provide this literature to the practice. Some noted the need for specific leaflets and others noted a value in providing lists of good websites or LGBTI support groups.

Seven respondents noted an interest in **guidelines**. One respondent asked for ‘a document advising us exactly what we should do’. One respondent wanted to be



directed towards guidelines and another respondent sought a greater awareness of existing guidelines. Two respondents suggested an information pack, one highlighting that it should include guidelines and patient information leaflets that could be placed in the waiting room.

Four respondents stated an interest in **leaflets and posters for display** in the practice. These could 'advertise services available'.

Other ideas put forward by respondents included a 'dedicated outreach person', 'contact with professional LGBTI counselors', 'discussion of LGBTI issues at regular team meetings', 'small group meetings' on LGBTI issues, a 'specific website as a resource', and 'public information to overcome LGBTI reluctance to attend GPs'.

### *Conclusion*

A number of important and useful **themes** emerge from the responses. These include:

- The importance of leadership for equality and diversity in practice settings.
- The value of practice reputation, particularly in small scale rural settings.
- The use of practice meetings to discuss issues and set standards for responding to issues.

The predominant message from the survey is that General Practitioners are committed to an approach that is based on treating people the same, treating people equally and/or treating people non-judgmentally. This approach leaves little room for initiatives that make adjustments for difference in areas such as public profile, practice policy, professional development and programme development.

There was little mention of existing guidelines in the survey responses. Equality legislation, HSE guidelines and the joint guidance developed by GLEN and the ICGP received no mention. ICGP resources were referenced in relation to guidance protocols and training material on their website.

Particular health issues were identified as being presented by LGBTI clients. These covered mental health, sexual health and reproductive health. There was mention of minority stress in one reference to homophobic bullying but nothing beyond that.

Some **challenges** were posed in the responses to the questionnaire. These include:

- Difficulties experienced when patients do not identify as LGBTI.
- Fears of attitudes held by other staff and patients.
- The lack of local back-up for some referrals and the need to refer to Dublin.

There was significant interest in developing supports in this area. A large number of respondents were interested in training with a proviso that it could be local and accessible. Many respondents were open to disseminating literature and putting up posters within their practices. Some were open to guidelines in this area.

## 3.2 Primary Care Teams

### *Introduction*

The researcher attended six primary care team meetings in Tullow, Campile, Waterford Health Park, Ferrybank, Freshford and Clonmel. This provided an opportunity to present the research project and the progress in implementing the research and to take feedback on the project and the issues involved. A survey questionnaire was made available to all those attending these meetings. Members of the research steering group circulated survey questionnaires to all primary care teams in the region.

The survey for primary care teams followed the same pattern as for General Practitioners. It focused on centres:

- Giving 'public profile' to their commitment to LGBTI issues.
- Implementing 'policies and procedures' for inclusion of LGBTI people.
- Ensuring 'professional development' for staff on LGBTI issues.
- Ensuring 'programme development' to address LGBTI issues.

The survey also sought responses on the supports that respondents thought might be useful in achieving an LGBTI friendly service.

Thirty one responses were received to the survey questionnaire. These came primarily from Waterford Health Park (seven responses), Tullow (five responses), Campile (four responses), Wexford (three responses), Gorey (three responses) and Clonmel (one response). Responses were received from five other locations. Three responses did not identify a particular area.

A range of different health professionals responded to the survey. The largest groups were Primary Healthcare Nurses (eight responses), Physiotherapists (seven responses) and Community Occupational Therapists (three responses). Other responses included speech and language therapists, social workers, home helps, dietetics, services for older people and trainees.

### *Public Profile*

Respondents taking steps on public profile	3
Respondents not taking steps on public profile	28

Twenty eight respondents reported that no steps had been taken in their centre to communicate that their services were open to the different gender identities and sexual identities of those attending their services. Most respondents suggested that this was because this diversity was not a relevant issue and the need had not arisen. One respondent stated that they had never thought about it. Another respondent stated that the topic had never needed to be discussed.

Three respondents stated that they had taken steps to communicate that their services were open to the different gender identities and sexual identities of those using their

services. One respondent stated that they communicated about issues that were important to this group using posters and information leaflets. One respondent suggested that it was sufficient that their practice was inclusive and that the referral process was the same for everyone. Another stated that they treated everybody the same.

There was interest in two of the primary care team meetings in having relevant literature and posters available and on display in the waiting room that would be welcoming to LGBTI patients.

### *Policies and Procedures*

Respondents with policies and procedures	3
Respondents without policies and procedures	28

Twenty eight respondents stated that they had no policies or standards in place or available to them dealing with equality and diversity in relation to LGBTI people. Many stated that these were not necessary as all patients were treated equally or treated the same. Some stated that they follow standard guidelines for client care. One respondent said the lack of such a policy was due to lack of knowledge.

Three respondents stated that they had such a policy in place or available to them. One said that guidelines were communicated to staff by poster displayed in the tea-room. Another applied general HSE guidelines that are communicated through general HSE communication pathways. Another suggested that the Code of Conduct of the society of Physiotherapists provided adequately for equality and diversity and that they followed this code.

An issue of debate in three of the primary care team meetings was whether a policy for a centre should concern itself solely with LGBTI issues or whether a multi-ground equality and diversity policy would be better.

### *Professional Development*

Respondents attended training	3
Respondents did not attend training	28

Three respondents had attended some form of training related to LGBTI issues. One respondent attended a talk given by their professional association on LGBTI issues out of personal interest. Another respondent attended corporate induction training that included a focus on equality and diversity when recruited in the UK. Another respondent covered social diversity in their PHN HDip.

Few of the twenty eight respondents that had not done such training identified barriers. Two respondents identified time and resources as being an issue. Two respondents suggested that such training was not required and there were more important training topics. One respondent said they did not see the need for it as there was no need to treat LGBT patients differently to others.

Trans issues and intersex issues emerged in two of the primary care team meetings as areas that could be a focus for further professional development. The lack of back-up in this area was noted.

### *Programme Development*

Respondents reporting attendance as often	2
Respondents reporting attendance as regular	4
Respondents reporting attendance as rare	15
Respondents do not know or no answer	10

Most respondents stated that attendance by LGBTI patients was rare. Two respondents suggested that LGBTI clients often attend. Four respondents identified that they regularly attend their practice and. Fifteen respondents stated that LGBTI clients rarely attend though three of these noted that they had no way of knowing for sure. Eight respondents stated that they did not know how often LGBT clients attend their service given that they did not ask their clients and that their clients did not identify themselves. Two respondents left these questions blank.

Those reporting attendance for same reasons as general population with no specific issues presenting	8
Those reporting attendance for wound care	4
Those reporting attendance for mental health	2
Those providing no answer	17

Respondents from the primary care centres were drawn from specific professional fields and this influences their answer to this question. Seventeen respondents gave no

answer to this question. Eight respondents reported that the issues presented by LGBTI clients were the same as by the general population with no specific issues arising. Six respondents reported specific issues presented by LGBTI people: wound care and post-hospital discharge issues and mental health issues.

Family issues were also identified as specific at one of the primary care team meetings. Poor services and the lack of treatment pathways for Trans people were identified in another of the primary care team meetings with particular concern at dealing with poor surgical interventions done in other jurisdictions. Sexual health was identified as another such issue in one of the primary care team meetings.

No respondents reported any outreach activity to LGBTI people.

Two respondents reported difficulties: one in terms of their lack of understanding and knowledge of LGBTI issues serving as a potential barrier and the other in terms of not knowing clients are LGBTI and guessing whether or not they are.

### *Supports*

Respondents interested in training	23
Respondents open to disseminating LGBTI friendly literature	7
Respondents interested in guidelines	2
Respondents open to using LGBTI friendly leaflets and posters for display	4

Twenty three respondents suggested they would be interested in attending **training** on LGBTI issues. One of these respondents highlighted the need for ‘more awareness of the whole subject’. Another of these respondents pointed to the need for ‘increased education’ in the area. Seven respondents said they would not be interested. Two of these respondents suggested that such training was not required.

Seven respondents noted a value in dissemination **LGBTI friendly literature**. There was a focus on access to literature on LGBTI issues. One respondent asked for such literature to be provided. Two respondents asked that knowledge about such literature should be made available. Another respondent suggested the provision of relevant information by email.

Two respondents noted the need for **guidelines** or policies and another respondent sought advice on the guidelines that were available. A number of respondents pointed to the need for training on such guidelines and policies.

There was interest from four respondents in having **LGBTI friendly materials** available. Three respondents identified a value in posters for the waiting areas including posters with information for LGBTI clients. Another respondent suggested handouts being made available.

*Conclusion*

The picture that emerges from the survey work and meetings with primary care teams mirrors that reported by the general practitioners. There is a predominant perspective based on treating patients the same with little evidence of taking the practical implications of difference into account.

There was significant interest expressed in the provision of supports for work with LGBTI clients or patients both in the meetings with the primary care teams and in the survey. There was a particularly high level of interest in attending training on LGBTI issues. A similar level of interest was evident in relation to using posters and information leaflets in waiting areas to create a welcoming environment with some interest in developing an equality policy, whether in relation to LGBTI people or in relation to members of all groups experiencing inequality or discrimination in society.

**3.3 Hospital Staff**

*Introduction*

The survey for hospital staff followed the same pattern as for General Practitioners and primary care teams. It focused on the four practice elements identified as holding the potential to break the invisibility surrounding LGBTI issues. This is based on organizations:

- Giving ‘public profile’ to their commitment to LGBTI issues.
- Implementing ‘policies and procedures’ for inclusion of LGBTI people.
- Ensuring ‘professional development’ for their staff on LGBTI issues.
- Ensuring ‘programme development’ to address LGBTI issues.

The survey also sought responses on the supports that respondents thought might be useful in achieving an LGBTI friendly service.

Forty six responses were received to the online survey questionnaire for hospital staff. Staff from hospitals in Waterford (31 responses), Wexford (8 responses), Kilkenny (5 responses) and other locations (2 responses) responded to the survey. Staff from across most sectors within hospitals responded. This included staff involved in management, administration, quality and safety, finance, engineering, nursing, midwifery, oncology, physiotherapy, radiology, psychology, STI clinic, urology, anaesthesia, speech and language therapy, ambulance, palliative and medical consultant.

*Public Profile*

Respondents taking steps on public profile	8
Respondents not taking steps on public profile	28
Question left blank	10

Most respondents suggested that there were no specific steps taken to communicate that their service was open to the different sexual and gender identities of those using the services. Twenty eight respondents stated that there were no such steps taken and ten further respondents left this question blank.

The eight respondents that reported taking steps to profile that their services were open to people of different sexual identities and gender identities were from five areas: psychology, speech and language therapy, nursing, quality and safety, and the STI clinic. Two principal approaches are evident in this.

The first approach suggested that the referral system could communicate an LGBTI friendly profile. This was reported in relation to psychology and speech and language therapy and in relation to psychology services but was not explained in any detail. The referral system was reported as being 'completely open' and those making referrals understand this. 'Communication with consultants' is noted in relation to referring trans people for voice therapy. The referral system can ensure the service is available to people of different sexual and gender identities on an equal basis.

The second approach, reported by personnel from the STI clinic, involved a focus on the provision of contact numbers and information on various HSE websites, displaying posters and fliers in the clinic on safer sex for people of all sexual identities, and having Gay Community News magazine readily available in the clinic. This is closer to a model focused on ensuring the service is available to and experienced as friendly by people of different sexual identities.

One respondent also highlighted that their hospital had an inclusive mission statement. Another respondent noted that they planned bring this issue up with their patient partnership committee to assess its importance.

The main argument made to explain the lack of specific steps in other areas related to the fact that the service was fully open to all, treated everyone according to their needs, and treated everyone with equality, sensitivity, respect and dignity. Some suggested that it has never been an issue, one responded that they had just not 'thought of it', and another stated that 'no information was available in the hospital'. One respondent from the area of administration stated that this was irrelevant.

### *Policies and Procedures*

Respondents with policies and procedures	3
Respondents without policies and procedures	25
Question left blank	18

Three respondents reported the existence of standards for equality and diversity that they could call on in their area of the hospital. Two of these respondents were located in administration, the third in nursing and midwifery. One respondent usefully mentioned the equality legislation in this regard. This legislation does set a general minimum standard of non-discrimination and non-harassment that governs both employment and the provision of services in hospitals. Another respondent made a general reference to

national guidelines. The third respondent referred to National Quality Standards and that these were a focus for discussion in meetings, newsletters and a patient partnership forum.

Twenty five respondents reported no such policies or standards in place. Eighteen respondents left this question blank.

The main rationale for the absence of such policies or standards was that everyone receives the same standard of care and all are treated the same. One respondent stated that all patients are treated with equality and dignity. Another was more tentative in 'hoping that all are treated to the best standards'.

There is a focus on 'treatment' in the responses to this question that might emphasise a medical dimension to the responses. The 'needs' of all are treated but it is not clear that the relationships that shape this treatment are being considered. This issue is captured in the section on professional development where one respondent got training on LGBTI issues, as they 'wanted to be sure their actions and words are LGBT friendly'.

### *Professional Development*

Respondents attended training	6
Respondents did not attend training	24
Question left blank	16

Six respondents reported being trained on LGBTI issues. Two of these were from the STI clinic. They wanted to 'further my knowledge to help LGBT people attending the clinic' and to 'be sure my actions and words were LGBT friendly'. One was involved in employee assistance and attended to 'understand LGBT issues better'. Another respondent had participated on a course that included a presentation on Trans issues from TENI. One respondent stated that they had done such training as part of their specialised training as a medical consultant. Another respondent was in management and had sent two staff on training on LGBTI issues and noted that the patient liaison officer had done such training.

Twenty four respondents said that they had done no training on LGBTI issues. Sixteen respondents left this question blank. Most respondents who had not done training stated that it was not necessary or not relevant. Some reported a lack of awareness of the availability of such training as a barrier. One respondent had applied to do such training but had desisted when queried as to its relevance to their work.



### *Programme Development*

Respondents reporting attendance as often	2
Respondents reporting attendance as regular	10
Respondents reporting attendance as rare	2
Respondents do not know or no answer	15
Question left blank	17

Two respondents said that LGBTI patients attended often, ten respondents were able to identify that LGBTI patients attended their services regularly, and two further respondents stated that LGBTI patients rarely attended their service. Fifteen respondents stated that they did not know how often LGBTI patients access their services. Many noted that they do not ask patients about their sexual identity. Seventeen respondents left this question blank.

Respondents from the STI clinic stood out in that they ask about sexual identity as part of taking the sexual history of a patient. However, two other respondents pointed out that clients disclose their sexual identity formally or informally. Another respondent noted that they know about sexual identify 'through conversations'. This respondent pointed to the nurse to patient relationship developed over time and, in the particular circumstances, the need to ensure care extends to the 'significant partner' of a patient. One respondent states that they 'would always assume patients could be LGBTI and would be considerate of that possibility'.

No respondents reported any outreach activity to LGBTI people. However, one respondent noted that they were revising membership of their patient partnership forum. This could be an opportunity to include LGBTI people.

### *Supports*

Respondents interested in training	13
Respondents open to disseminating/using LGBTI friendly leaflets and posters	5
Respondents interested in information on guidelines	2
Respondents raising other ideas than referred to	5
Respondents who stated	8

no supports required	
Question left blank	20

There is limited interest in supports for good practice among the respondents. Eight respondents stated that no specific supports were needed. Twenty respondents left these questions blank.

Those that stated no specific supports were needed suggested that staff only needed to be 'educated properly', that LGBTI people should not be separated out or 'isolated', that they felt 'equipped' already, that training was already done, or that it was 'not an issue'. One queried why this 'community want to be treated differently' and suggested this did not need to be made an issue of.

Thirteen respondents stated that they would be interested in training on LGBTI issues. One of these noted the need for this training to 'local and relevant'. One other respondent stated that 'all healthcare workers should have a good understanding and awareness of LGBTI issues'. Another respondent pointed to the need for 'more knowledge on how LGBTI people want to be treated'.

Five respondents were interested in using leaflets and posters in their location. One respondent suggested using the reception area for these. One respondent suggested placing leaflets in all areas of the hospital.

Two respondents pointed to the need for 'more information' about guidelines or standards.

Five respondents came up with further ideas for supports that could be developed. These included:

- The need for a multi-disciplinary team approach in responding to trans people.
- The presence of openly LGBTI staff.
- Regular notices on LGBTI issues on HSE websites.
- Involvement of LGBTI people in patient partnership forum.
- Engagement by LGBTI people with patient liaison officer.
- Deploying the arts officer to engage with LGBTI issues.

### *Conclusion*

There are instances of **good practice and understanding** evident in the responses to the survey including:

- Reference to equality legislation as an existing standard.
- Staff members assuming patients could be LGBTI people
- Staff members identifying sexual identity in conversations with clients.
- Staff members affording care to same sex partners.
- Making posters and magazines that reflect a diversity of sexual identities and gender identities available in hospital areas.

- Staff members taking training to understand LGBTI issues and to ensure their actions and words are LGBTI friendly.
- The potential to include LGBTI people in a patient partnership forum.
- Openness on the part of management to send staff on training on LGBTI issues and to develop initiatives to make services more explicitly LGBTI friendly.

*The dominant trend in the responses, however, is that people are treated the same regardless of their gender identity or sexual identity.* In this there could be an emphasis on medical treatment without focusing on the relationships involved in the provision of the service. There is little evidence of any practice developed to enable a visibility of diverse sexual identities or gender identities or take specific account of these differences. Significant store, however, does seem to be set on values of respect and dignity.

There appears to be limited interest in developing supports to better understand, make visible and make adjustments for diversity in gender identity or sexual identity. There is some interest in getting training to enable an understanding of this diversity and of how to relate in a context of diversity.

## 4.0 LGBT Perspectives

### 4.1 Lesbian, Gay and Bisexual People's Perspectives

#### *Introduction*

Forty three lesbian, gay and bisexual people and one bi-gender person were interviewed in different settings around the region. This included twenty two lesbian women, twenty gay men, and one bi-gender person. Seventeen people were interviewed individually, eight people in four couples, and eighteen people in four group settings. Three of the individual interviews were by telephone.

Total number interviewed	43
Lesbian women interviewed	22
Gay men interviewed	20
Bi-gender people interviewed	1
People interviewed individually	17
People interviewed in couples	8
People interviewed in groups	18

The interviews covered the following four topics:

- Needs: What parts of the health services have you used? What parts of the health services are most used by LGB people generally?
- Experiences: What have been your experiences of health service provision – in particular hospital provision and general practice provision?
- Good Practice: In what parts of the health sector have you come across good practice in responding to LGB people and their health needs? What did this practice involve? What made it effective?
- Recommendations: What changes would you like to see in the policies, programmes, and/or practices of the health services in the South-East region to make them more LGB friendly?

#### *The Experience*

The experience of the health service recounted by lesbian, gay and bisexual interviewees had a **strong and significant strand of positivity**.

A constant positive refrain included a focus on different health professions and issues:

- *'My G.P. is very good, very helpful. He knows me';*
- *'My G.P. is very good. Initially it was difficult but following my psychological issues he reacted well';*
- *'There is no problem raising issues with my own G.P., not judgemental, I have a close relationship, a sense of confidence';*

- *'Counseling was good, it helped, they accepted me for who I was, they knew about diverse sexual identities';*
- *'Had a Consultant who treated my partner as my spouse and included her in all decisions';*
- *'I had a lovely experience of childbirth';*
- *'I fostered a child, it was never an issue, just normal';*
- *'There was no problem being named as next of kin, very inclusive';*
- *'I have no bad experiences';*
- *'I'm Bi and there is not much hassle';*
- *'There was no awkwardness when I said I was gay';*
- *'I have no horror stories'.*

It is of note that these positive statements focus on the nature of the relationship and interaction involved rather than just on the medical treatment given. This offers evidence of the importance of the relationships and interaction with health professionals for LGB patients.

There was a dominant sense of societal change driving new attitudes and new experiences. A lesbian woman noted that 'LGB awareness has momentum. Trans awareness has a long way to go.' The introduction of civil partnership and the promise of marriage equality have done much to normalise difference. Another lesbian woman pointed out that 'Ireland has moved on, Civil Partnership has set a strong grounding for people to be exposed to same sex partnerships. It has been normalised'. A gay man noted that 'if you had asked me ten years ago it would have been a different story'.

Many interviewees had limited contact with the health services. 'I am rarely there so it is not an issue'. 'I haven't been much'. 'I haven't had a problem ever'. 'I have never been in a position to rely on HSE, only in hospital with an ankle injury'. Many were confident in asserting their sexual identity if necessary. 'There is an assumption of heterosexuality but once I correct them it is not an issue'. 'We are quite up front and people just accept'. 'Because we are open we don't create an issue around our sexual identity'. 'I am quite a pushy person, not vulnerable, I could take control of things'. These could have been factors underpinning the positive strand of responses.

There was a common **experience of awkwardness** noted in the response of health professionals, once sexual identity and sexual orientation issues were raised. A lesbian woman noted this 'was not deliberately bad but once you say you have a partner awkwardness sets in and they don't know how to deal with it'. A gay man said 'my G.P. ignores the topic, doesn't talk about sexual topics, there is an awkwardness, he will push me elsewhere'. Another lesbian woman said 'they struggle with the word partner. "Do you want your friend with you". But it is low level'. A lesbian woman felt 'they are not adequately educated, they have a fear they will insult you'.

A bisexual woman pointed to the importance of this issue in that 'subtle things make a difference. Trust is shot. Silly questions matter even if they do mean well'. A lesbian woman noted that 'If you identify as gay, the last thing you want to see is "God how am I going to deal with this" on the face of your G.P. All you want to do is normalise it'. Another lesbian woman suggested that 'uncomfortable is a polite form of homophobia'.

A lesbian woman noted that 'I can understand people believing they are treating people the same but when it comes down to it, maybe they objectively don't. There is an internal homophobia'.

A lesbian woman who had tried to organise introductory LGBT workshops for health personnel noted that they 'could not fill the places. There was no interest. They don't see it as a priority'.

The experience of being **assumed heterosexual** is common and an issue. A bisexual woman said 'I go for a regular cervical smear and they assume I am an active heterosexual'. This can be linked to difficulties in coming out to the health professional. A bi-gender person noted 'My G.P. doesn't know. I don't know if he would get it. It is the fear of the unknown reaction. If I saw a 'rainbow' I would feel much better'. A lesbian woman was 'asked if she was sexually active. I said it did not apply to me but they didn't pick it up. They asked did I have a boyfriend'.

This issue also came up in relation to visibility for LGBT people on health sector forms. A gay man said 'they don't keep records. You go through the whole process every time. They should have my sexuality on record now'. A lesbian woman said 'forms should have a tick box for LGBT'. Another lesbian woman noted 'there is no way to identify yourself on forms. Even to have it there would be important'. A lesbian woman said 'the most annoying thing is having to explain yourself, civil partnership is not on the forms, we don't fit into your boxes. It is not yet in the mindset of administration staff'. A gay man pointed out 'G.P. forms ask if you are married, nothing about civil partnership'. 'The forms don't catch people's reality' according to another lesbian woman.

**Incidents of discrimination, harassment or poor treatment** were reported:

- A lesbian woman recounted the story of a gay man who had been beaten up and taken to Accident and Emergency. His gay partner was there and hugged him. He was told to leave as only family could come in.
- A gay man told of a complaint he took to the Equality Authority. He presented an issue to his G.P. who went on to express 'negative assumptions about sleeping around, once I said I was gay'. All he got from the practice 'was a note to say they didn't want him as a patient any more'.
- Another gay man told of a nurse in a public ward who refused to treat him. 'She let her religion take precedence'. He didn't take it any further.
- A lesbian woman 'felt a bit of homophobic reaction from nurses' when she was in hospital giving birth. It was clear to her that they were 'not over enamoured, they were judgmental. There were lots of positives but there were moments like that. When we went home my G.P. also assigned me another PHN as he felt she would be better for us than the one who covered our area'.

Only a few such incidents were reported. What is striking about the incidents is that people usually did not feel able to challenge them. What is of further interest is that when a challenge was made there did not appear to be any capacity to resolve the incident.

A gay man raised the issue that gay men cannot give blood. Another gay man suggested 'the staff were apologetic in the blood bank'.

Few interviewees were able to identify any particular **LGB friendly practice** in the health service in relation to LGB issues. A small number of such practices were identified.

- A lesbian woman noted 'a discrete rainbow in the doorway of a counseling agency. It was a boost. I liked it'.
- Another lesbian woman noted that the local 'G.P. clinic has LGBT posters up'.
- A gay man told of 'when I was coming out I saw a poster in a doctor's office. It was a BeLonG To poster in the waiting room. I was fearful at the time and I still remember seeing it eight years on. It gave me confidence'.
- Another gay man noted 'a rainbow flag on the door of the counseling service. It was fantastic, the power of an image'.
- A lesbian woman highlighted how she 'was asked if the woman with me was my partner. She wasn't but it demonstrated an awareness, an acceptance'.
- A gay man highlighted that 'TENI has a good presence'.
- A lesbian woman described her work in the local youth service. 'My boss was supportive. I gave workshops for all staff on LGBT issues. We did a policy up. We made sure LGBT posters and leaflets were visibly displayed. Initiatives taken named and included young LGBT people'.

**Issues arise when difference becomes relevant.** As one lesbian woman noted 'I don't want to be treated differently because of my sexuality. However, there are points where it can be an issue'. These points, according to the interviews, include the fields of mental health, sexual health, family, connecting, and particular groups of LGB people:

### *Mental Health*

**Access** to mental health services was raised by a number of interviewees, including the long waiting lists shared by all groups. A lesbian woman highlighted that 'there was very little support for young LGB people under stress with coming out. Psychological problems can arise and there is no specific service for them or there is no service that has some awareness of the issues'.

Another lesbian woman spoke of her work with the LGB community and 'trying to find services for people with issues. I approached counselors but there was a distinct lack of understanding. They didn't know about minority stress. I found only two that were aware'.

The lack of mental health professionals with an **understanding of LGB issues** was a frequent concern in the interviews. A gay man told of 'when coming out I had a lot of issues going on. It was difficult. The psychiatric service was a negative experience. Communication was an issue with the professional. There was a lack of understanding. It was a lonely experience'. Another gay man noted 'lack of knowledge is a huge thing. They want to do the right thing but get stuck on stereotypes. They depend on the client to educate them'.

A bi-gender person highlighted 'I am Bi-gender. There is nothing to support us mentally. My therapist and my psychiatrist don't have a clue'. A gay man was attending mental health services for depression and was asked 'did I have a girlfriend or partner to monitor me. He brushed off my answer. It was not

positive'. A lesbian woman suggested 'they don't really like the difficult issues. They don't like the at-risk groups. They just apply their medical model'.

The lack of **outreach** to LGB people was also raised. A gay man noted 'no sense of proactive engagement with LGBT people'. A lesbian woman suggested 'they are not comfortable outside their zone'. Another gay man mentioned the need to 'tailor mental health messages into the LGBT community'.

### *Sexual Health*

Access, catering for difference, outreach and privacy were raised in the interviews as issues in relation to sexual health. Many interviewees raised these issues with a sense of urgency given their sense that sexual health practices are not as positive as they had been. 'There is a reversal in sexual health. Unprotected sex is on the rise' in the words of one lesbian woman. A gay man noted that 'some people are involved in high risk activity'. Another gay man said he was 'absolutely shocked at the levels of unprotected sex. Contacts made online are one source'. A lesbian woman highlighted that 'young people are involved in risky behaviour'. Another gay man said people 'don't have the same fear of HIV. STDs are a growing problem. Outreach is needed. The message needs to be targeted to LGB people'.

**Access** was raised mainly in terms of the absence of local facilities. Two interviewees noted problems due to there being 'no sexual health clinic in Kilkenny'. A gay man noted 'there is no clinic in Wexford, you have to go to Waterford or Dublin'. Another gay man said 'screening in Wexford is possible, just not known'. A gay man suggested that people are 'slow to get checked by their G.P. in case it goes down on their health insurance'. Another gay man said that 'there is nowhere to go if you want screening locally'. A gay man suggested 'there should be a clinic in every town'. It was also raised in terms of information about services. 'I need to know where to go' according to one bisexual woman.

**Difference** was raised in terms of the capacity of health professionals to cater for needs that arise from the sexual practices of LGB patients. 'They don't give you tips about protection. They are awkward and don't tell me what to do with girls' according to one bisexual woman. She noted that 'they don't have protection for lesbian sex'. A lesbian woman pointed out that 'latex squares for gay women to use are not available now'. A gay man noted the lack of 'supply of the special condoms'.

A gay man noted the issues of 'doctors not knowing about gay sex. There is a knowledge gap. They don't have a capacity to advise us'. A lesbian woman said 'there was a lack of recognition, a lack of awareness, they gave me information on having sex with a man'.

A gay man noted a strength in one clinic in that there is 'more of a counseling input around it. There is connection, understanding and support'.

No **outreach** activities in the field of sexual health were identified in the interviews. A lesbian woman pointed to the difficulties that arise in this regard given 'there is nowhere for people to congregate, there is a lack of groups and a lack of venues'.



A bisexual woman said 'there is no mention of LGBT people in sexual health in schools'. A lesbian woman spoke of giving workshops for some transition year children and 'when asked if RSE dealt with LGBT issues, none had ever spoken about it'. A gay man highlighted that 'the youth services are key. But there are people who don't come to these spaces'.

The lack of public education was noted by a gay man who pointed out that 'there are no billboards on the issue as there is in England'.

**Privacy** was at issue on a number of occasions. A gay man told of 'going to the clinic and finding that it was not confidential. There was no privacy. The nurse apologised after'. The search for privacy can influence choices in relation to screening, both in terms of whether to go and where to go.

### *Family*

The theme of family emerged in a variety of ways in the interviews. This included recognition of next of kin, reproductive rights, and responding to same-sex parents.

The need to ensure recognition of **next of kin** in medical settings was raised in a number of interviews. A lesbian woman noted her experience in Accident and Emergency with her children where her 'partner is not seen as next of kin'. A gay man spoke of his 'concern about my partner visiting me if I was very sick'. In hospital a gay man said his partner 'was my "friend", not seen as my partner'. A lesbian woman said her 'partner was asked to leave when I was being examined. I couldn't challenge it'. A gay man noted 'I always felt I had to explain. Why is that? Are you a brother? It's annoying at a stressful moment. I was not sure at any stage I would be consulted'.

A Lesbian woman noted 'there needs to be more progress on **reproductive rights**. G.P.s should have the necessary information'. Another Lesbian woman said 'reproductive rights information is not easy to find'. A lesbian woman said 'I would like to have children but I don't know where to go'.

Another Lesbian woman recounted positive experiences of the health services in having her child. However, this brought back memories of the difficulties she had had in organising to conceive the child. 'Access to information was an issue. Where do you find out where it is best to go and what it is best to do. Many fertility clinics were not treating same sex couples. We phoned around and got a number of rude and unhelpful responses'.

A Lesbian spoke of her positive experience of foreign **adoption** due to an 'extremely open social worker'. Difficulties in the training for **fostering** with 'allusions to the traditional family and assumptions of heterosexuality' were mentioned by a lesbian woman.

The issue of her children and how her family was treated in an Accident and Emergency setting was raised by a lesbian woman. 'There was a lack of understanding that my **partner is their mother**. They are afraid to treat the non-biological parent as a parent'.

## *Connecting*

The absence of places for **LGB people to meet** and make connections was raised in many interviews. There was a sense that LGB groups had disappeared in recent years, whether because of funding issues or because of divisions within the community. A gay man talked of ‘the LGBT infrastructure is collapsing. A new one hasn’t happened’. Another gay man said ‘HSE support for organisations is really only bits and pieces’. A gay man noted that he ‘would find an LGBT group important but people just stopped coming, people moved on’. This was seen as limiting community solidarity and opportunities for health outreach to the community.

A gay man said ‘I tried to set up a group, barely anyone would come, it was hard to advertise in a small town’. A lesbian woman pointed out that ‘there is very little in Kilkenny for people coming out’. Another lesbian woman noted ‘we struggled to meet gay people’. A lesbian woman noted that ‘socially there is nothing for LGBT people in Tipperary. We have no lesbian place. There are good networks in Dublin but not here. There is no one to share experiences with’. A gay man said that ‘an LGBT space is important to get messages out about mental health, sexual health’.

A lesbian woman who works in the field of mental health noted ‘there is a huge need. There is not one client who hasn’t asked for a group. They end up going to support groups in Dublin’. This infrastructure was seen as important for ‘LGB resilience’.

## *Particular Groups*

There is diversity within the LGB community. This diversity includes different age groups, groups differentiated by their status, and different ethnic groups. These different groups can have particular needs that the HSE is challenged to respond to. They can experience a double discrimination on the ground of sexual orientation and on other grounds such as age, socio-economic status or ethnicity.

The position of **older LGB people** was raised in a number of interviews. A gay man suggested ‘HSE support is mainly to youth organisations with an LGBT element. There is nothing for the older category’. Another gay man noted ‘there is nothing for the older group. They might be coming out late or experiencing isolation and need services’.

Particular concern was expressed in relation to older LGB people in care. A lesbian woman expressed her concern about ‘older people who are not out and are now in a nursing home burdened with the assumption that they are straight’. A gay man noted that ‘identity gets lost in care and care homes. Older LGB people tend not to be cared for in the family’.

The importance and quality of the services in the community and voluntary sector for **young LGB people** was frequently acknowledged. The availability of these services across all counties was queried.

Evidence of ageism in relation to young people in mainstream medical settings was presented. A bi-gender person noted ‘there is an age thing going on...“It’s a phase you’re going through”’. A gay man said ‘there is an awkwardness, young people are not taken seriously when the topic of sexual health comes up. The

stereotypical response of “Are you sure?” comes up’. ‘There is a stigma attached to sexual health, they are judgmental around age’ in sexual health services according to another gay man. A Gay man highlighted the ‘crisis gap for the 12-16 year olds. People are coming out younger and younger’.

A lesbian couple with experience of **homelessness** had a particularly positive experience of voluntary service providers. They found these to be ‘really supportive. We were accepted as a couple. They were never uncomfortable’. They found that their ‘G.P.s were sound’, the ‘probation officer was fully supportive’, there were ‘no difficulties in the transitional refuge’, and the ‘drug treatment counselor was delighted for the two of us’. The only negative note related to one of their social workers and access to her children for the one of the women. The social worker ‘thinks it is a phase’ and ‘was shocked when my partner moved in’ and the ‘foster parents aren’t comfortable’.

Other particular LGB groups named in the interviews as having specific needs were people with disabilities, Travellers, refugees and asylum seekers.

### *The Suggestions*

The nature of the **strategy** for taking on these issues was explored in some of the interviews. These discussions addressed issues of positive action, taking difference into account, and treating everyone the same. A gay man captured a dominant theme in stating he ‘was not in favour of positive discrimination. It is not about different rights or anything extra. Sexual orientation is not a special need, not a handicap. However, you do have to respect difference and give consideration to the fact that not everybody is the same. There is minority stress and recognition of that is important medically’. A lesbian woman noted ‘difference does matter. Our experiences aren’t the same’.

These discussions also addressed issues of using targeted services or general services to provide for LGB people. Many interviewees emphasised the need for targeted services for LGB people. A lesbian woman noted that in a context of ‘internalised homophobia, LGB people won’t thrive in the mainstream’. Others challenged the segregation or labeling inherent in targeted services and sought to ensure access to mainstream services. ‘It is better in the mainstream setting, everything can be interlinked. We need to be referred into the mainstream’ according to a gay man. Others noted the value in a named and specific LGB element located in a mainstream service.

A final part to these discussions related to whether to take on an LGB strategy for equality or to include LGB people within a wider strategy for equality for all groups. A lesbian woman posed a challenge in stating ‘it would be a good thing to have something to tell me a service is LGBT friendly. However, you can’t single out every group and a general equality symbol would be useful, saying we take difference into account’.

The need to recognise diversity among LGB people was also raised. This was in terms of age, ethnicity and gender as well as of geographical location. A lesbian woman noted the need ‘to know the subcultures. Lesbian women can’t be treated as gay men’. A gay man noted the need for ‘the rural dimension to come out in any response to the research’.

**Training** for health professionals and front line administrative staff was repeatedly identified as necessary. Steps need to be taken to ensure that people take up training opportunities even to the point of making it mandatory. Continuing Medical Education and Continuing Professional Development points were suggested in a number of interviews.

Communication skills were seen as particularly important. A lesbian woman suggested 'professionals need to be taught to ask questions. Communication skills are needed. They need to be comfortable with differences of sexual identity'. Another lesbian woman suggested 'customer service training' should be provided. Health professionals need to be helped to feel less uncomfortable. It was felt that practice meetings should be used to talk issues through and explore how to respond to issues arising.

**Visibility** was another theme in relation to necessary change. A lesbian woman suggested 'Something is needed in each doctor's surgery stating that they don't discriminate and that names LGBT people'. 'A little poster, positive signs, would be useful' according to another lesbian woman. A gay man said that G.P.s need to offer a 'safe space' with 'composure and good communication' and 'with more information in their offices'. A campaign for G.P.s could be developed to ensure LGB people 'see something up on notice boards about sexual health and LGB people'. A 'Practice for Everybody' label could be developed.

Record keeping on a patient's sexual identity once disclosed was encouraged. Many interviewees felt that health forms should include an option to identify your sexual identity. Others felt it was important to capture the status of civil partnership.

The need for a **change of culture** in organisations was suggested. Cultural shift was seen as involving change in how you receive people, talk to people and communicate with people. The need for change in health service systems to complement change that is already happening for individual health professionals was highlighted.

Access to **information** specifically required by LGB people was raised. LGB people were seen as needing specific information in relation to sexual health and safe sex practices. Access to specific information on where to get necessary services for same sex couple who want to have children was also seen as necessary. The HSE booklet 'Look After Yourself, Look after your Mental Health' was referenced by two gay men.

LGBT liaison officers were recommended. They could signpost LGBT friendly services. They could make LGBT people aware of the services available.

A **standard policy** on equality and a complaints procedure were recommended for health organisations so that LGBT patients could raise issues. It was emphasised that steps needed to be taken to support such a policy being put into practice. Keeping the policy live was a concern. Regular email updates on the policy were suggested.

**Outreach** activities are needed in relation to sexual health within the LGB community. This was emphasised in a context of what is perceived to be a deteriorating sexual health context. There needs to be more visibility for safe sex issues.

The need to ensure LGBT issues are included in school classes on sexual health was stressed. Pop-up screening centres were suggested. The example of GOSHH in Limerick was instanced with a recommendation that it should be expanded into the South East Region. GOSHH stands for Gender, Orientation, Sexual Health, and HIV. It is based in Limerick and provides training, education, personal support, counseling and outreach to people in relation to these issues. This could serve 'as a flagship to attract LGBT people in the absence of outreach activities' according to two gay men.

It was felt that mental health services also have to be targeted at LGBT people. It was felt that they are not getting the help that they need.

Social media could be more frequently and effectively used as a channel of communication. Specific channels of communication to rural populations should be explored.

The need to create **social spaces** for LGB people was identified. Funding is needed to establish drop in centres. A lesbian woman suggested the need 'for something more fluid, not groups, to network people'.

Specific **supports for parents** of LGB children were also recommended.

## 4.2 Trans People's Perspectives

### *Introduction*

Ten trans people were interviewed in one group setting. Four parents of trans children were interviewed in another group setting. Both these meetings were enabled by TENI. The interviews covered the following four topics:

- Needs: What parts of the health services have you used? What parts of the health services are most used by trans people generally?
- Experiences: What have been your experiences of health service provision – in particular hospital provision and general practice provision?
- Good Practice: In what parts of the health sector have you come across good practice in responding to trans people and their health needs? What did this practice involve? What made it effective?
- Recommendations: What changes would you like to see in the policies, programmes, and/or practices of the health services in the South-East region to make them more trans friendly?

### *The Experience*

The experience of the health service recounted by trans interviewees and by parents of trans children was **predominantly negative**.

A trans person asked 'Are they not bothering because I am trans?' Another trans person suggested that their 'experience was a shambles', that they had been 'left hanging' and that it was only 'after a suicide attempt that they started to take notice'. Another trans person concluded that 'you end up case-managing yourself'.

There was a shared acknowledgement that, as stated by one trans person, the 'HSE has good counselors and psychologists with a long history of dealing with Trans people based in Dublin'. A trans person recounted that they 'had a good counsellor' and were 'very lucky'. This trans person paid for their transition but was 'grateful to the HSE for help received'. A parent had a 'really good G.P., understanding and unflappable, told me to tell him to come in and see him, used the right word straight away'. The same parent said they waited nine months for referral to Loughlinstown but the 'team there were excellent'.

The negative experiences recounted seem, firstly, to reflect a **lack of knowledge and skills** in relation to the treatment of trans people. A trans person highlighted that their G.P. 'couldn't handle it' and was referred to and went, with reluctance, to two psychologists, 'one of whom tried Cognitive Behavioural Therapy before referring me for a second opinion to a psychologist who declared "I'll have you cured by the end of the year"'. This trans person felt that the psychiatrists 'hadn't a clue what they were doing but still went ahead and dealt with me'.

Another trans person described a difficult experience with their G.P. who said 'I haven't a clue' and who 'couldn't even refer me' to someone who did. Another trans person noted that 'my own doctor doesn't do training, my experience wasn't great'. A parent approached their G.P. about their trans child but 'the look on his face told me he had not dealt with it. He wouldn't admit it though. I had to tell him what to do'. Another parent spoke of the G.P. they went to as being 'very unhelpful, had no idea'.

The issue of **inconsistency** came up from a number of people. A trans person stated that 'you can't rely on the knowledge and understanding being there, even within the same practice'. Another trans person referred to their experience as being 'hit or miss'. A trans person suggested 'you have to keep asking and asking before getting to where you need to be'. A parent pointed up this issue in stating that 'no one has given us any direction'. There was also a sense that the different parts of the health service were not communicating with each other. One trans person highlighted that 'people are not talking, you get lost in translation'.

A second element in the negative experiences recounted reflects the **specific relationships involved**. This was put forcefully by a trans person who 'felt dehumanised', found the 'questions invasive', and was frustrated at having 'had no control over my treatment'. Another trans person noted how the health professionals 'won't give you information and are not giving me options'.

A third element in these negative experiences appeared to be the **pressures on the services** for trans people in Loughlinstown. A trans person detailed how hard it was to contact the team there to make an appointment and concluded the experience was 'bad for my mental health' and that 'bad service over seven years was stressful'. Another trans person spoke of making phone calls to Loughlinstown and waiting 'twenty to thirty minutes to get an answer'.

A trans person who had returned after the transition operation, spoke of waiting lists that meant it 'took three years to get aftercare'. Another trans person raised the cost of travelling to Loughlinstown and delays there that nearly led to trains being missed and extra expense incurred. A parent pointed out that 'Loughlinstown is great but it is a full day off work to get there'.

A number of parents expressed concerns about the **mental health** services for children and young people. One parent said they 'had to push to get seen quickly'. They saw a 'social worker who didn't know enough about trans issues. The psychiatrist was nice and understanding but was lost at what to do. There are no pathways'. One parent pointed out 'you need trans specific help'.

Another parent felt the mental health service was 'not helpful. My daughter was not listened to. She said she was not being listened to. They had no idea about transgender

so they sent her to Tavistock<sup>49</sup>. It took two years there for a diagnosis. It was only six years later we were linked into Loughlinstown'. One parent said the psychiatrist 'tried to dissuade' her child. It was the 'it's a phase' thing. She admitted in the end that she was always a girl'. The issue of age as an additional factor was highlighted in a number of instances. The 'child is not respected despite being very articulate. They don't listen' according to one parent.

A particular benefit of Tavistock, referenced by a parent, was access to hormone blockers at fourteen years of age. This parent noted 'this stopped her from taking her own life'.

There were no instances of **Trans friendly practice** given by the interviewees that could serve as an exemplar.

### *The Suggestions*

It was strongly argued that there should be a **distinct approach** to supporting equality and non-discrimination for trans people. This needs to be understood and pursued as a separate strand of activity. This reflects the need to develop particular treatment pathways for trans people just as it reflects the specific situation, experience and identity of trans people.

There was a consensus that some of the services for trans people needed to be **localised**. Core interventions on the treatment path could be made in the specialised context of Loughlinstown or other such centres but ongoing treatment needs could be provided for locally. Outreach could be deployed once the treatment path is established.

It was suggested that there needed to be a better **signposting** of those health professionals with knowledge and understanding of trans issues. This would allow for improved access and better referrals. Another proposal was that on foot of a trans person presenting to a G.P., a team could be set up around that person to enable effective treatment and care and to allow for good communication between health professionals. A parent highlighted this in pointing to the need for a 'joined up' service.

**Training** for health professionals on trans issues was seen as important. This was emphasised in relation to G.P.s as they are the first point of contact for many parents and trans people. The particular gap in the quality of mental health services experienced by young trans people, in their teenage years, was highlighted as needing to be addressed.

It was highlighted that **access to hormone blockers** is needed at an earlier age. A parent put it that 'trans children should not have to worry about puberty'.

There was a need identified to address the **two different systems** for treatment of trans people in England and in Ireland. This was important given the reliance on English provision for surgical interventions. More effective linking between different systems is seen as being required.

**Financial barriers** are seen as needing to be addressed. Some trans people and some of the parents had gone private with resulting financial hardship. Others had considered it but had to not been able to do so. The need to pay for medical interventions had caused

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<sup>49</sup> The Tavistock is part of The Tavistock and Portman, an NHS Foundation. It provides a Gender Identity Development Service.

hardship for some. The need to cover transport costs to and from Dublin was also identified as a source of hardship.

Many of those interviewed noted that '**families** are not supported'. Counselling needs to be provided for families of trans people, the whole family. The support from being able to participate in TransParenCi was highlighted by all parents. TransParenCi is a group for parents and family members of trans people based in Carlow. It aims to break the silence by offering support and giving voice to parents and families of trans children.

A parent said that 'without TransParenCi I would struggle hard to support my child'. Another said that 'you are alone until you meet other parents'. Another parent pointed out that 'our kids have our support' and many trans children are not so fortunate. The need to expand the reach of TransParenCi was noted.

**Advocacy** and access to advocates was seen as important. There is a need for someone to represent trans people as a group. This would enable greater accountability from health services. It was important to enable more effective communication with trans people. There is a need to support more interaction between trans people. One person noted 'we are the best therapy for each other'.

Building resilience among trans people and their families was identified as key to addressing the minority stress experienced. Advocacy, interaction among trans people, and support for families were seen as important in this regard.

#### **4.2 Intersex People's Perspectives**

It did prove possible to interview any Intersex people.



## 5.0 Conclusions and Recommendations

### 5.1 Conclusions

#### 5.1.1 Introduction

The experience of the health service recounted by lesbian, gay and bisexual interviewees had a strong and significant strand of positivity. Positive statements encompassed a wide range of different health professions. There was a dominant sense of change within society that was driving new attitudes and new experiences within the health service. These positive statements focus on the nature of the interaction involved rather than just on the medical treatment given, offering evidence of the importance of the interaction for LGB patients. However, there remained concerns about the nature of this interaction and about the manner in which difference in sexual identity was being addressed where this was relevant.

*'Had a Consultant who treated my partner as my spouse and included her in all decisions'*

*'There was no awkwardness when I said I was gay'*

The experience of the health service recounted by trans interviewees and by parents of trans children was predominantly negative. The negative experiences recounted seem to reflect a lack of knowledge and skills in relation to the treatment of trans people, the nature of the interaction with health professionals, and the pressures on the services for trans people. Particular concerns were expressed at the lack of a treatment pathway for trans people.

*'one of whom tried Cognitive Behavioural Therapy before referring me for a second opinion to a psychologist who declared "I'll have you cured by the end of the year"'*

*'the look on his face told me he had not dealt with it. He wouldn't admit it though. I had to tell him what to do'*

#### 5.1.2 Literature

The naming of LGBTI people in **health policy** in Ireland is still only emerging and developing as a coherent practice. However, it has been sufficient to allow a significant targeting of LGBT people to be developed in some instances. Policies in relation to children and in the areas of suicide prevention, mental health, sexual health, and drugs have usefully named LGBT people. This naming has, at times, been of a minimal nature, based on an understanding of LGBT people as being one of a number of marginalised groups. The concept of 'additional need' for LGBT people is usefully introduced in the 'Vision for Change' mental health policy. Intersex people remain largely invisible in policy.

The 2009 Health Service Executive report "LGBT Health: Towards Meeting the Health Care Needs of Lesbian, Gay, Bisexual and Transgender People" marked an important stage in according visibility to LGBT health needs and establishing the response required from health service providers. Service plans within the HSE largely confine reference to LGBT people as targets in their social inclusion strategies. The plans do

have a particular focus on trans people and the development of treatment paths for trans people. The recent publication of a proposed model of care is a significant step forward in this regard. This is also the first policy related document to name intersex people.

International and national standards for health services to LGBTI people are identified in the literature. These include international human rights instruments that have been developed into more specific standards for health providers. They include national employment equality and equal status legislation. They also include practice guidelines for service providers developed by the HSE in 2009.

The literature identifies specific health needs for LGBTI people. Particular health issues of mental health, sexual health, reproductive health, and drug abuse are identified among LGBTI people in the literature. There is evidence of particular disadvantage in the situation of LGBTI people in these fields. Access to treatment pathways for trans people is identified. Inappropriate surgical interventions for intersex people are raised as an issue.

There is an emphasis on minority stress in relation to the specific health needs of LGBTI people. This is defined in terms of the mental health consequences of stigmatisation and harassment. It includes external stressors such as the impact of homophobic abuse and violence, isolation, fear, stigma, bullying and stigmatisation of families. It also includes internal stressors such as anxiety in coming out.

A range of **issues and challenges** emerge in the literature in ensuring an effective and accessible health service for LGBTI people. These include:

- Presumptions of heterosexuality by health service providers.
- Negative experiences on disclosure of sexual identity or of issues of gender identity.
- Lack of knowledge among health professionals of LGBTI issues.
- Lack of recognition for same-sex partners as next of kin.
- Failure to create a welcoming environment for the diversity of sexual and gender identities.
- Lack of a treatment pathway for trans people.
- Inappropriate surgical interventions for intersex people.

Difference and diversity are identified as having practical implications in the literature. This is relevant to difference in relation to sexual identity and in relation to gender identity. The specific elements of difference in relation to sexual identity and gender identity named in the literature cover issues of same sex partners, same sex parents, coming out, minority stress, and fluidity of gender identity. Difference is explored in terms of equal rights rather than special treatment in the literature.

A double discrimination is evident in the literature for particular groups of LGBTI people. Double discrimination involves people being disadvantaged for other elements to their identity as well as their LGBTI identity, for example LGBTI Travellers or older LGBTI people. Issues of age, gender, ethnicity and disability are raised in this regard.

Particular issues of isolation and lack of recognition for older people and access to reproductive services and recognition of lesbian family forms are explored.

The literature includes a range of recommendations for action by health service providers **to improve practice and to support improved practice**. There is a significant body of practice guidance developed for different groups of health service providers. The involvement of professional bodies in this work is important.

The key elements identified in the literature for this **good practice** revolve around a **framework** of:

- Public profile and communication that the service provider is LGBTI friendly;
- Inclusive policy and an equality and diversity policy setting standards for service provision;
- Professional development and training and equipping staff to engage effectively and appropriately with LGBTI clients; and
- Programme development and taking steps to engage with the LGBTI community and target their specific needs.

Partnership, collaboration and consultation with LGBTI organisations are frequently recommended. It is noteworthy that many of the publications in this literature review involve the Health Service Executive and/or the Department of Health as partners with LGBTI groups. Alongside this the literature reveals a concern with the lack of community infrastructure for LGBTI people.

It is clear from the literature that **trans people** have particular health needs and particular experiences of health services. This is reflected in a growing literature that has a specific focus on trans people. This literature is responding to the difficulties encountered in capturing the specific needs and issues of trans people in the wider LGBT literature. These particular needs focus attention on specific treatment pathways for trans people and specific difficulties of access to health services. These particular issues focus attention on the significance of gender transition to good mental health and wellbeing and the lack of specific knowledge and expertise on trans health issues among health professionals.

**Intersex people** have particular health needs and particular experiences of health services. They remain largely invisible in policy and practice literature in Ireland. There appears to be limited knowledge and understanding of their needs and issues.

### *5.1.3 Health Professionals*

The dominant perspective among the health professionals that engaged in this research was that there was no need for specific steps in relation to LGBTI people in a context where their service was open to all, where everyone was treated the same and where no specific group could be separated out. This was allied to a perception of pressure where health professionals pointed to barriers of time and resources in going further on this issue. There was an acknowledgement of particular issues in relation to trans people in terms of the lack of a treatment path, the lack of back up on the issues for trans people, and dealing with the results of surgical interventions conducted elsewhere.

*'I can understand people believing they are treating people the same but when it comes down to it, maybe they objectively don't. There is an internal homophobia'*

*'you do have to respect difference and give consideration to the fact that not everybody is the same. There is minority stress and recognition of that is important medically'*

There were few practical steps taken to implement the practice framework of public profile and communication that the service provider is LGBT friendly; inclusive policy and an equality and diversity policy setting standards for service provision; professional development and training and equipping staff to engage effectively and appropriately with LGBTI clients; and programme development and taking steps to engage with the LGBTI community and target their specific needs.

*'My G.P. doesn't know. I don't know if he would get it. It is the fear of the unknown reaction. If I saw a 'rainbow' I would feel much better'.*

*'the most annoying thing is having to explain yourself, civil partnership is not on the forms, we don't fit into your boxes. It is not yet in the mindset of administration staff'*

Individual leadership and practice reputation emerged as useful elements in relation to public profile. Equality legislation and existing guidance from the HSE and from specific professional bodies were named in terms of inclusive policy. However, there appeared to be a limited awareness of these standards. Practice meetings were identified as important sites within which to set and reiterate standards. The idea of a Patient Charter was mooted.

Few health professionals seem to have attended training on LGBTI issues as part of their professional development. Those that did attend such training reported this focus as a small element in a wider training programme. This was despite a number of health professionals identifying lack of knowledge as a barrier in this field. There was reliance by health professionals on long experience to cope with any gap. In terms of programme development, there was only one instance of a specific outreach programme to LGBTI people by one individual General Practitioner.

Many health professionals felt that LGBTI people presented with the same issues as the general population. However, mental health, sexual health, treatment of trans people, and reproductive health were often identified as presenting particular issues for LGBTI clients. There was no mention of intersex clients. There was only one reference to issues of minority stress.

The survey responses reflect an overriding concern with medical treatment and providing the same medical treatment to all patients. A more holistic response, equally concerned with the relationships involved in the provision of the medical treatment, was less evident. Yet it was in this area of relationships that some health professionals expressed a lack of confidence.

*'was not deliberately bad but once you say you have a partner awkwardness sets in and they don't know how to deal with it'*

*'subtle things make a difference. Trust is shot. Silly questions matter even if they do mean well'*

There was a significant level of interest among health professionals in getting supports in relation to LGBTI clients. Training was a particular focus and there was a high level of interest in receiving training on LGBTI issues, especially if it was local, time limited, and part of Continuing Medical Education. However, many health professionals were clear in stating no supports were needed.

Many health professionals were happy to disseminate literature on LGBTI issues. A smaller number were interested in guidelines and fewer again in displaying posters related to LGBTI issues in their practice areas.

#### *5.1.4 LGB People*

There was a strong positive strand of feedback from LGB people about their experiences of the health services. This was attributed to change in the wider society over the past ten years in perspectives on diverse sexual identities. There was a concern expressed by interviewees that this might be a result of their limited contact with the health services or the fact that they individually felt confident in expressing their sexual identity in public as necessary.

The core issues for LGB people were issues of awkwardness on the part of health professionals in engaging with them once their sexual identity was established. There was also a concern at the invisibility of LGB people in terms of posters and printed material available in health clinics and hospital settings, and in terms of the forms used for health services. There was strong support for training for health professionals that would focus on communication skills or customer service. The need for cultural change within health service settings was emphasised.

*'partner was asked to leave when I was being examined. I couldn't challenge it'*

*'I always felt I had to explain. Why is that? Are you a brother? It's annoying at a stressful moment. I was not sure at any stage I would be consulted'*

A small number of instances were recounted that could be considered as issues of discrimination or harassment. It was noteworthy that these were rarely challenged by those experiencing them, and, if challenged, that the response from health service providers was limited. There was strong support for health service policy that would set out equality and diversity standards and identify a process that could be invoked to address incidents where these standards were breached.

Most interviewees were clear that they did not require positive action or to be treated in any special manner. However, they were equally clear that there were points where different treatment was needed to take account of the practical implications of diverse sexual identities. These points tended to focus on mental health services, sexual health services, reproductive services and family recognition.

The lack of understanding of the difference presented by LGB clients and the practical implications of these differences was highlighted in relation to mental health services and sexual health services. The need for outreach to LGB communities by these services was noted. There was a critique of a medical model that focused on treatment of the medical issue without taking a wider perspective on the LGB person involved. Privacy issues were also highlighted.

*'there was very little support for young LGB people under stress with coming out. Psychological problems can arise and there is no specific service for them or there is no service that has some awareness of the issues'*

*'doctors not knowing about gay sex. There is a knowledge gap. They don't have a capacity to advise us'.*

*'there is no mention of LGBT people in sexual health in schools'*

Access to and information on reproductive services for lesbian women were identified as issues. The lack of recognition of next of kin for same sex partners and of recognition of same sex parents in health settings was a frequent complaint. The need to provide supports for parents of LGB children was highlighted.

There was a strong sense that the community infrastructure for LGB people had been diminished in recent times. This limited social interaction, connection and sharing experiences, and possibilities for health service outreach to the community. Funding issues were raised in explaining this, alongside issues of loss of interest in the groups from LGB people and difficulties in advertising the groups in some settings. Networking systems among LGB people were seen as a useful focus for support and development in order to address the issues that arise from the loss of this community infrastructure.

The need to address issues for older LGB people was raised in a number of interviews. Older LGB people were identified as experiencing isolation and at risk of having their identity lost in care settings. Similar issues were raised in relation to LGB people with disabilities in care settings. The need to target action to raise awareness and understanding of LGB issues among care providers is clear. The issue of ageism was raised in relation to young LGB people. There was a sense that their views and experience were not being taken seriously by health professionals. The particular challenge facing young LGB people between the ages of 12 to 16 years was raised.

*'identity gets lost in care and care homes. Older LGB people tend not to be cared for in the family'*

*'there is an awkwardness, young people are not taken seriously when the topic of sexual health comes up. The stereotypical response of "Are you sure?" comes up'*

### **5.1.5 Trans People**

There was a strong negative viewpoint in the commentary of trans people and the families of trans people about their experiences of the health services. Core issues in this were the lack of a treatment path for trans people and the lack of knowledge and understanding of trans issues among health professionals. The need for training of health professionals in relation to trans issues was consistently recommended. It was

also suggested that there should be some form of signposting for trans people to those health professionals that had knowledge, skills and openness in relation to trans issues.

*'social worker who didn't know enough about trans issues. The psychiatrist was nice and understanding but was lost at what to do. There are no pathways'*

The current situation is seen as leading to inconsistency in the responses from different health professionals to trans people. It can result in a lack of adequate communication between different health professionals about a trans client. There was significant support for forming a team around a trans person once they have presented to their G.P.

The relationships between health professionals and trans people were largely experienced as disempowering by trans people. Training in this field of relating and communicating with trans people was seen as important.

*'felt dehumanised'*

*'child is not respected despite being very articulate. They don't listen'*

Particular issues were put forward in relation to mental health services for young trans people. These involved a critique of the lack of understanding of trans issues and of the issue of ageism evident in the failure to take young people seriously. The need for trans specific help was highlighted. The particular issue of the need for access to hormone blockers at a younger age than is currently allowed was raised.

*'not helpful. My daughter was not listened to. She said she was not being listened to. They had no idea about transgender so they sent her to Tavistock. It took two years there for a diagnosis. It was only six years later we were linked into Loughlinstown'*

A range of issues was raised in relation to services that are centralised in Dublin. These issues focused on the costs involved in travelling and spending time in Dublin and the pressures on these services and resulting problems. The need to localise treatment of trans people once a treatment path had been established was emphasised.

The need to support families of trans people was stressed. In particular, it was felt that the reach of TransParenCi needed to be expanded. Advocacy support and support for interaction among trans people was also recommended. Developments in these areas would build the resilience among trans people and their families that is key to addressing the minority stress experienced.

*'without TransParenCi I would struggle hard to support my child'*

*'you are alone until you meet other parents'*

## 5.2 Strategy

Difference matters if equality is to be progressed. A central component of most health professionals' responses to LGBTI people is to treat people the same. This is countered by the perspectives of LGBTI people that suggest that this approach begins to go wrong

when difference of sexual identity or gender identity kicks in as being relevant. It is also suggested that stereotypes can continue to influence where difference is not acknowledged and there was a concern that an internalised homophobia can also be at play under cover of same treatment.

*'difference does matter. Our experiences aren't the same'*

*'I don't want to be treated differently because of my sexuality. However, there are points where it can be an issue'*

*'you need trans specific help'*

Responses to difference across the wider society can be problematic. There is a fear of difference evident in experiences of stereotyping, discrimination and harassment. Difference can be misunderstood. This is evident in a determination to treat people the same, despite being different. It is evident in the dominant response of tolerance, where difference is diminished as something that has to be put up with. Rarely is difference valued or celebrated. This would be evident in acknowledging that difference has practical implications that require adjustments and that mean business as usual is unlikely to produce results.

The difference brought up in the interviews as having practical implications for LGBTI people included: the specific health needs of trans people and of intersex people; the minority stress experienced by LGBTI people; vulnerability in coming out in terms of both sexual identity and gender identity; diverse sexual practices of LGB people; and the formation of same sex couples and families. Diversity within the LGBTI communities also emerged as important. This included gender differences and younger and older, and minority ethnic LGBTI people. It covered difference in status such as homelessness and refugee/asylum seeker legal status.

The challenge is to recognise difference, identify the practical implications of difference, and make adjustments in service provision to take account of these practical implications.

Equality is the goal. The purpose of taking account of difference is to achieve equality in health outcomes for LGBTI people with the general population. This goal is shared with a range of other minorities and with women. Equality for LGBTI people can be pursued within a commitment to equality for all groups experiencing inequality. However, it will be important to ensure a visibility for LGBTI people within any such integrated strategy.

Action can be taken that advance equality for all groups simultaneously, or to address the situation of people at the intersections between the groups, where age and sexual identity intersect for older people for example, or that focus on a specific group such as LGB people or trans people or intersex people to meet needs or address issues that are specific to these groups.

Mainstreaming is key. Eliminating discrimination, taking account of difference and achieving equality requires that mainstream or general service provision achieves outcomes for LGBTI people. General services need to be accessible to, and to be able to secure outcomes for, LGBTI people. This requires change within these services to take difference into account and to assess and monitor their impact on LGBTI people.



A dual strategy of mainstreaming and targeting is required. Mainstreaming needs to be accompanied by initiatives targeted on LGBTI people if it is to be effective. Targeted initiatives can meet health needs specific to Lesbian, Gay, Bisexual, Trans, and Intersex people, enable these groups to access general services more effectively, and respond to issues particular to these groups.

## 5.3 Recommendations

### 5.3.1 The Research

The HSE South East Region Social Inclusion Unit should play a central role in disseminating the conclusions and recommendations of this research to all HSE units and staff with a view to reinforcing an awareness of LGBTI needs and a commitment to implementing the recommendations. Action on foot of the research should be promoted by developing partnerships with the relevant units within HSE South East Region and with other relevant agencies and non-governmental organisations.

### 5.3.2 Equal Treatment Legislation

Equal treatment legislation sets an important standard of non-discrimination for health service providers in the Employment Equality Acts and the Equal Status Acts. The Irish Human Rights and Equality Commission Act includes a duty on public sector bodies to have regard to the need to eliminate discrimination, promote equality of opportunity and treatment, and protect human rights in the performance of their functions. The HSE South East Region could set a standard in implementing this new duty in all service plans and annual reports and could include specific reference to LGBTI people in doing so.

The HSE South East Region should assess new programmes or initiatives or projects at design stage for their potential impact on LGBTI people. This should ensure a visibility for LGBTI people in any such new developments. It should lead to design adjustments to take account of diversity in sexual identity and in gender identity where this is found to be necessary.

### 5.3.3 An Inclusive Practice that Recognises Difference

The HSE South East Region Social Inclusion Unit has a key role to play in supporting access to services for LGBTI people. It should adopt an approach to inclusion for LGBTI people based on the public profile, inclusive policy, professional development, and programme development framework set out above. It should develop a campaign within all parts of the health sector in the region to promote and support the implementation of this framework. Hospitals and primary care teams should be a primary focus in this work.

The HSE South East Region Social Inclusion Unit should, in partnership with Primary Care, Tusla, and service users:

- Devise and promote a model equality and diversity policy to establish the commitment of health service providers to equality for LGBTI clients and to set out the steps that would be taken by health service providers to realise this commitment in practice. It would identify any process that health service providers would implement in situations where there is a complaint that this

commitment has not been realised in practice, in particular highlighting the Your Service Your Say process.

- Devise and disseminate a sticker that could be used in all health service settings to communicate openness to both diverse sexual identities and diverse gender identities. This could make use of the rainbow imagery.
- Devise and provide training modules on LGBTI issues to health professionals and administration staff in all settings. This training needs to be delivered and accessed locally. It could usefully involve key training providers within the HSE and be linked to Continuing Medical Education/Continuous Professional Development requirements. The training content should prioritise skills in communication across boundaries of difference, knowledge of LGBTI issues, and values of equality and diversity. It needs to be designed in formats that take account of the limited time available for health professionals to take up such training. Social media channels could be used to reinforce and sustain the training provided.

#### *5.3.4 Implementing a Treatment Pathway for Trans People*

The recently published model treatment path for trans people published by the HSE marks an important point of departure for a new experience of the health service for trans people. The HSE South East Region could take a lead role in responding to the proposal and in rolling out its implementation.

The HSE South East Region should in particular:

- Provide training opportunities to health professionals to develop the medical skills necessary to contribute and play a role within this treatment path.
- Develop a system of signposting to enable trans people to know with ease the points of initial contact with the health service that would be open to and knowledgeable about trans people and to identify the specialist trans services that are available to trans people in the region.

The hospitals and Primary Care could take a lead role in this.

There should be particular attention given to securing local health services to trans people once their treatment pathway has been established. These local services should be networked around individual trans patients so that there is effective and adequate communication and exchange of information.

Specific supports should be developed for the families of trans people. This could build on and extend the TransParenCi model.

#### *5.3.5 Intersex People*

Babies diagnosed as intersex and the medical interventions proposed in these instances need to be tracked and monitored. This should be done with a view to developing standards in this area of treatment over the longer term. The Quality and Patient Safety division within the HSE could take a leadership role on this.

### *5.3.6 General Practitioners*

General Practitioners should implement the framework defined in 5.3.2 above to support inclusion of LGBTI people in the services they provide. They should use practice meetings to ensure a common approach to the standards that they set for treating and engaging with LGBTI patients and to discuss any issues arising.

This approach could be extended to primary care team meetings their general practice is involved in. General Practitioners should engage with LGBTI organisations in supporting this process within the primary care team setting. They should outreach to these LGBTI organisations to support a focus on health issues in the work of these organisations. The HSE South East Region Social Inclusion Unit could support and guide this work.

General practitioners should include an LGBTI identifier in their patient forms. This question should be voluntary. It should be clarified that it is being asked for equal opportunity purposes and to ensure that services meet the specific needs of all clients. Receptionists and front line administrative staff should be included in training on LGBTI issues.

### *5.3.7 Hospitals*

Hospital managers should implement the framework defined in 5.3.2 above to support inclusion of LGBTI people in the services they provide. Senior management teams in hospitals should lead this work. They should engage with LGBTI organisations in implementing this approach. LGBTI people could be involved in structures and systems for patient liaison and patient feedback. The HSE South East Region Social Inclusion Unit could guide and support this work.

Hospitals should include an LGBTI identifier in their patient forms. This question should be voluntary. It should be clarified that it is being asked for equal opportunity purposes and to ensure that services meet the specific needs of all clients. Receptionists and front line administrative staff should be included in training on LGBTI issues.

### *5.3.8 Mental Health Services and Sexual Health Services*

Specific and intensive interventions targeting LGBTI people should be developed by mental health services and sexual health services in the region. Responsibility for progressing this work should rest with the relevant units with the HSE South East Region. The HSE South East Region Social Inclusion Unit could support and guide these services in making adjustments to take account of different gender identities and sexual identities as necessary.

Training modules and information provision should be developed and provided to build understanding of particular needs of LGBTI people in these service areas. Minority stress and issues of ageism should be part of the training and information content for mental health service providers. Minority stress, privacy and confidentiality, and particular sexual practices of LGBTI people should be part of the training and information content for sexual health service providers.

Specific outreach initiatives should be developed. Outreach for mental health services should promote appropriate engagement by LGBTI people with mental health services and recognition of need in this area by LGBTI people. Outreach for sexual health services should promote safe sex and enable more effective screening uptake by LGBTI

people. The model developed by, for example, GOSHH in Limerick could be replicated or expanded in this regard.

Outreach could engage with school-based provision of education on sexual health and on mental health to ensure an LGBTI dimension to this provision. Particular strategies need to be developed to reach out to LGBTI children in the 12 years to 16 years age bracket. These should form part of the Children and Young People's Services Plan in each county in the region.

### *5.3.9 Reproductive Health Services*

Reproductive health services should take steps in their literature and in their promotion work to identify that they are welcoming to lesbian women. Training should be provided to staff in these services to enable them to understand issues of diversity of sexual identities and gender identities. Specific information materials should be developed for lesbian women and disseminated through communication channels that are used by lesbian women in the region.

### *5.3.10 Care Services for Older People and for People with Disabilities*

Care providers for older people and people with disabilities, in particular those responsible for institutional care settings, should develop initiatives to take account of the diversity of sexual identities and gender identities among the people that are cared for. These interventions should include training of care staff and developing an LGBTI friendly care environment. The HSE South East Region Social Inclusion Unit could support and guide these services in this.

### *5.3.11 Family Recognition*

All health services caring for LGBTI should recognise and cater for the diversity of family forms. The acknowledgement of same sex families should include recognition of partners as parents, inclusive language, and appropriate next of kin arrangements.

### *5.3.12 Blood Donation*

The ban on gay men giving blood was raised as a concern during the research. This issue is currently under review in the Department of Health. The HSE South East Region Social Inclusion Unit should communicate this concern to the Department to inform their review.

### *5.3.13 Community Infrastructure*

The Community Development Departments under Tusla in each county in the region should develop a strategy for supporting the community and youth infrastructure of the LGBTI community. This should start with sustaining those groups and initiatives still in place. It should include devising and developing innovative networking systems within the LGBTI communities. This work should include development of supports for parents of LGBTI children.

This work should ensure that the LGBTI organisations have a capacity to make demands on health service to be LGBTI friendly, knowledgeable about LGBTI issues, and accommodating to the practical implications of diversity of gender identity and sexual identity. This LGBTI infrastructure should be a key partner in developing, supporting and implementing the practice framework defined above.

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## Appendices

### Appendix One: General Practitioner Survey

Dear Doctor,

I am writing to request your support for a research project on the health needs and experiences of Lesbian, Gay, Bisexual, Trans, and Intersex (LGBTI) people in the South-East region. I hope you might complete the enclosed short survey and *return it to me in the accompanying stamped addressed envelope before 17<sup>th</sup> November*. I am grateful to the Primary Care Unit of the HSE for facilitating this survey.

The research has been commissioned by the HSE South East Region Social Inclusion Unit to better understand the experience of LGBTI people of the health services in the region and to better support health professionals in the region to respond effectively to the needs of LGBTI clients.

International and national research has identified various issues for LGBTI people in accessing health services. There has been no such research in the South-East region. There is also little research work done on the perspectives and experiences of health professionals with regard to LGBTI issues and clients. This research will fill these gaps and support further initiatives to enable LGBTI people's effective access to health services.

Your contribution in filling out this survey is completely voluntary, but it would be much appreciated. It will provide the key material for the research and add to its quality and impact. Short answers will suffice and answers will be treated confidentially.

Thank you for taking the time and giving this some consideration. If you have any queries please do contact me.

Yours,

Niall Crowley

*SURVEY: General Practice Doctors*

*All Survey Responses will be treated confidentially*

*Respondent Details:*

Name of Primary Care Team: \_\_\_\_\_

*1 Practice Profile: Communicating your Service as Friendly to LGBTI Clients*

1.1 Have you been in a position to communicate publicly or within your practice that your practice is open to the diverse sexual and gender identities of clients?

\_\_\_\_\_ 1.2 If  
yes, what steps have you taken?

\_\_\_\_\_  
\_\_\_\_\_

1.3 If no, is there any barrier to doing so?  
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*2 Policy: Practice Guidelines in Responding to LGBTI Clients*

2.1 Are you following any practice guidelines for equality and diversity in your treatment or care of LGBTI clients?

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2.2 If yes, how are these practice guidelines communicated to all team members?

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2.3 What steps do you and your team members take to implement these practice guidelines?

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2.4 Is there any particular barrier to establishing such practice guidelines?

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*3 Professional Development: Knowledge and skills about LGBTI Issues*

3.1 What training have you participated in on LGBTI related issues?

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3.2 What LGBTI related training have members of your team participated in?

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3.3 Is there any barrier to you or your team participating in such training?

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*4 Provision: The Service Provided to LGBTI Clients*

4.1 Do LGBTI clients 'rarely' or 'regularly' or 'often' attend your practice?

Rarely  Regularly  Often

4.2 What are the main medical issues that LGBTI clients are presenting with?

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4.3 What difficulties, if any, do you have in responding to your LGBTI clients?

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4.4 Have you taken outreach actions to the LGBTI community, if so please list?

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*5 Supports: Developing LGBTI friendly services*

5.1 What support would enable you to implement practice guidelines for LGBTI clients?

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5.2 What supports would enable you to disseminate LGBTI friendly literature?

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5.3 Would you be interested in attending training on LGBTI issues?

Yes  No

**Appendix Two: Primary Care Team Survey**

*RESEARCH PROJECT: Lesbian Gay Bisexual, Transgender and Intersex (LGBTI) Health Needs & Experiences and Health Sector Responses in HSE South East*

Your contribution in filling out this survey is completely voluntary but it would be much appreciated. Short answers will suffice. Answers will be treated confidentially. This survey will provide key material for a research project on Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people's health needs and experiences and on health sector responses to LGBTI people. Your cooperation will ensure the quality and impact of the research. The completed forms will be forwarded directly to Niall Crowley, who is conducting this research.

The research has been commissioned by the HSE South East Region Social Inclusion Unit to better understand the experience of LGBTI people of the health services in the

region and to better support health professionals in the region to respond effectively to the needs of LGBTI clients.

International and national research has identified various issues for LGBTI people in accessing health services. However, there has been no such research in the South-East region. There is also little research work done on the perspectives and experiences of health professionals with regard to LGBTI issues and clients. This research will fill these gaps and support further initiatives to enable LGBTI people’s effective access to health services.

Thank you for your cooperation.

Niall Crowley

*SURVEY: Primary Care Team Members*

*All Survey Responses will be treated confidentially*

*Respondent Details:*

Field of Work of Respondent: \_\_\_\_\_

Name of Primary Care Team: \_\_\_\_\_

*1 Practice Profile: Communicating your Service as Friendly to LGBTI Clients*

1.1 Have you or your team been in a position to communicate publicly or within your practice that your practice is open to the diverse sexual and gender identities of clients?

\_\_\_\_\_ 1.2 If

yes, what steps have you taken?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1.3 If no, is there any barrier to doing so?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*2 Policy: Practice Guidelines in Responding to LGBTI Clients*

2.1 Are you or your team following any practice guidelines for equality and diversity in your treatment or care of LGBTI clients?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2.2 If yes, how are these practice guidelines communicated to all team members and to LGBTI clients?

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2.3 What steps do you and your team members take to implement these practice guidelines?

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2.4 Is there any particular barrier to establishing such practice guidelines?

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*3 Professional Development: Knowledge and skills about LGBTI Issues.*

3.1 What training have you or your team participated in on LGBTI related issues?

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3.2 If you have participated in such training, why did you participate?

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3.3 Is there any barrier to you or your team participating in such training?

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*4 Provision: The Service Provided to LGBTI Clients.*

4.1 Do LGBTI clients 'rarely' or 'regularly' or 'often' attend your practice?

Rarely  Regularly  Often

4.2 What are the main medical issues that LGBTI clients are presenting with?

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4.3 What difficulties, if any, do you have in responding to your LGBTI clients?

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4.4 Have you taken outreach actions to the LGBTI community, if so please list?

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*5 Supports: Developing LGBYI friendly services.*

5.1 What support would enable you to implement practice guidelines for LGBTI clients?

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5.2 What supports would enable you to disseminate LGBTI friendly literature?

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5.3 Would you be interested in attending training on LGBTI issues?

Yes  No

### **Appendix Three: Hospital Staff Survey**

*RESEARCH PROJECT SURVEY: Lesbian Gay Bisexual, Transgender and Intersex (LGBTI) Health Needs & Experiences and Health Sector Responses in HSE South East*

Thank you for filling out this survey. Your contribution is completely voluntary but it would be much appreciated. Short answers will suffice. Answers will be treated confidentially. This survey provides the key material for a research project on Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people's health needs and experiences and on health sector responses to LGBTI people in the region. The research has been commissioned by the HSE South East Region Social Inclusion Unit to better understand the experience of LGBTI people of the health services and to better support health professionals to respond to the needs of LGBTI service users.

Niall Crowley

*SURVEY: Hospital Personnel*

*All Survey Responses will be Treated Confidentially*

*Respondent Details.*

Sector of work of Respondent:

Name of Hospital:

*Practice Profile: Communicating your Service as Friendly to LGBTI Clients.*

Have you, your Team, or your hospital communicated publicly or within the service you provide that your service is open to the different sexual and gender identities of those using the service?

If so, what steps have been taken?

If no such steps have been taken, why not?

*Policy: Standards in Responding to LGBTI Clients.*

What, if any, standards of equality and diversity have been set for your treatment or care of LGBTI clients?

If so, how are these standards communicated to you and to your LGBTI clients?

If so, what steps do you take to achieve these standards?

If no such standards have been set, why not?

*Professional Development: Knowledge and skills about LGBTI Issues.*

What, if any, training have you participated in on LGBTI related issues?

If you have participated in such training, why did you participate?

If you have not participated in such training, why not?

*Provision: The Service Provided to LGBT Clients.*

Do LGBTI clients 'rarely' or 'regularly' or 'often' access your services?

How do you know if service users are LGBTI people?

What are the main issues that your LGBTI clients are presenting with?

What difficulties, if any, do you have in responding to your LGBTI clients?

What, if any, outreach actions have you taken to the LGBTI community?

*Supports: Developing LGBTI friendly services.*

What supports would help you to communicate that your service is LGBTI friendly?

What supports would help you to set and implement standards for LGBTI service users?

What supports would help you further develop your service to LGBTI service users?

Would you be interested in attending training on LGBTI health needs and issues?

## **Appendix Four: LGBTI Interview Guide**

*Focus Group Meetings and Interviews with Lesbian, Gay, Bisexual, Trans, and Intersex People to inform a research project on Lesbian Gay Bisexual, Transgender and Intersex (LGBTI) Health Needs & Experiences and Health Sector Responses in HSE South East*

### *The Research*

This research project is exploring the health needs and experiences of Lesbian, Gay, Bisexual, Transgender and Intersex people (LGBTI) in the South-East region and the responses of health sector personnel and institutions to LGBTI people and their health needs. The research has been commissioned by the HSE South-East Region Social Inclusion Unit to better understand the experiences of LGBTI people and to better support health professionals to respond effectively to the particular needs of LGBTI service users.

International and national research has identified various issues for LGBTI people in accessing health services. However, there has been no such research in the South-East region. There is also little research work done on the perspectives and experiences of health professionals with regard to LGBTI issues and service users. This research will fill these gaps and support initiatives to further enable LGBTI people's effective access to health services in the South-East region.

### *The Approach*

The focus group meetings and interviews will provide the key material for the research. Participation is voluntary and participants will be asked to sign a consent form. The

meetings and interviews will be confidential and there will be no attribution of any comments or contributions. The meetings will be free flowing and will allow participants to contribute as and where they feel comfortable rather than having to address every element of the research agenda.

### *The Focus Group Meetings and Interviews*

The meetings and interviews will be organised around four themes:

1. **LGBTI Needs:** What parts of the health services have you used? What parts of the health services are most used by LGBTI people generally?
2. **Experiences:** What have been your experiences of health service provision – in particular hospital provision and general practice provision? How would you rate your experiences? What are the experiences of LGBTI people generally? What issues arise and in what parts of the health service? How have you managed these issues? How do LGBTI people generally manage these issues?
3. **Good Practice:** In what parts of the health sector have you come across good practice in responding to LGBTI people and their health needs? What did this practice involve? What made it effective?
4. **Recommendations:** What changes would you like to see in the policies, programmes, and/or practices of the health services in the South-East region to make them more LGBTI friendly?

## **Appendix Five: Informed Consent Form**

### *Information*

Niall Crowley is the researcher.

HSE South East Region Social Inclusion Unit has commissioned the research.

'Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) Health Needs and Experiences and Health Sector Responses in HSE South East Region' is the title of the research.

This Informed Consent Form has two parts: Information Sheet (to share information about the study with you); and Certificate of Consent (for signatures if you choose to participate).

You will be given a copy of the full Informed Consent Form

### *The Research*

This research project is exploring the health needs and experiences of Lesbian, Gay, Bisexual, Transgender and Intersex people (LGBTI) in the South-East region and the responses of health sector personnel and institutions to LGBTI people and their health needs. The research has been commissioned by the HSE South-East Region Social Inclusion Unit to better understand the experiences of LGBTI people and to better support health professionals to respond effectively to the particular needs of LGBTI service users.

International and national research has identified various issues for LGBTI people in accessing health services. However, there has been no such research in the South-East region. There is also little research work done on the perspectives and experiences of health professionals with regard to LGBTI issues and service users. This research will



fill these gaps and support initiatives to further enable LGBTI people's effective access to health services in the South-East region.

### *The Approach*

The focus group meetings and interviews will provide the key material for the research. Participation is voluntary and participants will be asked to sign a consent form. The meetings and interviews will be confidential and there will be no attribution of any comments or contributions. The meetings will be free flowing and will allow participants to contribute as and where they feel comfortable rather than having to address every element of the research agenda.

### *The Focus Group Meetings and Interviews*

The meetings and interviews will be organised around four themes:

1. LGBTI Needs: What parts of the health services have you used? What parts of the health services are most used by LGBTI people generally?
2. Experiences: What have been your experiences of health service provision – in particular hospital provision and general practice provision? How would you rate your experiences? What are the experiences of LGBTI people generally? What issues arise and in what parts of the health service? How have you managed these issues? How do LGBTI people generally manage these issues?
3. Good Practice: In what parts of the health sector have you come across good practice in responding to LGBTI people and their health needs? What did this practice involve? What made it effective?
4. Recommendations: What changes would you like to see in the policies, programmes, and/or practices of the health services in the South-East region to make them more LGBTI friendly?

This proposal has been reviewed and approved by the project steering committee, which is a committee whose tasks include making sure that research participants are protected from harm. It has also been reviewed by the Ethics Review Committee of the HSE South East Region that is funding the study.

### *Certificate of Consent*

This research project is exploring the health needs and experiences of Lesbian, Gay, Bisexual, Transgender and Intersex people (LGBTI) in the South-East region and the responses of health sector personnel and institutions to LGBTI people and their health needs.

I have read the foregoing information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study

Print Name of Participant \_\_\_\_\_

Signature of Participant \_\_\_\_\_ Date \_\_\_\_\_

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands the research process. I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and

to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily. A copy of this Informed Consent Form was provided to the participant.

Print Name of Researcher\_\_\_\_\_

Signature of Researcher\_\_\_\_\_

## Some LGBTI Supports

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**Belongto:** Parliament House, 17 Parliament St., Dublin 2.

Belongto is the national organisation for Lesbian, Gay, Bisexual and Transgender young people aged between 14yrs and 23yrs. It supports a number of LGBT groups in the South East.

- Carlow – Vault Youth Project, Burrin St., Carlow. Tel 0852722379
- Kilkenny – Desart Hall, New St., Kilkenny. Tel 0567761200
- Tipperary – Tipperary Regional Youth Service, Tipp Town, 0879100727
- Waterford – Edmund Rice Youth & Community Centre, Manor St., Waterford.  
Tel 051 309064; email [chillout@wstcys.ie](mailto:chillout@wstcys.ie)
- Wexford – FDYS, Francis St., Wexford. Tel 0539123262; email [david.clark@fdys.ie](mailto:david.clark@fdys.ie)

**GLEN:** Gay & Lesbian Equality Network; Tel 01 6728650; email [info@glen.ie](mailto:info@glen.ie)

**TENI:** Transgender Equality Network Ireland; Tel 01 8733575; email [info@teni.ie](mailto:info@teni.ie).

While the Network has offices based in Dublin it operates & supports the following in the South East:

- Carlow: A support group for parents & families, can be contacted via emailing [transparencigroup@gmail.com](mailto:transparencigroup@gmail.com)
- Waterford: Support group for people who are transgender 0872046748 or 0862147633

**Focus:** The identity trust (supporting transgender & intersex individuals & their families Northern Ireland and Ireland) [www.thefocustrust.com](http://www.thefocustrust.com) email through online contact page.

**Accord Alliance:** Uk based organisation which also includes Ireland in promoting integrated approaches to care of people & families affected by Disorders of Sex Development. [www.accordalliance.org](http://www.accordalliance.org).









**We are all equal in the fact that we are all different. We are all the same  
in the fact that we will never be the same..... C. Joybell.**

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**An Ghíomhaireacht  
um Leanaí agus an Teaghlach**  
*Child and Family Agency*