Quality in Practice Committee

Lesbian, Gay and Bisexual Patients: The Issues for General Practice

Author: Odhrán Allen

Disclaimer and Waiver of Liability

Whilst every effort has been made by the Quality in Practice Committee to ensure the accuracy of the information and material contained in this document, errors or omissions may occur in the content.

This guidance represents the view of the ICGP which was arrived at after careful consideration of the evidence available.

This guide does not however override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of individual patients in consultation with the patient and/or guardian or carer.

Evidence-Based Medicine

Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients.

In this document you will see that evidence and recommendations are graded according to levels of evidence (Level 1 – 5) and grades of recommendations (Grades A-C) respectively. This grading system is an adaptation of the revised Oxford Centre 2011 Levels of Evidence.

Levels of evidence

Level 1: Evidence obtained from systematic review of randomised trials

Level 2: Evidence obtained from at least one randomised trial

Level 3: Evidence obtained from at least one non-randomised controlled cohort/follow-up study

Level 4: Evidence obtained from at least one case-series, case-control or historically controlled study

Level 5: Evidence obtained from mechanism-based reasoning

Grades of recommendations

A Requires at least one randomised controlled trial as part of a body of literature of overall good quality and consistency addressing the specific recommendation. (Evidence levels 1, 2)

B Requires the availability of well-conducted clinical studies but no randomised clinical trials on the topic of recommendation. (Evidence levels 3, 4).

C Requires evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities. Indicates an absence of directly applicable clinical studies of good quality. (Evidence level 5).

ICGP Quality in Practice (QIP) Committee

QIP Committee 2013 (First Update)
Dr. Paul Armstrong (Chair), Dr. Patricia Carmody, Dr. Sheena Finn, Dr. Susan McLaughlin, Dr. Ray O'Connor, Dr. Maria O'Mahony, Dr. Margaret O'Riordan, Dr. Ben Parmeter, Dr. Philip Sheeran Purcell

QIP Committee 2008 (Original Publication)
Dr. Mel Bates, Dr. Michael Boland, Dr. Dermot Folan, Dr. Elizabeth Maxwell, Dr. Ailis ni Riain, Dr Seamus O'Baoighill, Dr. Ray O'Connor, Dr. Margaret O'Riordan (Chair), Dr. Ben Parmeter, Dr Andree Rochfort, Dr. Sheila Rochford

Published: May 2013 Review date: May 2016

Table of Contents

		Page
1	**Introduction**	**1**
1.1	Background	1
1.2	Aims of the Document	1
1.3	Key Points / Recommendations	1
2	**Lesbian, Gay and Bisexual Patients: The Issues for General Practice**	**2**
2.1	Sexual Orientation – concepts and language use	2
2.2	Review of lesbian, gay and bisexual health issues	4
2.3	Good practice in service provision to lesbian, gay and bisexual patients	9
3	**References**	13
4	**Appendices**	
	Appendix 1 Glossary of Key Terms	17
	Appendix 2 Useful resources	18
	Appendix 3 Organisations and Services	19

1 Introduction

1.1 Background

This guide is written for general practitioners to advance their understanding of what they need to know when treating lesbian, gay or bisexual (LGB) people in the primary care setting. In recent years, a number of national policies and reports[1,2,3,4,5,6,7] have highlighted the need for LGB people's health needs to be considered by health professionals and for health care providers to be inclusive of this patient group in their practice.

A recent Irish study[6] found that 45% of participants actively seek out LGB-friendly healthcare professionals because of bad experiences they had in the past and 28% admitted to hiding the fact that they were gay for fear of a negative response from professionals. This guide has been developed to support general practitioners in their efforts to provide an appropriate and accessible primary care service to LGB people in their care.

1.2 Aims of the Document

This guide aims to address the most common questions and information gaps that general practitioners may have in relation to providing primary care to LGB people. To achieve this it covers:

- Sexual orientation concepts and language
- A review of LGB health issues
- Good practice in service provision to LGB patients

This guide also contains a glossary of terms, a services directory, and a list of resources for general practitioners and references.

1.3 Key Points & Recommendations

For the most part LGB people face the same health issues as heterosexual men and women. However, there are a number of specific health issues which general practitioners should be aware of in relation to these patients particularly in the areas of mental health, sexual health and general health and screening. A good understanding of these issues is the foundation of providing an inclusive service to LGB patients.

This guide makes five recommendations for good practice with LGB patients:

- 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

GLEN would like to acknowledge the Irish College of General Practitioners' commitment to promoting the highest standards of primary care for all patients, including LGB patients, and would like to thank Dr. Margaret O' Riordan, Dr. Maria O' Mahony and the Quality in Practice Committee for their support in developing this quick reference guide.

Odhrán Allen
Director of Mental Health
Gay & Lesbian Equality Network

2 Lesbian, Gay & Bisexual Patients: The Issues for General Practice

In order to support general practitioners to respond appropriately and effectively to lesbian, gay and bisexual patients, this section will clarify terms and concepts relevant to lesbian, gay and bisexual people and their sexual orientation.

2.1 Sexual Orientation – concepts and language use

Sexual Orientation

LGB is an acronym used throughout this document to refer to lesbian, gay and bisexual people. Sexual orientation is one of the four components of sexuality and is distinguished by an emotional, romantic, sexual or affectionate attraction to individuals of a particular sex. The three other components of sexuality are biological sex (whether we are born as a male or female), gender identity (the psychological sense of being male or female) and social gender role (the extent to which people conform to what is regarded in our society as feminine and masculine behaviour).[8]

Three sexual orientations are commonly recognised: heterosexual (attraction to individuals of the opposite sex), homosexual (attraction to individuals of one's own sex) and bisexual (attraction to members of both sexes). Many LGB people do not like the use of the term homosexual to describe their sexual orientation because of negative historical associations with this word. Most people prefer the word gay if they are male and lesbian if they are female.

Sexual orientation is different from sexual behaviour because it refers to feelings and individuals' views about who they consider themselves to be. Sexual behaviour is simply how people behave in a sexual situation. Individuals may or may not express their sexual orientation in their behaviours. Being lesbian, gay or bisexual is not a preference and is not chosen. It is integral to a person's life and their identity rather than being a lifestyle. Our sexual orientation reflects a complexity of factors that determine who we are sexually attracted to and who we fall in love with.

Coming Out

Disclosure that one is lesbian, gay or bisexual is often referred to as 'coming out'. However, there is more to coming out than disclosure of one's sexual orientation. Coming out is an important and affirmative developmental process in the lives of LGB people with distinct phases. It first involves accepting one's sexual orientation and then choosing to share this with others as well as developing a positive sexual identity. While some people have negative experiences the majority of LGB people experience great relief when they come out and are met with support and acceptance from family, friends and colleagues. This is reflected in more positive social attitudes. However, coming out can be a time of heightened stress which may result in LGB people presenting to primary care and mental health services.[9]

Inclusive Practice

Inclusive practice applies 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
- Provide an accessible and appropriate service within their scope of practice and refer patients on to specialist or other services where necessary[10]

Since the declassification of homosexuality as a mental health disorder, health professionals have played a leading role in reducing the stigma and prejudice created by the pathologisation of homosexuality.[11] This has largely been achieved through the establishment of a more evidence-

based view of human sexuality, challenging the unscientific basis of anti-gay bias and by establishing standards for inclusive practice such as this guide.

Civil Partnership

The recent passing of the Civil Partnership and Certain Rights and Obligations of Cohabitants Act 2010[12] has introduced the new civil status of Civil Partner which confers broadly similar legal status as a married heterosexual couple. The Equality legislation has now been amended replacing marital status with the new category of civil status which prohibits discrimination on the grounds of being married, in a civil partnership or being single. Therefore, GPs should treat a same-sex civil partnered couple in the same way as they would a married heterosexual couple in the context of their legal rights and entitlements. Unless an LGB patient indicates otherwise, practitioners should recognise their same-sex partners as next-of-kin and involve them as appropriate in the service being provided.

The enactment of the civil partnership legislation provides same-sex couples with many of the same entitlements and will be subject to many of the same legally enforceable duties and obligations as parties to a civil marriage. The provisions of the Civil Partnership Act include protections and obligations across areas such as protection of the couple's shared home, next of kin, residential tenancies, pensions, taxation, maintenance, social welfare, succession, immigration, domestic violence and refugee law.

Despite the very significant progress civil partnerships brings, this legislation does not recognise or protect children in same-sex headed families. This leads to varying levels of uncertainty and vulnerability for gay and lesbian parents and their families. Some LGB people may have had their children in the context of a heterosexual relationship while others have children outside the context of heterosexual relationships and marriage (e.g. fostering, adoption and assisted human reproduction).[13] Unlike heterosexual parents, LGB parents can be subject to prejudice and negative assumptions about their parenting ability because of their sexual orientation.[14] The Irish Association of Social Workers review of international research comparing the development of children with gay and lesbian parents and children with heterosexual parents found no significant developmental differences between the two groups of children in their intelligence, psychological adjustment, social adjustment, popularity with friends, development of social sex role identity or development of sexual orientation. [15]

2.2 Review of lesbian, gay and bisexual health issues

For the most part LGB people face the same health issues as heterosexual men and women. However, 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
- General health and screening

Mental Health

A large body of published empirical research clearly refutes the notion that homosexuality *per se* is indicative of or correlated with psychopathology. However, given the stresses created by stigma, inequality and harassment, LGB people are at a heightened risk of psychological distress related to these experiences.[16,17,18,19,20] This is often referred to as *minority stress,* a term used to describe the mental health consequences of stigmatisation, social exclusion, discrimination and harassment of minority groups such as the LGB population. This concept is particularly useful when explaining mental health issues related to being LGB because it is centred on an understanding that alienation from social structures, norms and institutions can create psychological distress and increase the risk of suicide.[21,22]

While it is not the case that all LGB people are at elevated risk of poor mental health as a consequence of minority stress, research evidence consistently indicates elevated levels of suicidality among the LGB population and elevated levels of mental health risk factors, such as depression, isolation and substance misuse, which increase the likelihood of suicidal behaviour. The findings of this research have been consistently interpreted as resulting from the aforementioned minority stress.

Although social attitudes towards lesbian, gay and bisexual people have changed markedly in recent years, nevertheless LGB people can still experience discrimination, exclusion and harassment, and young people in particular may be affected by homophobic bullying, resulting in psychological distress and feelings of isolation. This is particularly true for people becoming aware of their lesbian, gay or bisexual orientation as a young person, which is increasingly common.[6,7,23,24,25] Depending on their families and where they live, LGB people may have to struggle against prejudice and misinformation about their sexual orientation and often fear being rejected by family and friends if they come out.[8,9] This can be compounded by rural isolation for those living outside of urban areas.[6,7]

Research has also found that coming out and acceptance of one's LGB sexual orientation is strongly related to good psychological adjustment, i.e. the more positive one's lesbian, gay or bisexual identity is, the better one's mental health and the higher one's self-esteem.[7,26]

General practitioners should provide these patients with the opportunity to discuss experiences which have impacted on their mental health and where appropriate screen LGB patients for mental health and suicide risk factors such as psychological distress, depression, anxiety, substance misuse and lack of social support. Referral to mental health services and other support services, such as counselling and psychotherapy, should be considered where appropriate. Patients can also benefit from referral to LGB organisations (See Appendix).

The Supporting LGBT Lives Report

The *Supporting LGBT Lives* study[6] examined LGBT mental health risk and resilience for the first time in an Irish context. A key finding of this study, in which 1,110 people participated, was that LGBT people, and young people in particular, are at risk of suicidal behaviour related to difficulties before and after coming out to their family and in school. Below are the key mental health findings of the study.

Findings on 'Coming Out'

- 12 years of age = the most common age to realise one's LGBT identity
- 17 years of age = the most common age to first disclose one's LGBT identity to anyone
- 5 years = the most common number of years that young LGBT people conceal their identity from others. This 5 year period coincides with puberty, school and a critical period of social, emotion and vocational development.
- The period prior to coming out was particularly stressful because of fear of rejection (from parents in particular) and because of isolation
- The majority came out to a friend or another trusted individual before coming out to their family. Friends and family, but parents in particular, have a crucial role to play in supporting LGBT people as they come out and this support can act as a protective buffer against specific stresses LGBT young people may encounter such as homophobic bullying in school

Findings on Mental Health and Suicidality

- 27% had self-harmed and 85% of these did so more than once
- 16 years was the average age of first self-harming
- 40% of females and 20% of males had self-harmed
- 18% had attempted suicide and 85% saw their first attempt as related to stresses associated with their LGBT identity (e.g. fear of rejection by family or friends)
- 17.5 years was the average age of first suicide attempt
- 24% of females and 15% of males attempted suicide at least once
- Over a third of those aged 25 years and under had thought seriously about ending their lives within the past year and over 50% had done so at some time
- The 3 most common LGBT-specific stresses identified were:
  - fear of rejection when considering coming out;
  - negative school experiences; and
  - experiences of harassment and victimisation

SUMMARY OF LGB MENTAL HEALTH		
Mental Health Issue	**Evidence Grade**	**References**
Minority stress leads to elevated levels of suicidal behaviour and self-harm among LGB people	1	27, 28, 29, 30, 31, 32, 33, 34, 35
LGB people are at increased risk of psychological distress compared to heterosexual people as a result of minority stress	2	18, 21, 27, 36, 37, 38
LGB people are at increased risk for depression, anxiety and substance use disorders as a result of minority stress	1	18, 22, 31, 34, 27
Lack of social support at the time of coming out can increase the risk of suicidal behaviour particularly among younger LGB people	2	8, 32, 33, 39

Sexual Health

As noted above, most LGB patients present to general practitioners with the usual range of health issues seen in general practice and routine recommendations apply.[40,41] However, there are particular sexual health issues that should be considered by general practitioners when assessing these patients. Provision of screening services for sexually-transmitted infections (STI) for all patients at primary care level is under-developed in Ireland.[42] This, coupled with some patients' reluctance to disclose their sexual orientation to general practitioners and/or discuss their sexual behaviour, may result in inadequate sexual health screening and treatment.[40,43] As there are some differences between sexual health issues for gay and bisexual men and lesbian and bisexual women, this section will discuss these separately.

Gay and Bisexual Men's Sexual Health

In discussing gay and bisexual men's sexual health it is important to consider other men who have sex with men but who do not identify as gay or bisexual. MSM is an epidemiological term to encompass all men in this group.[44,45] STI screening and HIV prevention remains central to primary health care for MSM.[40,44,46,47,48]

In recent years there has been a marked increase in the level of HIV and sexually transmitted infection (STI) diagnoses in the MSM group.[49] The sharp increase in HIV diagnosis rates comes at a time when there have been marked decreases in diagnosis rates for heterosexual transmission and transmission through injecting drug use (IDU). In addition there have been outbreaks of syphilis concentrated within the MSM population.[50] Some of the key statistics and emerging trends are:

- 127% increase in MSM HIV diagnoses between 2005 and 2011
- Highest proportion of new HIV diagnoses in 2011 were among MSM (43%)
- The median age of newly diagnosed MSM patients is declining. It was 33 years 2011
- 72% of cases in 2011 were white MSM
- 147% increase in MSM syphilis diagnoses between 2005 and 2011
- MSM accounted for 80% of early case syphilis diagnoses in 2011

HIV diagnoses in Ireland 2004 to 2011								
	2004	2005	2006	2007	2008	2009	2010	2011
MSM	63	60	89	82	102	138	134	136
Heterosexual	179	171	181	161	185	156	123	108
IDU	72	67	59	50	36	30	22	16
Other	44	28	24	98	82	71	52	60
Total	358	326	353	391	405	395	331	320
Syphilis diagnoses in Ireland 2004 to 2011								
	2004	2005	2006	2007	2008	2009	2010	2011
MSM	55	49	64	59	101	138	116	136
Non-MSM	26	13	13	24	21	27	28	28
Unknown	1	4	2	1	3	1	1	7
Total	82	66	79	84	125	166	145	171

There are several direct linkages between patients accessing sexual health services and HIV and STI infection rates. It is in the early stages of HIV that the condition is most highly transmissible.[51] This is because the viral load is very high in the first few months. If the person is unaware of their status then this increases the potential for further transmission of the condition. Early detection of infection at a time of high HIV infectivity will be more advantageous to lowering HIV incidence than later diagnosis and more advantageous in the care and treatment of people living with HIV.[52] Recent research using phylogenetic technology highlighted the occurrence of transmission clusters of new HIV cases, mainly amongst younger men, who have been recently infected and who were unaware of their HIV positive status.[53] Irish data also suggest that re-infection of syphilis is common among MSM and in particular, among those who are HIV positive.[50]

General practitioners should assess the STI-related risks for all male patients, including a routine inquiry about the gender(s) of sexual partners. STI-risk level is influenced by factors including relationship status, HIV status, number of sexual partners and recreational drug use. MSM at higher risk should be screened for STIs including HIV, syphilis, gonorrhoea and chlamydia at least on an annual basis (even in the absence of any symptoms) and immunisation against hepatitis A and B should also be advised.[51] Increasing both the numbers and frequency of MSM accessing sexual health services is a critical part of HIV/STI prevention, both for the individual patients and for reducing onward transmission rates.[58]

HIV-related sexual risk-taking among MSM is more likely when excessive alcohol consumption co-occurs with sexual activity.[54,55,56] Recent research indicates that patients presenting to GPs with symptoms of early-stage HIV infection (e.g. sore throat, fever and rash within two to six weeks of infection) are often misdiagnosed.[57] It should be noted that gay and bisexual men do not encounter more sexual dysfunction than heterosexual men.[37]

GPs have a role in motivating patients to reduce risky sexual behaviours by discussing recent increases in STIs among MSM, explaining the transmission synergy between HIV and other STIs and helping them understand how STIs are contracted.[40,44] Sexual health literature for gay and bisexual men is available from the various LGB organisations (See Appendix 2).

Lesbian and Bisexual Women's Sexual and Gynaecological Health

Lesbian and bisexual women have some specific sexual health needs. Lesbian and bisexual women have been perceived as a low risk group by both lesbians and bisexual women and healthcare providers. As a result, they can run the risk of being largely over-looked in terms of sexually transmitted infections and cervical cytology screening initiatives.[58]

While many lesbian and bisexual women have children, they have significantly fewer pregnancies, miscarriages and abortions than heterosexual women, as well as a lower use of birth control pills. These factors place lesbian women at higher risk of developing ovarian cancer.[59,60,61] Research also indicates that lesbians are less likely than heterosexual women to avail of or be referred for cervical smear tests and mammography or to examine their own breasts.[59,62] General practitioners should encourage lesbian and bisexual women to have regular cervical smear tests and carry out regular breast self-examination.

General practitioners may incorrectly assume that lesbian and bisexual women are at low risk for cervical dysplasia and need less frequent cervical smears than heterosexual women.[63,64,65] Human papillomavirus-associated squamous intraepithelial lesions have occurred in lesbians who have never had sex with men.[66] Recommendations for cervical cancer screening in lesbian and bisexual women, regardless of their sexual history with men, should therefore not differ from screening recommendations for women in general.[64,67,68] It should be noted that lesbian and bisexual women encounter no more sexual dysfunction than heterosexual women.[37]

STI screening is an important component of primary health care for lesbian and bisexual women.[51,69] Lesbian and bisexual women are less likely than heterosexual women to be tested regularly for STIs.[69]

Lesbian and bisexual women who believe themselves to be in a low risk group for HIV and STIs are less likely to practise safer sex than heterosexual women with partners from higher prevalence groups.[70] A significant number of lesbian and bisexual women have a history of having previous or current sexual contact with men.[70] This demonstrates that a woman's sexual identity is not always an accurate predictor of her sexual behaviour or risk level, with women who define themselves as lesbian sometimes engaging in high-risk sexual contact with men. In addition, many STIs can be contracted through other sexual practices more common to lesbian and bisexual women such as oral sex and the use of sex toys. For this reason lesbian and bisexual women should be offered full STI screening.[58]

Educating lesbian and bisexual women about the risks of STIs and dispelling the perception that the transmission of STIs between women is negligible will help patients make more informed decisions. General practitioners should encourage sexually active lesbian and bisexual women to be screened for STIs in the same way as with heterosexual female patients.

Taking a Sexual History

When patients present with symptoms related to sexual activity they may feel embarrassed. Gay men may find it difficult to discuss certain sexual practices such as anal sex[35] while lesbian women report finding it harder to talk to a male doctor.[71,72] General practitioners can help alleviate this

discomfort by taking a patient's sexual history in a sensitive, non-judgemental and comprehensive manner; by emphasising that the discussion is routine and confidential; and by underscoring the importance of needing to know the patient's sexual practices in order to determine risk, appropriate screening and treatment options for optimal care.[40,70]

Each doctor develops their own style of taking a sexual history. There are many helpful publications to assist in developing this skill such as Tomlinson[73] or Lloyd and Bor.[74] It is also worth considering developing a practice guide based on the template from Curtis et al.[75] As a GP, the focus is on sexual behaviour and the risks associated with this. Below are suggested questions for taking a sexual history from patients.

TAKING A SEXUAL HISTORY
Ask Men and Women:
• Are you sexually active? • Do you have sex with men, women or both? • How many partners have you had in the past six months? • What sexual acts do you engage in? (check for oral, vaginal and anal sex) • Are you aware of the times when you should use condoms/dental dam? • What do you do to protect yourself from STI and HIV infection? • Have you any concerns about sexual risks you may have taken? • Do you have any questions about STIs? • Do you have any questions or concerns about sex?
Additional Questions for Women:
• Have you ever been pregnant? • Is there any chance you might be pregnant? • Do you have any questions or concerns about your gynaecological health?

General Health & Screening

Most LGB people will present to GPs with the usual range of health issues seen in general practice and routine health recommendations will apply.[40,41] However, research on health-related behaviours among this group has shown elevated levels of smoking, alcohol consumption and recreational drug use when compared to their heterosexual peers. There is also some evidence that lesbian women may be at more risk of obesity than their heterosexual peers. Little data exists to describe why these elevated levels exist but it's useful for general practitioners to be aware of these findings and to screen LGB patients for tobacco, alcohol and drug use and offer appropriate interventions. The following table summarises the research evidence on LGB health-related behaviours.

SUMMARY OF HEALTH-RELATED BEHAVIOURS AMONG LGB PEOPLE		
Health-Related Behaviour	**Evidence Grade**	**References**
Elevated levels of smoking have been found among LGB people when compared to heterosexual peers	3	37, 76, 77, 78, 79
Elevated levels of alcohol consumption have been found among LGB people when compared to heterosexual peers	3	37, 79, 80, 81, 82
Elevated levels of recreational drug use have been found among LGB people when compared to heterosexual peers	3	38, 81, 82, 83, 84, 85
Lesbian women are more at risk of obesity than their heterosexual peers	4	86, 87, 88

2.3 Good practice in service provision to lesbian, gay and bisexual patients

This section will describe the different ways that general practitioners can improve service provision to ensure that their practice is inclusive of the needs of LGB patients. Given that approximately 8 per cent of the population identify as LGB[89] it follows that a similar percentage of patients attending a given general practice will also be LGB. A recent study of 1,110 LGB people in Ireland[6] which examined amongst other things LGB people's experience of using GP services, found that:

- 76.9% felt GPs need to have more knowledge and sensitivity to LGB issues
- GPs were only aware of respondents LGB identity in 44% of cases
- Only 40% felt respected as an LGB person by their GP
- 28% admitted to hiding the fact that they were gay for fear of a negative reaction

This indicates that a significant number of LGB respondents perceived their GP as not having the knowledge and understanding to provide a service appropriate to their needs. In addition to this, GPs typically presumed that their patients were heterosexual, leading to reluctance on the part of these patients to disclose their sexual orientation and associated health issues or concerns. Lesbian patients were more likely than gay men to report a history of difficulties with GPs, and in particular reported difficulties having their sexual and gynaecological health needs met. Below are five general guidelines to support GPs in providing a service to their LGB patients.

1 Stay informed on LGB health issues

While LGB people are as diverse and varied a group as heterosexual people, these patients can face a number of barriers to receiving quality health care, including:

- Doctors' assumption that patients are heterosexual and/or their hesitancy to inquire about sexual orientation
- Doctors' lack of understanding of LGB health issues
- LGB patients' fear of negative reaction when disclosing their sexual orientation or previous experience of negative responses from practitioners
- LGB patients' discomfort discussing their sexual behaviour[6]

Being aware of the health needs of this patient group (see 2.2) and of the barriers they can face in having their health needs met is key to improving service provision to LGB patients. The *Supporting LGBT Lives*[6] and Visible Lives[7] research reports provide very useful information for practitioners and increasing research publication in peer review journals can also assist GPs in keeping informed on LGB health.

2 Don't assume patients are heterosexual

Any person who uses your service may identify as gay, lesbian, or bisexual or have a history of relationships with members of the same sex. Such patients may or may not have come out. By asking open and inclusive questions when taking a patient's medical history, you are demonstrating to LGB patients and those questioning their sexual orientation that they are welcome to disclose their sexual orientation to you or to discuss issues related to their sexual orientation that may be relevant to their health needs.

Be aware that you already have lesbian, gay and bisexual service users, even if you don't know who they are. Use the terms lesbian, gay and bisexual instead of the term homosexual when talking to patients as most LGB people are more comfortable with this language and may associate the word homosexuality with pathologisation. Using open language and questions is a very good of demonstrating to patients that you are not assuming they are heterosexual.

The following are some examples:

EXAMPLES OF INCLUSIVE QUESTIONS	
Say:	***Instead of:***
Do you have a partner?	Are you married?
Are you in a relationship?	Do you have a girlfriend/ boyfriend?
What is your partner's name?	What is your husband/wife's name?

A situation that may arise is that you think a patient is struggling to disclose their sexual orientation to you. In this instance, as with any sensitive matter, you can encourage them to disclose by providing them with reassurance and showing interest in understanding them. The following are some suggestions for how you may do this:

- Reassure the patient that all personal information disclosed is confidential and that you provide a non-judgemental service
- Explain the importance for you as their general practitioner in understanding issues that are relevant to their health so that you can identify the appropriate treatment or supports that they may need
- Enquire about relationships both current and past
- Try asking indirectly. For example, "In my practice I see a lot of straight and gay people struggling with issues like relationships. Might this be relevant to you?"
- Try asking directly. For example, "Is your partner a man or a woman?" "Are you attracted to men, women or both?" "Have your past relationships been with men, women or both?"

If someone is hinting at an LGB issue, you could try asking something like "*It sounds as if you are questioning your feelings/identity/orientation… has that been on your mind"*. For some patients, using language like 'sexual orientation' or 'gay' may be too threatening. The above question is an example of how you can hint at these without stating them explicitly. You can also explain to the patient the importance for you as their doctor of understanding issues that are relevant to their health so that you can identify the appropriate treatment or supports that they may need.

3 Acknowledge when patients disclose they are lesbian, gay or bisexual

Young LGB people in particular may be questioning their sexual orientation or seeking help in clarifying romantic feelings. Helping young people to feel safe and supported will facilitate their process of self-acceptance and coming out. Just as we know that talking with teens about sex does not increase their sexual behaviour, talking about sexual orientation does not make a teen homosexual or heterosexual

Coming out is an important time in LGB people's lives and asking LGB patients about their experience of coming out demonstrates your understanding that this is an important part of their lives. Clinically, it is potentially also a time of heightened mental health risk, particularly for younger LGB people.[32,33,39] Ways of asking patients about coming out and related life experiences include:

- "Do any of your friends know you are lesbian/gay/bisexual?"
- "Have you come out to anyone in your family?"
- "How have things been for you since you came out?"
- "Have you had any negative experiences since coming out?"
- "Are there lesbian/gay/bisexual people you know that you can talk to? Are they supportive?"
- "Are there any issues you would like to discuss with me related to your sexual orientation?"

While these questions may be relevant to ask, LGB patients' sexual orientation may not be relevant to their use of your service at a particular time. Also remember that some LGB patients may not have fully accepted their sexual orientation or may only be in the very initial stages of coming out. This should be dealt with sensitively by general practitioners. If a young person tells you he or she may be

or is lesbian, gay or bisexual, it is appropriate to respond in a positive and supportive way. Try to avoid the assumption that he or she is going through a phase or is too young to make such a declaration. Provide information that will support and reassure the young person and consider referring them to an LGB organisation for support.

4 Take a gay-affirmative approach and challenge bias

A gay-affirmative approach affirms a lesbian, gay or bisexual identity as an equally positive human experience and expression to heterosexual identity and is increasingly considered the preferred method to work in a culturally competent manner with this patient group.[15]

While anti-gay bias is something that many GPs would not consider to be an issue in their own practice, it is important to acknowledge that where it does exist it results in LGB patients receiving sub-optimal care. Even the most subtle or indirect forms may have an adverse effect on the doctor-patient relationship and the person's willingness to disclose relevant personal information and health concerns to their general practitioner. The characteristics of professional anti-gay bias are:

- Presuming patients are heterosexual
- Pathologising, stereotyping and stigmatising LGB patients
- Failing to empathise with or recognise LGB patients' health concerns
- Failing to appreciate any non-heterosexual form of behaviour, identity, relationship, family or community
- Making unsolicited attempts to change a patient's sexual orientation[11]

Reparative therapy or any attempts to alter LGB patients' sexual orientation should be avoided by general practitioners. All guidance and counselling offered to these patients should be person-centred and gay-affirmative.

General practitioners should also be mindful of bias when treating a child with same-sex parents. If you are seeing a child with same-sex parents, include both parents in the discussion. Health care may be compromised if one of the primary caregivers is excluded. LGB people may wish to be parents and lesbian women may intend future pregnancies and have concerns about their fertility. Questions about planning a family are an important part of their sexual health assessment. Biological parent and non-biological parent are the respective terms to describe the parent who did and didn't conceive the child.

RESPECTING FAMILY DIVERSITY	
Ask:	***Instead of:***
Who is the child's parent or guardian?	Who is the child's mother/ father?
Who is the biological parent?	Who is the real mother/ father?

5 Demonstrate that your practice is LGB-friendly

There are a number of practical things you can do to demonstrate your openness to and inclusion of LGB people in your practice:

- Ensure all relevant paperwork, information leaflets and history taking questions use language which is inclusive of LGB people and their families. For example, on a registration form rather than asking for *Marital Status* ask for *Civil Status.*
- Consider displaying LGB leaflets and/or a poster in your waiting room e.g. leaflets from an LGB service, LGBT helpline poster or specific LGB information (available from your local LGB organisation – see appendix 3).

This practice values the dignity of all patients and does not discriminate on the basis of gender, marital status, family status, age, disability, race, nationality, sexual orientation, or religious belief

Inclusive Practice - Suggested Wording for Waiting Room Poster

- Include LGB people in general health information, e.g. in sexual health leaflet for female patients include information for lesbian and bisexual women, such as the need for smear tests.
- Name LGB people in service ethos statement, e.g. that your service recognises and respects the diversity of patients based on age, gender, sexual orientation, etc.

The doctor-patient relationship is central to the quality of care provided and health outcomes achieved when treating all patients. These five recommendations address the different ways of communicating your openness, respect and understanding to LGB patients which will promote an optimum doctor-patient relationship between you and your LGB patients. By following these recommendations you can ensure you are providing an accessible and appropriate primary care service to LGB patients attending your practice.

References

1. Department of Health & Children (2000). The national health promotion strategy 2000-2005. Dublin: Department of Health & Children.
2. Department of Health & Children (2006). A vision for change - report of the expert group on mental health policy. Dublin: Department of Health & Children.
3. Equality Authority (2002). Implementing Equality for Lesbians, Gays and Bisexuals, Dublin: Equality Authority.
4. Health Service Executive, (2005). Reach out: national strategy for action on suicide prevention. Dublin: Health Service Executive.
5. National Economic & Social Forum, (2003). Equality policies for lesbian, gay and bisexual people: implementation issues. Dublin: National Economic & Social Forum.
6. Mayock, P., Bryan, A., Carr, N. & Kitching, K. (2008). Supporting LGBT lives: a study of mental health and well-being www.glen.ie/attachments/Supporting_LGBT_Lives_Report.PDF
7. Higgins, A., Sharek, D., McCann, E., Sheerin, F., Glacken, M. Breen, M. & McCarron, M. (2011). Visible lives: identifying the experiences and needs of older LGBT people in Ireland www.glen.ie/attachments/Visible_Lives_Report.PDF
8. American Psychological Association (2004). Sexual orientation and homosexuality www.apahelpcenter.org/articles/article.php?id=31
9. Ryan, C. Huebner, D., Diaz, R. & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in White and Latino lesbian, gay and bisexual young people. *Paediatrics, 129*: 346-352.
10. Psychological Society of Ireland (2008). Policy on Equality and Inclusive Practice. www.psihq.ie/EQUALITY%20&%20INCLUSIVE.pdf
11. Group for the Advancement of Psychiatry (2000). Homosexuality and the mental health professions: the impact of bias. New Jersey: Analytic Press.
12. Oireachtas Eireann (2010).Civil partnership and certain rights and obligations of cohabitants Act. www.oireachtas.ie/documents/bills28/acts/2010/a2410.pdf
13. American Psychological Association (2008). Lesbian and gay parenting. Washington, DC: APA.
14. Patterson, J.C. (1992). Children of lesbian and gay parents. Child Development, 63: 1025 – 1042.
15. Irish Association of Social Workers (2011). Lesbian, gay & bisexual people: a guide to good practice for social workers www.glen.ie/attachments/IASW_LGB_Mental_Health_Guide.PDF
16. Bailey, J.M. (1999). Homosexuality and mental illness. *Archives of General Psychiatry,* 56: 883-884.
17. Cochran, S.D. & Mays, V.M. (2006). Estimating prevalence of mental and substance-use disorders among lesbians and gay men from existing national health data, In Omoto, A.M. & Kurtzman, H.S. (Eds.) *Sexual Orientation and Mental Health: Examining Identity and Development in Lesbian, Gay, and Bisexual People* (pp. 143-165). Washington, DC: American Psychological Association.
18. Cochran, S. D., Mays, V. M. & Sullivan, J. G. (2003). Prevalence of mental disorders, psychological distress and mental health services use among lesbian, gay and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology*, 71 (1): 53-61.
19. Friedman, R.C. (1999). Homosexuality, psychopathology and suicidality. *Archives of General Psychiatry,* 56:887-888.
20. Ramafedi, G. (1999). Suicide and sexual orientation: nearing the end of controversy? *Archives of General Psychiatry,* 56: 885-886.
21. Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behaviour,* 36 (1), pp. 38 – 56.
22. Meyer, I. H. (2003). Prejudice, social stress and mental health in lesbian, gay and bisexual populations: conceptual issues and research evidence. *Psychol Bull,* 129(5): 674-697.
23. Minton, S.J., Dahl, T., O'Moore, A.M. & Tuck, D. (2008). An exploratory survey of the experiences of homophobic bullying among lesbian, gay, bisexual and transgendered young people in Ireland. *Irish Educational Studies*, 27(2): 177-191.
24. Pobal, (2006). More than a phase. Dublin: Pobal.
25. YouthNet, (2004). The Shout Report: research into the needs of young people in Northern Ireland who identify as lesbian, gay, bisexual and/or transgendered. Belfast: YouthNet.

26. Herek, G. M., Cogan, J. C., Gillis, J. R., & Glunt, E. K. (1998) Correlates of Internalized Homophobia in a Community Sample of Lesbians and Gay Men. *Journal of the Gay and Lesbian Medical Association*, 2, 17-25.
27. King, M., Semlyen, J., Tai, S., Killaspy, H., Osborn, D., Popelyuk, D. & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry* 2008, 8:70 www.biomedcentral.com/1471-244X/8/70/
28. Balsam, K.F., Beauchaine, T.P., Mickey, R.M. & Rothblum, E.D. (2005). Mental health of lesbian, gay, bisexual and heterosexual siblings: effects of gender, sexual orientation and gender. *Journal of Abnormal Psychology,* 114(3): 471-476.
29. Skegg, K. (2005). Self harm. *Lancet,* 366:1471-83.
30. Paul, J.P., Catania, J., Pollack, L., Moskowitz, J., Cachola, J., Mills, T. et al. (2002). Suicide attempts among gay and bisexual men: lifetime prevalence and antecedents. *American Journal of Public Health,* 92: 1338-1345.
31. Cochran, S.D. & Mays, V.M. (2000). Lifetime prevalence of suicide symptoms and affective disorders among men reporting same-sex sexual partners: results from NHANES III. *American Journal of Public Health,* 90: 573-578.
32. Fergusson, D., Hoorwood, J. & Beautrais, A. (1999). Is sexual orientation related to mental health problems and suicidality in young people? *Archives of General Psychiatry,* 55:876-880.
33. Herrell, R., Goldberg, J., True, W., Ramakrishnan, V., Lyons, M., Elsen, S. & Ming, T. (1999). Sexual orientation and suicidality. *Archives of General Psychiatry,* 56:867- 875.
34. Safren, S.A. & Heimberg, R.G. (1999). Depression, hopelessness, suicidality and related factors in sexual minority and heterosexual adolescents. *Journal of Consulting and Clinical Psychology,* 67: 859-866.
35. Bagley, C. & Tremblay, P. (1997). Suicidal behaviours in homosexual and bisexual males. *Crisis,* 18:24-34.
36. Fergusson, D., Horwood, J., Riddler, E.M. & Beautrais, A. (2005). Sexual orientation and mental health in a birth cohort of young adults. *Psychological Medicine,* 35: 971-981.
37. King, M. & Nazareth, I. (2006). The health of people classified as lesbian, gay and bisexual attending family practitioners in London: a controlled study. *BMC Public Health,* 6:127.
38. King, M., McKeown, E., Warner, J., Ramsay, A., Johnson, K., Cort, C., Wright, L., Blizard, R. & Davidson, O. (2003). Mental health and quality of life of gay men and lesbians in England and Wales: a controlled, cross-sectional study. *British Journal of Psychiatry*, 183: 552 – 558.
39. Hegna, K. & Wichstrøm, L. (2007). Suicide attempts among Norwegian gay, lesbian and bisexual youths. *Acta Sociologica,* 50(1): 21-37.
40. Makadon, H.J., Mayer, K.H. & Garofalo, R. (2006). Optimising care for men who have sex with men. *JAMA,* 296: 2362-2365.
41. Lee, R. (2000). Healthcare problems of lesbian, gay, bisexual and transgender patients. *West J Med,* 172: 403-408.
42. Health Service Executive, (2005). The sexual health strategy. Dublin: Health Service Executive Eastern Region.
43. Keogh, P., Weatherburn, P., Henderson, L., Reid, D., Dodds, C. & Hickson, F. (2004). Doctoring gay men: exploring the contribution of general practice. London: Sigma Research.
44. Knight, D. (2004). Health care screening for men who have sex with men. *American Family Physician*, 69(9): 2149-2156.
45. Fenton, K.A. & Imrie, J. (2005). Increasing rates of sexually transmitted diseases in homosexual men in Western Europe and the United States: why? *Infect Dis Clin North Am.* 19: 311-331.
46. Carroll, D., Foley, B., Hickson, F., O'Connor, J., Quinlan, M., Sheehan, B., Waters, R. & Weatherburn, P. (eds.) (2002) *Vital Statistics - findings from the All Ireland Gay Sex Survey, 2000,* Dublin: Gay Health Network.
47. Devine, P., Hickson, F., McNamee, H. & Quinlan, M. (2006) *Real Lives - Findings from the all-Ireland internet gay sex survey 2003 and 2004.* Dublin: GMHP.
48. United Nations, (2006). UNAIDS www.unaids.org/en/Policies/Affected_communities/MSM.asp
49. Health Protection Surveillance Centre (2012). New Diagnoses of HIV and AIDS in Ireland 2000 to 2011 www.hpsc.ie/hpsc/A-Z/HIVSTIs/HIVandAIDS/SurveillanceReports/File,13070,en.pdf
50. Health Protection Surveillance Centre (2010). Epidemiology of Syphilis in Ireland 2000 to 2008. http://bit.ly/SyphilisinIreland
51. Centers for Disease Control and Prevention, (2010). Sexually transmitted diseases treatment guidelines www.cdc.gov/std/treatment/2010/specialpops.htm

52. Chalmet, K., Staelens, D., Blot, S., Dinakis, S., Pelgrom, J., Plum, J., Vogelaers, D., Vandekerckhove, L. & Verhofstede, C. (2010). Epidemiological study of phylogenetic transmission clusters in a local HIV-1 epidemic reveals distinct differences between subtype B and non-B infections. *BMC Infectious Diseases*, 10:262
53. Pao, D., Fisher, M., Hué, S., Dean, G., Murphy, G., Cane, P., Sabin, C. & Pillay, D. (2005). Transmission of HIV-1 during primary infection: relationship to sexual risk and sexually transmitted infections. *AIDS,* Jan 3; 19(1): 85-90.
54. Knowlton, R., McCusker, J., Stoddard, A., Zapka, J. & Mayer, K. (1994). The use of the CAGE questionnaire in a cohort of homosexually active men. *Journal of Studies on Alcohol,* 55: 692-694.
55. Seage, G.R., Mayer, K.H., Wold, C., Lenderking, W.R., Goldstein, R., Cai, B. et al. (1998). The social context of drinking, drug use and unsafe sex in the Boston Young Men Study. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology,* 17: 368-375.
56. Stall, R., McKusick, L., Wiley, J., Coates, T.J. & Ostrow, D.G. (1986). Alcohol and drug use during sexual activity and compliance with safe sex guidelines for AIDS: The AIDS Behavioural Research Project. *Health Education Quarterly,* 13: 359-371.
57. National AIDS Trust, (2008). Primary HIV infection: a policy report from the national AIDS trust www.nat.org.uk/Media%20library/Files/PDF%20documents/primary%20infection%20final.pdf
58. Gay HIV Strategies (2012). Lesbian, gay and bisexual sexual health: a good practice guide for health professionals www.glen.ie/attachments/LGB_sexual_health_guide.PDF
59. Cochran SD et al. (2001) *Cancer-related risk indicators and preventive screening behaviours among lesbians and bisexual women*. American Journal of Public Health 2001 Apr 91 591-597.
60. Dibble, S., Roberts, S.A., Robertson, P.A., & Paul, S.M. (2002). Risk factors for ovarian cancer: lesbian and heterosexual women. *Oncology Nursing Forum,* 29(1): 373-373.
61. Solarz, A.L. (1993). Lesbian health: current assessment and directions for the future, in Stern P.N. (Ed.) *Lesbian Health: What Are the Issues?* Washington, DC: Taylor and Francis.
62. Buenting, J.A. (1993). Health life-choices of lesbian and heterosexual women. In Stern P.N. (Ed.) *Lesbian Health: What Are the Issues?* Washington, DC: Taylor and Francis.
63. Diamant, A.L., Schuster, M.A. & Lever, J. (2000). Receipt of preventive health care services by lesbians. *Am J Prev Med*, 19:141-148.
64. Matthews, A.K., Brandenburg, D.L., Johnson, T.P., & Hughes, TL. (2004). Correlates of underutilization of gynaecological cancer screening among lesbian and heterosexual women. *Prev Med,* 38:105-113.
65. White, J. & Levinson, W. (1993). Primary care of lesbian patients. *J Gen Intern Med*, 8:41-47.
66. Marrazzo, J.M., Koutsky, L.A., Kiviat, N.B., Kuypers, J.M. & Stine, K. (2001). Papanicolaou test screening and prevalence of genital human papillomavirus among women who have sex with women. *Am J Public Health*, 91:947-952.
67. O'Hanlan, K.A. & Crum, C.P. (1996). Human papillomavirus-associated cervical intraepithelial neoplasia following lesbian sex. *Obst Gynaecol,* 88(4):702-703.
68. Marrazzo, J.M., Koutsky, L.A., Stine, K.L., Kuypers, J.M., Grubert, T.A., Galloway, D.A., et al. (1998). Genital human papillomavirus infection in women who have sex with women. *J Infect Dis,* 178:1604-1609.
69. Bauer G.R. & Welles S.L. (2001). Beyond assumptions of negligible risk: sexually transmitted diseases and women who have sex with women. *Am J Public Health*, 91:1282-1286.
70. Bailey, J., Farquhar, C., Owen, C. & Whittaker, C. (2003). Sexual behaviour of lesbians and bisexual women. *Sex Transm Infect*; 79:147-150.
71. LINC, (2006) LINC lesbian health research: a study of the general health of the lesbian community in Cork. Cork: LINC.
72. Quiery, M. (2002). A mighty silence: a report on the needs of lesbian and bisexual women in Northern Ireland. Belfast: Lesbian Advocacy Services Initiative
73. Tomlinson, J. (1999). Taking a sexual history. In: *ABC of Sexual Health*. London: BMJ Books.
74. Lloyd, M. & Bor, R. (1996). Taking a sexual history. In: *Communication Skills for Medicine.* New York: Churchill Livingstone.
75. Curtis, H., Hoolaghan, T. & Jewitt, C. (1995). Sexual health promotion in general practice. Oxford: Radcliffe Medical Press.
76. Greenwood, G. L., Paul, J., Pollack, L., Binson, D., Catania, J., Chang, J., Humfleet, G. & Stall, R. (2005). Tobacco use and cessation among a household-based sample of US urban men who have sex with men. *American Journal of Public Health*, 95(1): 145 – 151.

77. Ryan, H. Wortley, P., Easton, A., Pederson, L. & Greenwood, G. (2001). Smoking among lesbians, gays and bisexuals: a review of the literature. *American Journal of Preventative Medicine,* 21(2): 142-149.
78. Tang, H., Greenwood, G., Cowling, D., Lloyd, J., Roeseler, A., Bal, D., (2004) Cigarette smoking among lesbians, gays and bisexuals. *Cancer Causes and Controls*, 15(8): 797 – 803.
79. Valanis, B., Bowen, D., Bassford, T., Whitlock, E., Charney, P. & Carter, R., (2000) Sexual orientation and health. *Arch Fam Med*, 9: 843 – 853.
80. Cochran, S.D., Keenan, C., Schober, C. & Mays, V.M. (2000). Estimates of alcohol use and clinical treatment needs among homosexually active men and women in the U.S. population. *Journal of Consulting and Clinical Psychology,* 68(6): 1062-1071.
81. Skinner, W. & Otis, M. (1996). Drug and alcohol use among lesbian and gay people in a southern US sample: epidemiological, comparative and methodological findings from the trilogy project. *Journal of Homosexuality,* 30(3): 59-92.
82. Stall, R., Paul, J., Greenwood, G., Pollack, L., Bein, E., Corsby, G.M., Mills, T., Binson, D., Coates, T. & Catania, J. (2001). Alcohol use, drug use and alcohol-related problems among men who have sex with men. *Addiction,* 96(11): 1589 – 1601.
83. Cochran, S.D., Ackerman, D., Mays, V.M. & Ross, M.W. (2004). Prevalence of non-medical drug use and dependence among homosexually active men and women in U.S. population. *Addiction,* 99(8): 989-998.
84. Skinner, W. (1994). The prevalence and demographic predictors of illicit and licit drug use among lesbians and gay men. *American Journal of Public Health,* 84:1307-1310.
85. Sarma, K. (2007). Drug use amongst lesbian, gay, bisexual & transgender young adults in Ireland. *Journal of Preventative Medicine*, 21(2): 142- 149.
86. Boehmer, U., Bowen, D. J. & Bauer, G. R. (2007). Overweight and obesity in sexual-minority women: evidence from population-based data. *American Journal of Public Health,* 97(6): 1134-1140.
87. Mays, V.M., Yancey, A.K., Cochran, S.D., Weber, M. & Fielding J.E. (2002). Heterogeneity of health disparities among African American, Hispanic, and Asian American women: unrecognized influences of sexual orientation. *Am J Public Health,* 92:632–639.
88. Yancey, A.K., Cochran, S.D., Corliss, H.L. & Mays, V.M. (2003). Correlates of overweight and obesity among lesbian and bisexual women. *Preventative Medicine*, 36(6): 676-683.
89. Headstrong (2012). My world survey: national study of youth mental health. www.headstrong.ie/sites/default/files/My%20World%20Survey%202012%20Online.pdf
90. American Psychological Association (2009). Report of the task force on appropriate therapeutic responses to sexual orientation. Washington, DC: American Psychological Association www.glen.ie/attachments/APA_Therapeutic_Responses.PDF

APPENDIX 1: Glossary of Key Terms

SEXUAL ORIENTATION is an enduring pattern of emotional, romantic, and/or sexual attractions to men, women, or both sexes. Sexual orientation also refers to a person's sense of identity based on those attractions, related behaviours, and membership of a community of others who share those attractions.

GAY A gay person is a man or woman who is romantically, sexually and/or emotionally attracted to people of the same sex. Most gay men prefer to be called gay rather than homosexual. Most gay women prefer to be identified as lesbian rather than gay or homosexual.

COMING OUT is the term used by lesbian, gay and bisexual people to describe their experience of self discovery, self-acceptance, openness and honesty about their sexual orientation and their decision to disclose, i.e. to share this with others when and how they choose.

LGBT is an acronym for lesbian, gay, bisexual and transgender.

TRANSGENDER is an umbrella term used to describe people whose gender identity (internal feeling of being male or female) and/or their outer gender expression, differs from that usually associated with their birth sex. Not everyone whose feelings, appearance or behaviour is gender-atypical will identify as a transgender person. Many transgender people live part-time or full-time in another gender. Transgender people can identify as transsexual, transvestite or another gender identity. See www.teni.ie for more information.

HOMOPHOBIA refers to fear of or prejudice and discrimination against lesbian, gay and bisexual people. It is also the dislike of same-sex attraction and love or the hatred of people who have those feelings. While homophobic comments or attitudes are often unintentional, they cause hurt and offence to LGB people.

INTERNALISED HOMOPHOBIA is the fear and dislike of one's sexual orientation that occurs in some lesbian, gay and bisexual people. Having been exposed to homophobia growing up, some LGB people internalise this stigmatisation of homosexuality resulting in feelings of fear, shame, guilt and low self-esteem. LGB people who experience internalised homophobia can overcome it by being supported to accept their sexual orientation and to build a positive LGB identity.

APPENDIX 2: Useful Resources for General Practitioners

Information for GPs

Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients
Gay & Lesbian Medical Association, 2006
www.qahc.org.au/files/shared/docs/GLMA_guide.pdf

10 Things Lesbian Women Should Discuss with their Doctor
Gay & Lesbian Medical Association, 2012
www.glma.org/_data/n_0001/resources/live/Top%2010%20forlesbians.pdf

10 Things Gay Men Should Discuss with their Doctor
Gay & Lesbian Medical Association, 2012
www.glma.org/_data/n_0001/resources/live/top%2010%20forGayMen.pdf

Standards of Care for the Health of Transsexual and Transgender People
World Professional Association for Transgender Health, 2011
www.wpath.org/publications_standards.cfm

Appropriate Therapeutic Responses to Sexual Orientation
American Psychological Association, 2009
www.apa.org/pi/lgbt/resources/therapeutic-response.pdf

Information for Patients & Families

Answers to Your Questions for a Better Understanding of Sexual Orientation
American Psychological Association, 2008
www.apa.org/topics/sexuality/sorientation.pdf

Answers to Your Questions about Transgender People and Gender Identity
American Psychological Association, 2011
www.apa.org/topics/sexuality/transgender.pdf

Look After Yourself, Look After Your Mental Health: Information for LGBT People
National Office for Suicide Prevention, 2010
www.glen.ie/attachments/NOSP_Mental_Health_Guide_for_LGBT_People.PDF

Coping with the Death of Your Same-Sex Partner
Irish Hospice Foundation & GLEN, 2010
www.glen.ie/attachments/Same-Sex_Partner_Bereavement_Leaflet.PDF

Irish Research & Reports

Supporting LGBT Lives: A Study of the Mental Health and Well-Being of LGBT People
Mayock, Bryan, Carr & Kitching, 2009
www.glen.ie/attachments/Supporting_LGBT_Lives_Report.PDF

Visible Lives: Identifying the Experiences and Needs of Older LGBT People in Ireland
Higgins, Sharek, McCann, Sheerin, Glacken, Breen & McCarron, 2011
www.glen.ie/attachments/Visible_Lives_Report.PDF

LGBT Health: Towards Meeting the Healthcare Needs of LGBT People
Health Service Executive, 2009
www.glen.ie/attachments/HSE_LGBT_Health_Report.PDF

APPENDIX 3: Organisations and Services

National LGBT Helpline
1890 929 539
www.lgbt.ie

LGBT Mental Health Website
www.lgbtmentalhealth.ie

Gay & Lesbian Equality Network
01-6728650
www.glen.ie

BeLonG To LGBT Youth Service
01-6706223
info@belongto.org

Transgender Equality Network Ireland
01-6334687
www.teni.ie

LINC (Lesbian Service)
021-4808600
www.linc.ie

Dundalk Outcomers
042-9329816
www.outcomers.org

Gay Men's Health Service
01-8734952
gmhpoutreach@eircom.net

The Other Place (Cork)
021-4278470
www.theotherplacecork.com

Outhouse Community Centre Dublin
01-8734932
www.outhouse.ie

LOOK (Parent Support)
087-2537699
www.lovingouroutkids.org

Greenbow Deaf LGBT Group
086 367 1375
www.greenbowdeaf.com

Up-to-date information and contact details for these and other services are available at www.lgbt.ie