Public Health Devon

Devon County Council

Lesbian, Gay, Bisexual & Transgender (LGB&T) Health Needs Assessment

August 2014

Contents

Foreword

Although good progress has been made in the field of equal rights for lesbian, gay, bisexual and transgender people in the UK, there are still many people who experience discrimination across the life-course as a result of their sexual orientation or gender identity. The public sector, including NHS and local authority partners, has a statutory duty to improve the population's health and reduce health inequalities. It also has a duty to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations between those who share a protected characteristic and those who do not.

This health needs assessment contributes to both these duties by highlighting the needs of the lesbian, gay, bisexual and transgender population in Devon. By building a better understanding of these needs as part of the Joint Strategic Needs Assessment, public sector organisations can start to reduce the health inequalities experienced by sexual and gender minorities.

Challenges in undertaking a health needs assessment based on sexual orientation and gender identity include the paucity of data available from routine sources. This is particularly significant for trans people. It is also a challenge, as with any protected characteristic, to summarise the main areas of health inequality across a very diverse population which cross-cuts the whole of society. This health needs assessment does not present a final picture, but provides a foundation to build on and undertake future work to improve the health and wellbeing of lesbian, gay, bisexual and transgender people in Devon.

1. Introduction

Purpose of a Health Needs Assessment

1.1 Cavanagh & Chadwick (2005) describe a health needs assessment (HNA) as a 'systematic method of reviewing the health needs and issues facing a given population leading to agreed priorities and resource allocation that will improve health and reduce inequalities.' Need can also be defined as having capacity to benefit.

1.2 In 2013-14, Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) was one of 20 health organisations taking part in Stonewall's Health Champions programme (www.healthylives.stonewall.org.uk). This Department of Health funded initiative aims to improve healthcare services for lesbian, gay, and bisexual people. Stonewall is a national charity for lesbian, gay and bisexual people. This health needs assessment contributes to the NEW Devon Clinical Commissioning Group Health Champions Action Plan.

Aim

1.3 The health needs assessment will seek to increase the healthy life expectancy of the lesbian, gay, bisexual and transgender (LGB&T) population in Devon and reduce the health inequalities that exist between these groups and the wider population. It is the first step in a process of ongoing work and development.

Objectives

1.4 The objectives of this Health Needs Assessment are:

- To describe the current health needs of LGB&T people in Devon.
- To assess the provision of, access to and utilisation of healthcare by these groups, identifying barriers and opportunities for improvement.
- To put forward considerations for further work to improve the health, and access to healthcare of LGB&T people in Devon.
- Identify opportunities to improve what is/is not known about the health needs of LGB&T people.

Definitions

1.5 The following definitions are provided for the purpose of this health needs assessment as guidance only. People self-identify using many other terms across the spectrum of sexual orientation and gender identity and language in this area is constantly evolving.[1]

- *Lesbian:* a woman who has an emotional and/or sexual attraction to other women.

[1] For further information: http://www.gires.org.uk/glossary.php#x1-90002.

- *Gay:* “gay” most commonly refers to men who have an emotional and/or sexual attraction to men. Some lesbians identify as “gay” or “gay women”.

- *Bisexual:* person who has an emotional and/or sexual attraction toward more than one gender.

- *Questioning:* usually refers to young people who have not yet identified their gender identity or sexual orientation.

- *Sex:* refers to biological development (male/female/intersex).

- *Gender identity:* the internal perception of an individual’s gender and where they identify (whether in accordance with the traditional gender binary or somewhere else along the gender continuum)

- *Gender dysphoria:* refers to the psychological distress caused by a discrepancy between a person’s gender identity and the sex assigned to them at birth.

- *Transgender/trans:* an umbrella term for people whose gender identity and/or gender expression diverges in some way from the sex they were assigned at birth. This includes those who have fully transitioned (medically and/or socially), some of whom will have a Gender Recognition Certificate (GRC) as well as those who do temporarily or permanently cross conventional gender boundaries, whether in physiology, clothing or other forms of expression.

- *Trans Man/FTM:* a person who was assigned female at birth but has a male gender identity and proposes to transition, is transitioning or has transitioned to live as a man. Where someone has fully transitioned, they may no longer wish to identify as ‘trans’ but simply as ‘man’.

- *Trans Woman/MTF:* a person who was assigned male at birth but has a female gender identity and proposes to transition, is transitioning or has transitioned to live as a woman. Where someone has fully transitioned, they may no longer wish to identify as ‘trans’ but simply as ‘woman’.

Scope

1.6 The scope of this health needs assessment covers lesbian, gay, bisexual *and* transgender people, while recognising that sexual orientation and gender identity are distinct characteristics. LGB&T people have often been grouped under the same umbrella term due to common links across issues such as discrimination and harassment. The scoping group considered that it would be valuable to consider the needs of LGB&T people in one report, while recognising each group’s distinct needs and disaggregating data wherever possible.

1.7 ‘The Laurels’ in Exeter is one of seven gender reassignment clinics in the UK providing services for adults who wish to transition. Gender identity development (GID) services for under 18s are provided by the Tavistock and Portman NHS Foundation Trust in London. Although trans people’s experiences of gender reassignment services are an important part of understanding their health needs, a review of the pathway and provision will

be outside the scope of the report. The report will instead focus on whether trans people are at a disadvantage compared with the non-trans population across health outcomes and their experience of mainstream health services. This encompasses the population on the wider trans spectrum – those who cross-dress or transition part-time or those of a non-specific gender identity, not just those who present for gender reassignment services.

1.8 The Health Needs Assessment takes a Devon-wide approach (the area covered by Devon, Torbay and Plymouth local authorities), taking into account differences between the areas where the data is available.

Background/Context

1.9 The Public Sector Equality Duty, which came into force in 2011 as a key part of the Equality Act 2010, places an obligation on all public sector organisations to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations between those who share a protected characteristic and those who do not. Sexual orientation and gender reassignment are protected characteristics under the Equality Act. Section 29 of the Equality Act also prohibits discrimination in the provision of services on the basis of sexual orientation or gender identity, including providing a service which is less accessible or of lesser quality than is provided to those who do not share the relevant protected characteristic.

1.10 Sexual orientation and gender identity have often been overlooked as a significant factor in health outcomes, and as a result there is a lack of data in this area. Sexual orientation and gender identity are not routinely monitored in service provision and health research.

1.11 A *Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document* has recently been published, which provides a useful overview of the current evidence base, set against the structure of the Public Health Outcomes Framework and the four domains of public health (Williams 2013).

1.12 A number of other needs assessments that have already been undertaken in Devon are relevant to this topic, including Mental Health, Substance Misuse, Sexual Health, and Domestic Violence, available at www.devonhealthandwellbeing.org.uk.

1.13 Meyer (2001) has suggested that LGB&T health issues can be categorised in three areas (see table 1):

Table 1: Framework for categorisation of LGB&T health issues (Meyer 2001)

	Area of Need	Examples
1	Areas in which LGB&T people are at an increased risk for disease because of unique exposures.	Sexual health, mental health problems related to 'minority stress' as a result of prejudice and discrimination.
2	Areas in which they have higher prevalence of diseases or problems that are not caused by unique exposures.	Smoking, alcohol and drug use.
3	Areas in which they are not at increased risk for disease but which nevertheless require specialised culturally competent approaches.	Access to health and social care, experience and perception of services.

1.14 This assessment categorises health needs according to these three areas. However, there is an overlap between areas. For example, mental health has both a causal and consequential relationship with physical health. Low self-esteem due to bullying could lead to an increase in harmful risk-taking behaviour; or the long-term stress of living with HIV may lead to poor mental health. There are strong associations between mental health problems, smoking, drug and alcohol use, and these problems often present concurrently (Devon Mental Health Needs Assessment 2013, Devon Substance Misuse Needs Assessment 2012).

2. Methods

2.1 This is primarily a normative health needs assessment where needs are defined by professionals and stakeholders from the LGB&T community and are relative to what can be provided through current health and social care infrastructures (Naidoo & Wills 2010).

2.2 An epidemiological approach to understanding the size and nature of the need was limited by the paucity of routinely available data in this area.

2.3 A table-top literature search was undertaken to review the secondary data on LGB&T health needs, using NHS Evidence and PubMED. Grey literature was searched online using a 'snowball' approach, to aid understanding of the policy context.

2.4 The headline results from the literature search were presented to local stakeholders at a half-day workshop. Stakeholders were asked to discuss their local experience in relation to these results, and then individually choose their top three priorities. They were also asked to identify if they thought any health needs had been overlooked, and what could be done to improve the health of the local LGB&T population. The discussion was collated into themes (section 3.43).

2.5 The Intercom Trust, a charity which provides support, advocacy and resources for LGB&T people in the South West, launched the 'Big LGBT

Community Survey' in summer 2013 (independently of this health needs assessment). Though they do not represent the full experience of all LGB&T individuals in Devon, results are included to add insight into local LGB&T experiences. The Intercom Trust also has anonymised datasets which give insight into the problems being experienced by their Help, Support and Advocacy service-users (for example prejudice, discrimination, mental health problems, harassment, relationship difficulties). Equality South West conducted a survey of 326 LGB&T people in 2012 (*Pride, Progress and Transformation: Dimensions of inequality for lesbian, gay, bisexual and transgender people in the South West*, Equality South West 2012). Although Equality South West ceased trading in October 2013, quotes from this report are included as they contribute understanding on a number of topics.

Caveats/Limitations

2.6 The data is limited by the variation in monitoring tools and definitions. For example, there are three common ways to describe sexual orientation: by identity, by desire/attraction, and by behaviour. Most studies find that sexual attraction gives the largest capture, followed by sexual behaviour; sexual identity being the smallest group (Aspinall 2009). The Office for National Statistics has published a paper that discusses the development of questions to monitor sexual orientation. Testing showed that sexual identity was the dimension of sexual orientation that was perceived as the most acceptable by respondents, and the most relevant in relation to equality legislation, since it is closely related to experiences of disadvantage and discrimination (Haseldon 2009). Self-identified sexual identity is the most appropriate and reliable method of measuring the lesbian, gay and bisexual population in the context of equality monitoring and routine data collection.

2.7 Accurately measuring the size and needs of the trans population in the UK is even more complex. The 'trans' umbrella term encompasses a number of subgroups, including those who cross-dress (part-time or full-time), through to those who have medically and/or socially transitioned, who may define themselves as transsexual, transgender or simply 'male' or 'female'. Many people will no longer regard themselves as 'trans' once their gender reassignment has taken place, or have fluid ways of describing their gender identity. Surveys have often wrongly included 'trans' as a response option under questions on sexual orientation, rather than under gender identity questions (Office for National Statistics 2009). There are stringent privacy duties in place which make it illegal to reveal a trans person's status without their permission (1999 Data Protection Act, 2004 Gender Recognition Act).

2.8 The 2011 Census did not measure sexual identity or gender identity, because of concerns over sensitivity and accuracy. There were concerns that underreporting would have a counterproductive effect on policymaking and service planning. These remain the only two protected characteristics not to be measured by the Census. Underreporting due to stigma and discrimination is an ongoing issue for the collection of data on sexual orientation and gender identity.

2.9 The Public Health Outcomes Framework does not present data by sexual orientation or gender identity. The NHS Outcomes Framework provides equality data and is working on disaggregation of data by equality strand. Some indicators are available by sexual orientation through the GP Practice

Survey, but none are available for trans people, either because the data are not collected or are not robust enough to be published.

2.10 Stonewall have undertaken a number of large surveys of the UK LGB population. 'The Gay and Bisexual Men's Health Survey (Guasp 2012) received 6,861 responses, making it the largest survey of gay and bisexual men's health needs in the world.[2] 'Prescription for Change' (Hunt 2008) received 6,178 responses, making it the largest survey of lesbian and bisexual health needs in Europe. This health needs assessment draws on the results from these surveys, along with other Stonewall surveys, though there are some limitations to be aware of. There are no comparator groups of heterosexual respondents (the exception is Guasp 2010 on older LGB people). The surveys present their results alongside general population statistics where possible to draw comparison, but the sources for these references are not always available. There are local samples available for Devon, Plymouth and Torbay but they are too small to show any statistical significance. The results for Devon (as the largest sample) have been included in brackets for interest but only the national results are statistically meaningful.

3. Results

Population Profile

3.1 The Integrated Household Survey introduced a sexual identity question in 2009. The 2011-12 survey found that 1.5% of adults in the UK identified themselves as gay, lesbian or bisexual (table 2). Prevalence differed by age; 2.7% of 16 to 24 year olds in the UK identified themselves as gay, lesbian or bisexual compared with 0.4% of 65 year olds and over.

Table 2: Sexual identity by gender[3] (percentage of the population), Integrated Household Survey 2011-12

	Men	Women	Total
Heterosexual	93.6	94.2	93.9
Gay/lesbian	1.5	0.7	1.1
Bisexual	0.3	0.5	0.4
Other	0.4	0.3	0.3
Don't know / refusal	3.5	3.8	3.6
No response	0.7	0.6	0.6

3.1.1 The Integrated Household Survey results can be applied as a crude estimate for the Devon population (Table 3). The estimate for the total LGB population of Devon is 14,281. This is likely to be an underestimation of the true population as the results are dependent on respondents feeling ready or able to openly self-identity as LGB in response to the survey.

[2] Larger surveys have taken place focusing on gay men's sexual health needs. The Community HIV and AIDS Prevention Strategy (CHAPS) led the Gay Men's Sex Survey (GMSS) which ran between 1993 and 2012 had sample sizes of up to 20,000 participants

[3] The Integrated Household Survey only allows for 'male' or 'female' in its question on gender. Gender identity is not monitored.

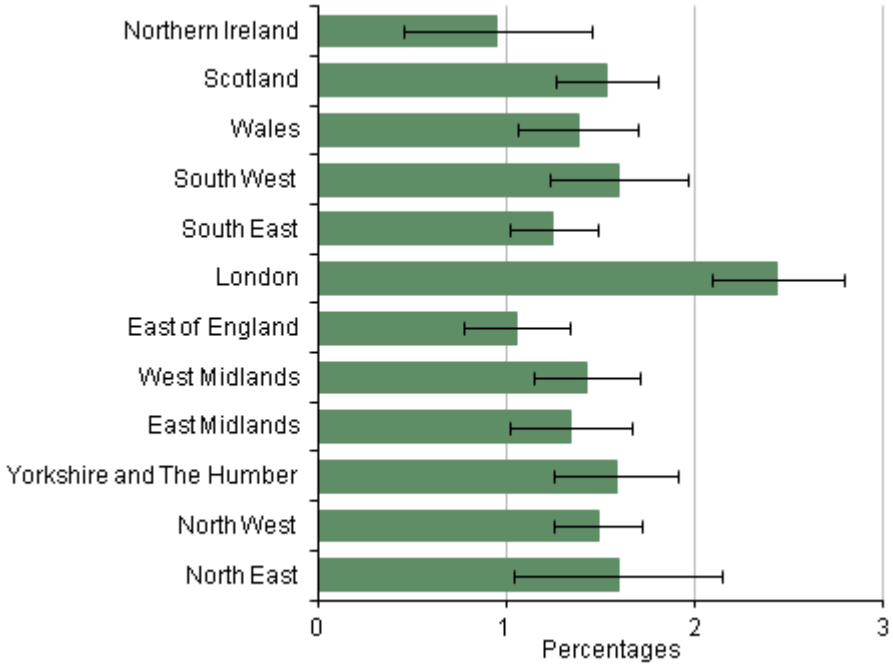
Table 3: Sexual identity by gender – population aged 16+ in Devon, Plymouth and Torbay combined

	Men	Women	Total*
Heterosexual	429,811	464,312	894,022
Gay/lesbian	6,888	3,450	10,473
Bisexual	1,378	2,465	3,808
Other	1,837	1,479	2,856
Don't know / refusal	16,072	18,730	34,276
No response	3,214	2,957	5,713

*Total is calculated from percentages in table 2 rather than the sum of men+women estimates in table 3.

3.1.2 Figure 1 shows that the South West does not have a significantly different proportion of LGB respondents than any other region except London.

Figure 1: Sexual identity by region (lesbian, gay and bisexual respondents) Source: Integrated Household Survey 2011-12



3.1.3 The GP Patient Survey July 2012 – March 2013 found that 2% (n=333) of respondents in the NEW Devon Clinical Commissioning Group area identified themselves as gay, lesbian or bisexual, and 2% (n=99) of respondents in the South Devon and Torbay Clinical Commissioning area.

3.1.4 The National Sexual Attitudes and Lifestyle Survey (NATSAL 3, Mercer 2013) recorded a slightly higher proportion, with 2.8% of the male sample and 2.7% of the female sample identifying as lesbian, gay, bisexual or 'other' (table 4).

Table 4: Sexual identity of respondents to the National Sexual Attitudes and Lifestyle Survey

Male							
Age	**16-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**All age groups**
Heterosexual/ straight	96.7	96.5	97.7	96.7	96.8	99	97.1
Gay/lesbian	1.5	2.4	1.3	1.8	1.3	0.2	1.5
Bisexual	1.5	0.7	0.9	1.2	1.3	0.5	1
Other	0.3	0.5	0.1	0.3	0.6	0.3	0.3
Female							
	16-24	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**All age groups**
Heterosexual/ straight	95.9	96.6	96.8	97.4	99.1	99.4	97.3
Gay/lesbian	1.2	1.2	1.5	1.1	0.8	0.1	1
Bisexual	2.5	2	1.4	1	0	0.3	1.4
Other	0.5	0.2	0.3	0.5	0.1	0.3	0.3

3.1.5 A frequently cited estimate is that 5-7% of the population are LGB (Department of Trade and Industry 2004), leading to an estimated population of approximately 47,605 - 66,647 LGB people in Devon, Plymouth and Torbay.[4]

3.1.6 A widely cited estimate is that the prevalence of gender dysphoria in the population is eight per 100,000 population aged over 16 (Van Kesteren 1996, Wilson 1999). The Gender Identity Research and Education Society (GIRES) recommends that estimate should be revised upwards to 20 per 100,000 population, based on the rapid growth in the number of people who are presenting for treatment in the UK (Reed 2009). This equates to 10,000 transsexuals living in the UK, of whom 6,000 have undergone full transition.

3.1.7 The incidence of gender dysphoria (based on 1,500 new cases presenting for treatment in 2008) is 3.0 per 100,000 population aged 16 and over per annum. The median age of presentation is 42 (Reed 2009).

3.1.8 There is an uneven geographic distribution of gender dysphoria prevalence that is not explained by variation in population density. GIRES used the responses to the *Engendered Penalties* Survey, (n=1,196) to estimate prevalence rates across the UK by police area. There were 38 respondents in Devon and Cornwall, an estimated prevalence of 23 per 100,000 people aged 16 and over who have presented with gender dysphoria (Reed 2009). This crude estimate would equate to 219 transgender people living in Devon, Plymouth and Torbay. However, the transgender population is fluid, often hidden and difficult to define, so this estimate should be used with caution.

[4] This figure was estimated by combining a number of surveys of varying degrees of rigour, across different population groups that may not be generalisable to the UK population, and measuring different dimensions of sexual orientation (across identity, attraction and behaviour). In a review of the current data sources for estimating the size of the LGB population in the UK, Aspinall concludes 'There are no reliable estimates of the size of the LGB population in Great Britain…It is unlikely that a definitive size of the LGB group, based upon self-declared identity, can be established for some time.' (Aspinall 2009).

3.1.9 There is no validated national estimate of the wider transgender population - those who are not planning to seek medical treatment, but experience some degree of gender variance.

Life Expectancy

3.2 The Public Health Outcomes Framework uses life expectancy and healthy life expectancy as overarching health outcome measurements.

- Life expectancy for LGB&T people has not been modelled in the UK. It would be reasonable to expect that on average, life expectancy would be lower due to higher rates of smoking, alcohol and drug use and mental ill health (Williams 2013).

- Healthy life expectancy is measured through a self-reported measure in the Integrated Household Survey. This found that self-reported health was slightly better in lesbian and gay men than heterosexuals, but much worse in bisexuals and other non-heterosexual identities. However, other surveys have found different results, so the evidence is mixed (Williams 2013).

Mental Health and Wellbeing

3.3 The *Pride, Progress and Transform* survey of LGB&T people in the South West asked respondents to identify the health issues that most concerned them. The most frequent concern was mental health (45%), followed by sexual health (35%). 53.5% (130) did not believe that the issues they were expressing concerns about were directly related to their gender or sexual identity. 36% (87) linked their concerns to their sexual identity while 18% (44) related them to their gender identity (Equality South West 2012).

Lesbian, Gay and Bisexual Mental Health

Depression and Anxiety

3.4. A large cross-sectional survey of England and Wales which compared LGB people with heterosexual people found that gay men and lesbians reported more psychological distress than heterosexuals, despite similar levels of social support and quality of physical health (King 2003). Bisexual men recorded a significantly higher score than gay men on the CIS-R (measure of psychological distress).

3.4.1 The risk for depression and anxiety disorders (over a period of 12 months or a lifetime) is at least 1.5 times higher in lesbian, gay and bisexual people (risk ratio range: 1.54–2.58) (King 2008). Stonewall found that 14% (15% in Devon) of gay and bisexual men reported currently experiencing moderate to severe levels of mixed depression and anxiety (Guasp 2012), compared to 7% of men in general experiencing mixed anxiety and depression disorders at any one time (Office for National Statistics 2000).

3.4.2 The Devon and Torbay Depression and Anxiety Service record sexual orientation but the data are only complete for 50% of clients from 1 April 2013 (4178/8469). Table 5 shows that 4.37% of clients identify as lesbian, gay, bisexual or ‘other’, which is a higher proportion than the 1.5% in the general population who identify as LGB (see table 2 for comparison).

Table 5: Devon and Torbay Depression and Anxiety Service clients by sexual orientation

Sexual Orientation	Number of Clients (April – Sept 2013)	Percentage
Heterosexual	3745	89.21%
Lesbian or gay	100	2.39%
Bisexual	67	1.60%
Other	17	0.41%
Not stated	243	5.82%
Unknown	6	0.14
Total	4178	100

3.4.3 Section 3.9 includes data from The Intercom Trust *Big Community Survey 2014* describing respondents' experience of mental health problems.

Self-Harm

3.5 There is some evidence that lifetime prevalence of deliberate self-harm is higher in LGB people (King 2008). Table 6 shows that LGB people are more likely to have considered self-harm, and more likely to have carried it out, than heterosexual men and women (King 2003). The study also found that gay men and lesbians were more likely than bisexual men and women to cite their sexual orientation as a reason for harming themselves. The levels of self-harm should not be taken to be exactly representative of prevalence in the wider population as there was some bias in the study recruitment methodology.

Table 6: Comparison of levels of self-harm in LGB and heterosexual people (King 2003)

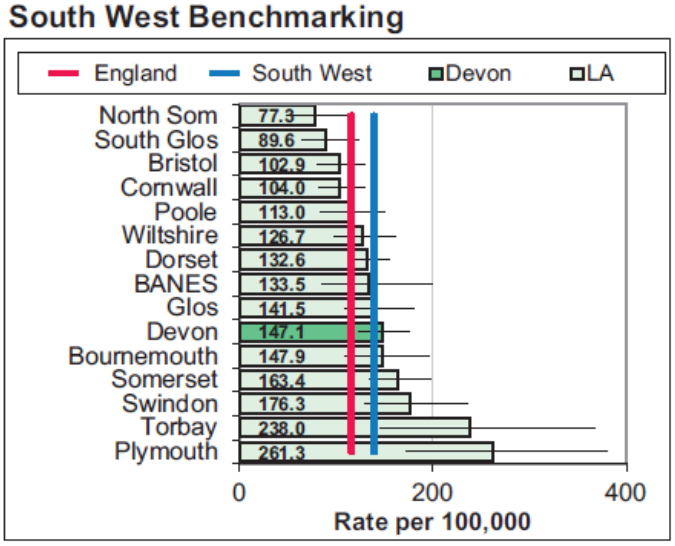
	Heterosexual Men	Gay/Bisexual Men	Heterosexual Women	Lesbian/ Bisexual
Self-harm considered	33% (166/499)	50%*** (311/627)	33% (193/586)	57% *** (240/424)
Self-harm carried out (of those who had considered it)	41% (66/166)	54%** (166/310)	50% (89/194)	56%* (135/241)
Significance level: * p≤0.05, ** p≤0.01, *** p≤0.001				

3.5.1 Stonewall found that 20% (18% in Devon) of lesbian and bisexual women had deliberately harmed themselves in some way in the last year compared to 0.4% of women in general (Hunt 2008). They found 7% of gay and bisexual men (9% in Devon) deliberately harmed themselves in the last year compared to 3% of men in general (Guasp 2012). Nationally, rates of reported self-harm are higher amongst bisexual people than gay men and lesbians (Guasp 2012), and higher amongst lesbian, gay and bisexual disabled people

compared to lesbian, gay and bisexual people who are not disabled (Guasp 2012).

3.5.2 Devon, Plymouth and Torbay all have significantly higher rates of hospital admissions for self-harm in ages 10-24 than the national average in the general population (figure 2). Rates are three times higher in females than males. Within the 10 to 24 age group admission rates were highest in those aged 15 to 19 (625.4). Admission rates also are higher in more deprived areas, with a rate of 1034.0 in the most deprived areas compared with 308.6 in the least deprived areas. Data are not available by sexual orientation, but measures to reduce self-harm admissions should consider the needs of lesbian, gay, bisexual and transgender youth, and consider the national research showing higher levels of self-harm in LGB&T youth.

Figure 2: Hospital admissions for self-harm (direct age standardised rate of finished admission episodes for self-harm per 100,000 population aged 10 to 24 years)



Source: Devon Health and Wellbeing Outcomes Report, using data from the CHIMAT Child Health Profiles. Uses Hospital Episode Statistics from Health and Social Care Information Centre.

Suicide

3.6 The Department of Health's Suicide Prevention Strategy (2012) has identified LGB&T people as a high risk group.

3.6.1 There is some evidence that lifetime prevalence of suicidal ideation is twice as high in LGB people (risk ratio: 2.04 for both sexes (range: both sexes 1.72-2.42; men 2.0-4.10; women 1.75-2.10) (King 2008).

3.6.2 There are also higher rates of suicide attempts in LGB people. Risk ratios for 12 month prevalence of suicide attempts ranged from 1.96 to 2.76 (men 2.23-2.53; women 1.94-2.46), with a pooled estimate for men and women of 2.56. Data from higher quality studies showed higher cumulative incidence of suicide in lesbian and bisexual school girls, increased lifetime risk of suicide attempts in gay and bisexual men and increased 12 months risk of suicidal ideation in lesbian and bisexual women (King 2008).

3.6.3 Certain risk factors for suicide (DH 2012) in the general population are found at a higher prevalence in LGB&T people, including:

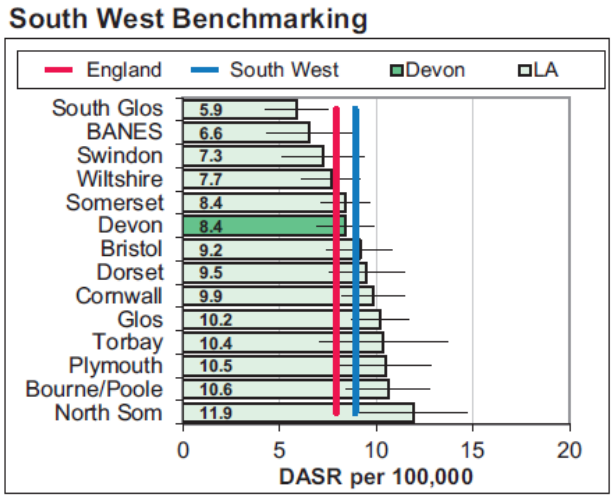
- Depression.
- History of self-harm.
- Use of drugs or alcohol.
- Smoking and nicotine dependence.
- Social isolation and loneliness (particularly for older people).

> *"I was isolated from the LGBT community and wondering what to do about it. Few friends at the moment."*
> *(The Big Community Survey, The Intercom Trust 2014)*

3.6.4 Stonewall found that 5% (same in Devon sample) of lesbian and bisexual women in Devon reported having made an attempt on their life in the last year (Hunt 2008). 3% (4% in Devon) of gay and bisexual men reported having made an attempt on their life in the last year.

3.6.5 Suicide rates in the general population in Devon are at a slightly higher level than the national average, but lower than the South West average (figure 3). There are higher rates in Torbay and Plymouth than the national and South West average. In 2011, 76 deaths in Devon, 24 in Plymouth and 13 in Torbay were registered as suicide or injury undetermined. The rate of completed suicide in LGB&T people is unknown as sexual orientation and gender identity are not recorded by coroners.

Figure 3: Suicide rate (direct age standardised rate per 100,000)



Eating Disorders

3.7 There is evidence from US studies that there are higher levels of disordered eating in LGB people, particularly young people, but the UK evidence base is limited. A large study of US high school students (Austin 2013) found that LGB identity was associated with substantially higher odds of purging and diet pill use in both girls and boys (odds ratios range: 1.9-6.8). Bisexual girls and boys were also at elevated odds of obesity compared to their heterosexual counterparts (odds ratio: 2.3 and 2.1, respectively). Gay men report significantly more body dissatisfaction, internalization, eating disorder symptomatology, drive for thinness, and drive for muscularity than heterosexual men (Yean 2013).

3.7.1 Lesbian and bisexual women are twice as likely to be obese compared to heterosexual women (odds ratio 1.90, confidence interval: 1.59-2.27, $p<0.0001$) (McElroy, 2014, Struble 2011). Anorexia and bulimia is no more common in lesbians than heterosexual women, but binge eating disorders are more common (Heffernan, 1996). Qualitative research has found that lesbian women struggle with many of the same issues that heterosexual women struggle with in terms of eating and body image, but that they also face unique issues such as coming out, and cultural pressures and norms within the lesbian community that are different than those in the heterosexual community, which can lead to binge eating as a coping strategy (Millner 2004).

3.7.2 Stonewall found that 21% of gay and bisexual men have been told they have problems with weight or eating at some point. 13% reported that they had had a problem with their weight or eating in the last year compared to 4% of men in general. Of those who had ever had a problem, this broke down to 20% anorexia, 11% bulimia, 40% binge eating (Guasp 2012). They found that 20% of lesbian and bisexual women said they have an eating disorder compared to 5% of the general female population (Hunt 2008).

3.7.3 19% of trans people say they have had an undiagnosed eating disorder, and 5% said they had an eating disorder diagnosed (McNeil 2012).

> *"Low self-confidence, esteem, self-worth, body image issues, feeling isolated and lonely."*
> (*The Big Community Survey*, *The Intercom Trust* 2014)
>
> - In response to 'Please provide more information if you feel your mental health problems are associated with your experience of being LGBT'

Trans Mental Health

3.8 The largest ever UK survey of trans people (n=889), *The Trans Mental Health Study* (McNeil 2012), found extremely high levels of previous or current self-reported depression (88%), stress (80%) and anxiety (75%) in trans people (McNeil 2012). The survey focused on how the process of transitioning (social and/or medical) impacts mental health and wellbeing. It should be noted that the survey did not include the wider trans population who were not undergoing permanent social or medical transition.

3.8.1 Respondents described feeling more comfortable, positive and balanced after starting hormone treatment (both masculinising and feminising). Surgery also had a positive effect on life satisfaction, with 8% (non-genital surgery) and 83% (genital surgery) more satisfied with their lives after the intervention, and only four cent of both groups less satisfied.[5]

3.8.2 Levels of depression (tested by the Centre for Epidemiological Studies Depression Scale – CES-D) were significantly higher in those who were unsure about transition, or who were proposing to undergo transition but had not yet started. Lower levels were found in those who were undergoing or had undergone a process of transition. Transition was related to a decrease in mental health service use.

3.8.3 53% of participants had self-harmed at some point, with 11% currently self-harming. Self-harm reduced following transition for the majority of those who had a history of self-harm. 63% felt that they harmed themselves more before they transitioned, with only 3% harming themselves more after transition.

3.8.4 Just under 60% of the participants felt that there were reasons they self-harmed which related to them being trans, while 70% felt there were non-trans related reasons for their self-injury.[6]

3.8.5 Reasons for self-harm which directly related to being trans included:

- Gender dysphoria.
- Delays in getting gender reassignment treatment.
- Stumbling blocks in treatment, and negative attitudes.
- Not being to access treatment or being denied treatment.
- Not being taken seriously by medical professionals.
- Treatment complications.
- Struggling coming to terms with identity or suppressing gender issues.
- Not understanding identity/unwilling to admit to difference.
- Not being accepted or experiencing negativity from others.
- Not having identity/gender recognised.

3.8.6 Indirect concerns included:

- Loss of employment or reduced income.
- Harassment and bullying.
- Feelings of guilt, shame or inadequacy.

[5] The report did not disaggregate by gender.
[6] Categories overlap as the participants could select more than one reason for their self-harm.

- Breakdown of relationships.

- Losing family, including contact with children.

3.8.7 Other reasons included: isolation, loneliness, misunderstanding, having a long-term disability or mental health condition, experiencing childhood abuse, rape, and homelessness.

3.8.8 The majority of participants, 84%, had thought about ending their lives at some point, including 63% in the last year, and 27% in the last week. Prevalence of actual suicide attempts among those who had thought about ending their lives at some point was 48%. 35% of the whole sample had attempted suicide at least once and 25% more than once.

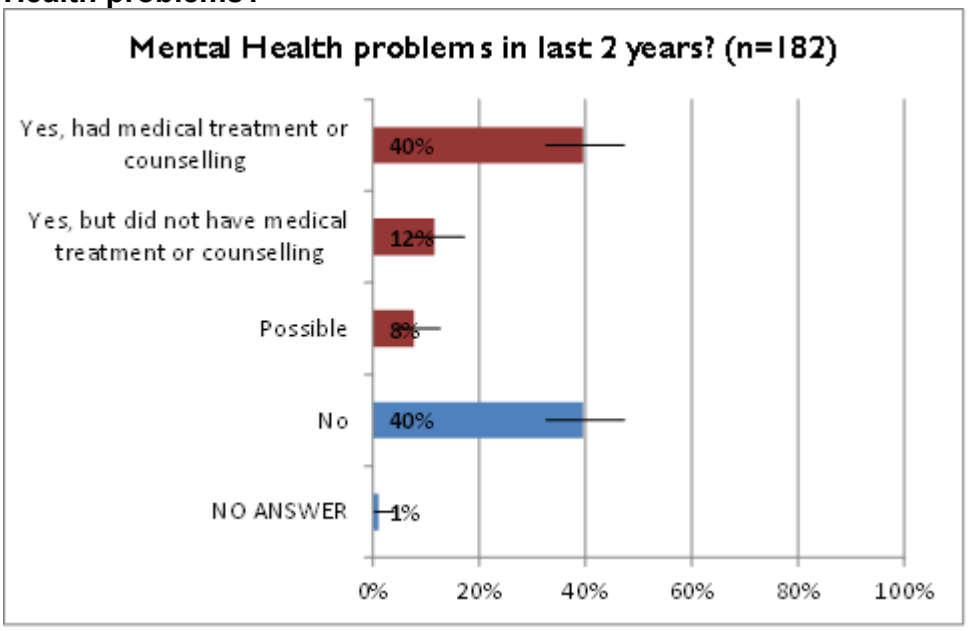
> *"Before coming out (almost two years ago) as trans I was suicidal, didn't think I could transition, was scared about losing family and friends, being unable to find employment (I didn't have a job at the time) and never being able to 'pass'."*
> *(The Big Community Survey, The Intercom Trust 2014)*

3.8.9 Suicidal ideation and attempts reduced post-transition, with 63% thinking about or attempting suicide more before they transition and only three% thinking about or attempting suicide more after transition.

The Intercom Trust: The Big Community Survey 2014 and Help, Support and Advocacy Casework

3.9 The Big Community Survey (The Intercom Trust 2014) asked respondents: "In the past two years have you experienced any Mental Health problems?" Figure 4 shows that 39% of respondents answered yes, and had medical treatment or counselling. In total 108 (58%) said they had, or possibly had, a mental health problem in the previous two years (self-defined mental health problem).

Figure 4: "In the past two years have you experienced any Mental Health problems?"



3.9.1 Respondents were asked to describe the nature of the problem, including a free-text option for conditions that has not been listed (figure 5). The most commonly listed problems were depression, anxiety, stress and lack of self-worth. Figure 6 shows what proportion of the total respondents reported experiencing mental health problems (including those who answered yes or possible).

Figure 5: Principal mental health problems as a percentage of all respondents with a mental health problem

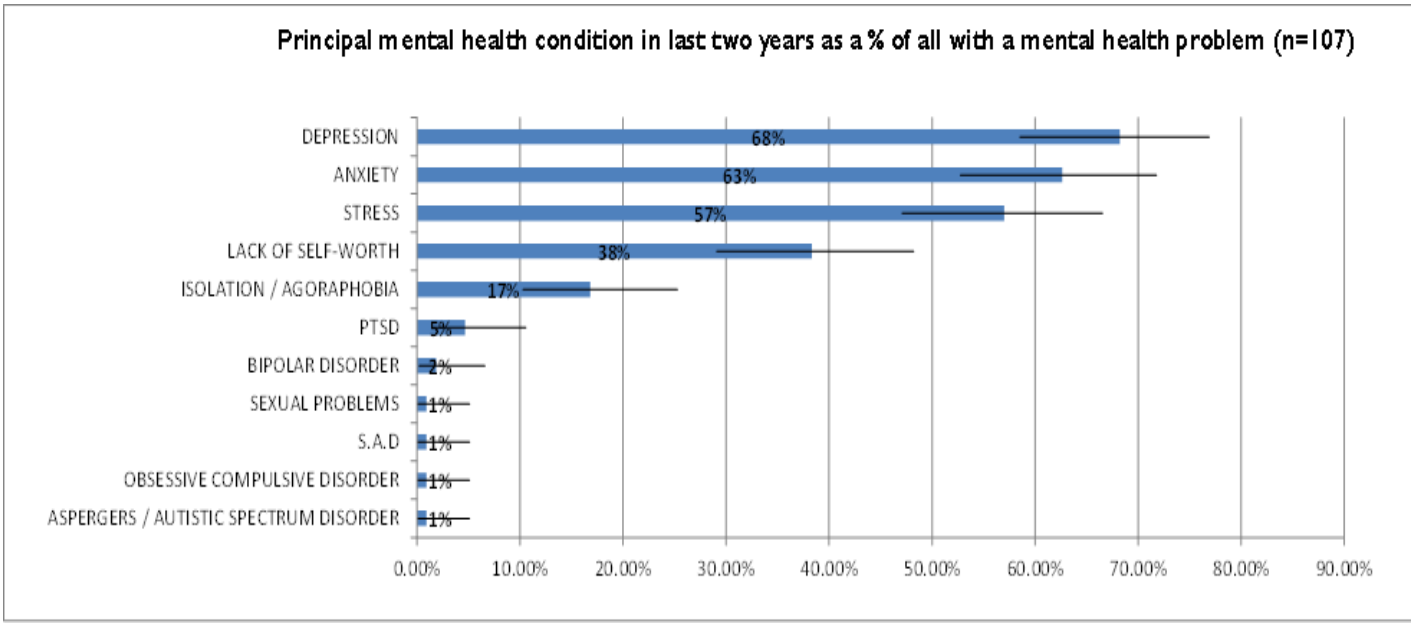
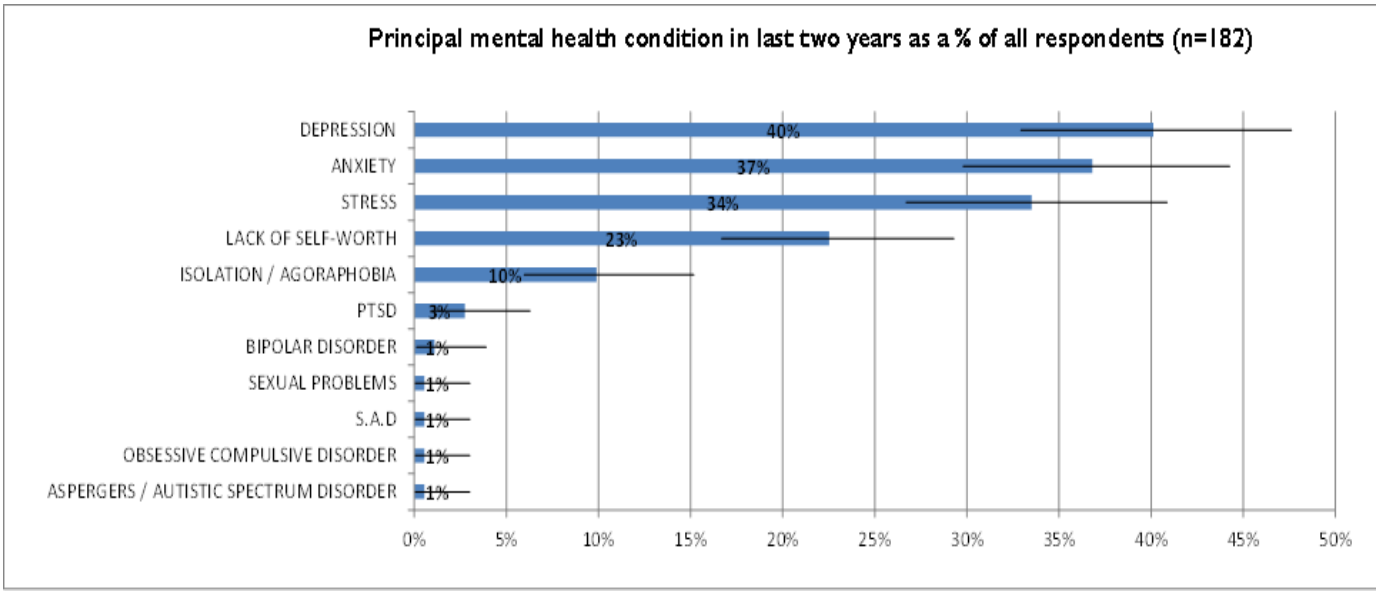
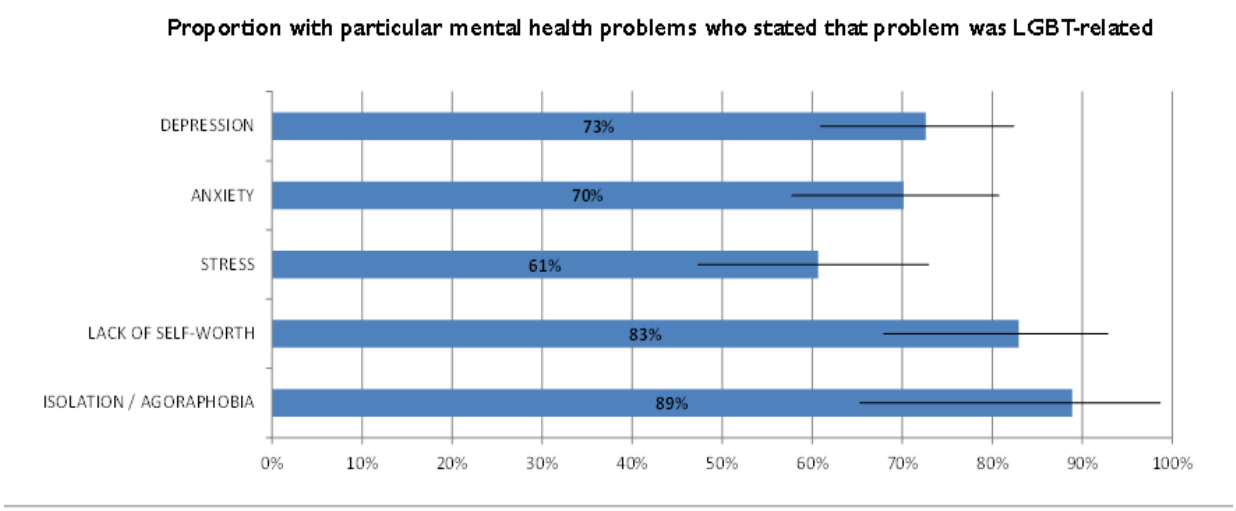


Figure 6: Principal mental health problems as a proportion of all respondents



3.9.2 Respondents who reported they had experienced a mental health problem (yes or possible) were asked whether they associated their mental health problem with their experience of being LGB or trans. 53% said “Yes, fully” or “Yes, partly”; a further 12% said “Not sure”; 33% said “No”. Depression, anxiety, stress, lack of self-worth and isolation/agoraphobia showed the highest levels of respondents associating their problem with being LGBT (figure 7).

Figure 7: Respondents who associated MH condition with being LGBT



“Accessing medical support to progress towards gender reassignment was difficult at one stage because of a specific GP's approach. This, along with threats of a violent nature from a neighbour intensified my condition and pushed me to the brink.”
(The Big Community Survey, The Intercom Trust 2014)

3.9.3 The Intercom Trust have recorded high levels of mental health and social isolation in their Help, Support and Advocacy casework monitoring from supporting 617 individuals across Devon, Cornwall and Dorset (1,255 face to face meetings and 4,349 helpline calls and emails). The issues identified by the caseworkers include internalised homophobia/transphobia and low self-esteem, depress and anxiety, sexual behaviours, suicide issues, self-harm, grief and loss, addiction to drugs and alcohol, anger management and eating disorders.

3.9.4 The Intercom Trust have also found high levels of social isolation among their casework clients – 60% (372/617) were living with isolation as part of or alongside the problem they presented with. A high proportion of all clients identified as trans (85 female and 23 male), and these clients represented a disproportionately high number of the mental health and social isolation issues: 78% (84/108) were dealing with mental health related issues, and 72% (78/108) had issues with social isolation.

Minority Stress

3.10 There is a lack of prospective research that examines the mechanisms behind higher rates of mental health problems in LGB people, however it has been suggested that 'it is likely that the social hostility, stigma and discrimination that most LGB people experience is at least part of the reason for the higher rates of psychological morbidity observed' (King 2008).

3.10.1 The high prevalence of mental health problems in lesbian, gay and bisexual people has been explained in terms of minority stress, the theory that stigma, prejudice and discrimination creates a hostile and stressful social environment that leads to mental health problems (Meyer 2003).

3.10.2 A recent systematic review has strengthened the evidence for this theory, finding that discrimination on the grounds of sexual orientation predicted certain neurotic disorder outcomes, even after adjusting for potentially confounding demographic variables (Chakraborty 2011).

3.10.3 Meyer has suggested three processes of minority stress relevant to LGB individuals, which are also applicable to transgendered individuals:

a) External, objective stressful events and conditions (chronic and acute)
b) Expectations of such events and the vigilance this expectation requires
c) The internalisation of negative societal attitudes

> *"I have experienced a lot of negative and nasty experiences from people due to my sexual orientation."*
> *(The Big Community Survey, The Intercom Trust 2014)*

> *"Stress of coming out led to an increase in the severity of auditory hallucinations."*
> *(The Big Community Survey, The Intercom Trust 2014)*

Sexual Health

3.11 This section concerns only the sexual *behaviour* aspect of sexual orientation. Same-sex sexual activity and sexual identity can be mutually exclusive; people who do not identify as lesbian, gay or bisexual may choose to engage in same-sex sexual activity. For this reason, this section uses the terms 'men who have sex with men' (MSM) and 'women who have sex with women' (WSW), while acknowledging that this only captures behaviour and not identity.

3.11.1 The proportion of the population who have had a sexual experience or contact with a person of the same sex is higher than those who self-identify as LGB. The National Sexual Attitudes and Lifestyle Survey (NATSAL) found that 8% of men and 11.5% of women had ever had a sexual experience or contact with a person of the same sex (Mercer 2013).

3.11.2 In women, the proportion reporting ever having had a sexual experience with genital contact with another woman (age-adjusted odds ratio: 1.69, 95% confidence interval: 1.43–2.00), and proportion reporting at least one female sexual partner in the past five years (OR: 2.00, 95% CI: 1.59–2.51) increased since the previous NATSAL survey (2001). The proportion reporting any sexual experience or contact with another woman was 11.5% (95% CI: 10.7-12.3%), and 6.1% (95% CI: 5.6-6.7%) reported any sexual experience with genital contact with another woman.

3.11.3 The proportion of participants of all ages reporting ever having a same-sex sexual experience hardly varied by age in men, but varied substantially in women, with the highest proportions reported for those under 35.

3.11.4 Sexual experience or contact with an individual of the same sex is associated with managerial and professional occupations and increased educational attainment.[7] Individuals with higher educational attainment and socio-economic status also reported more tolerant attitudes towards same-sex partnerships.

3.11.5 NATSAL also found a strong association between same sex sexual experience and experience of non-volitional sex (sex without consent) (Macdowall 2013), and a higher proportion of same-sex experience respondents reported low sexual function (34.4% compared to 19.5%) (Mitchell 2013), though the reason for these associations is not fully understood.

3.11.6 There is a notable lack of data on trans sexual health and trans people's experience of sexual health services. The lack of data in this section reflects a need for further work in this area.

Men Who Have Sex with Men

3.12 The rate of men who currently have sex with men for areas outside London is estimated to be 2.8% of the male population over 15 years of age (exceptions are Bournemouth, Poole, Bristol and Swindon where an estimate of 3.4% is

[7] NB. Correlation does not imply causation.

used).[8] Table 7 shows the approximate numbers of MSM in Devon, Plymouth and Torbay based on this estimate.

Table 7: approximate numbers of MSM based on 2.8% estimated prevalence

Area	Male population aged 16 and over	Approximate number of MSM
Devon	302,100	8,459
Plymouth	104,700	2,932
Torbay	52,300	1,464
Total	**459,200**	**12,858**

National HIV Prevalence

3.13 In 2012, the estimated number of people living with an HIV infection in the UK reached 98,400 [95% confidence interval: 93,500-104,300] (*HIV in the United Kingdom: 2013 report*, Public Health England). The proportion of these who were undiagnosed had declined slightly from 25% in 2011 to 22% in 2012.

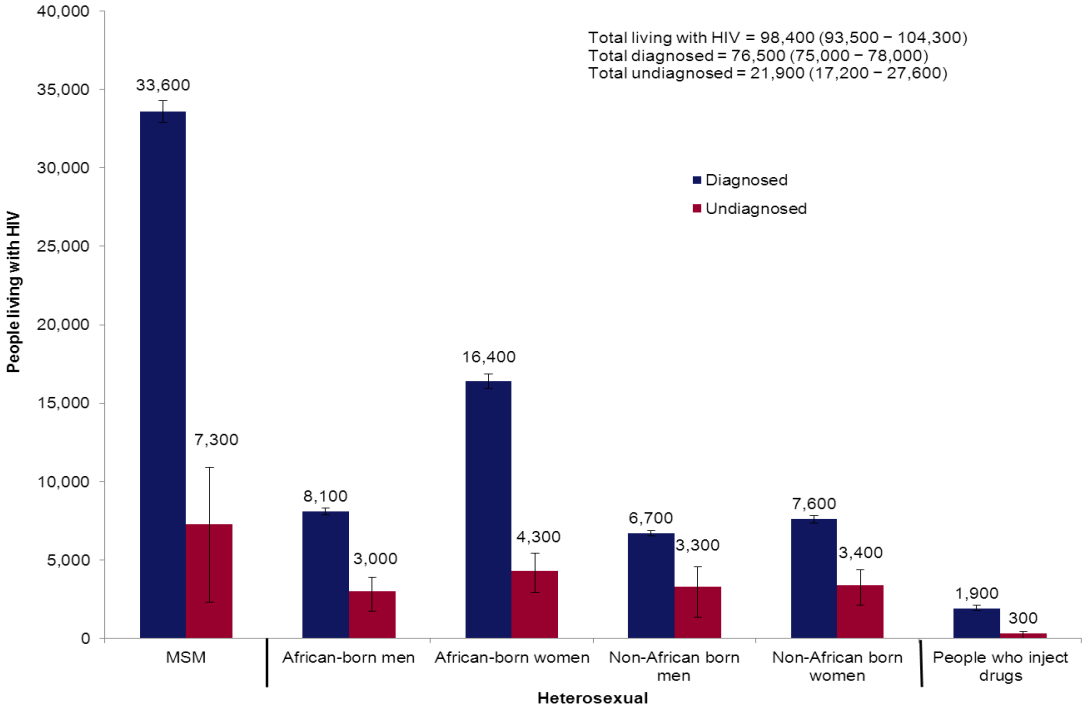
3.13.1 In the UK, men who have sex with men (MSM) remain the group most affected by HIV with a prevalence of 47 per 1,000 in 2012. This is equivalent to an estimated 41,000 [95% confidence interval: 37,300-46,000] MSM living with HIV, with 18% or 7,300 (3,700-12,300) unaware of their infection (figure 8).

3.13.2 Over the past decade, an estimated 2,400 [95% CI: 1,600-4,100] MSM acquired HIV infection each year. New diagnoses among MSM continued to rise and reached an all-time high of 3,250 in 2012. This reflects both high levels of HIV transmission and an increase in HIV testing.

3.13.3 While the number of MSM having HIV tests at sexual health clinics has increased, almost half of MSM diagnosed with HIV between 2010-12 were being tested for the first time.

[8] UK guideline for the use of post-exposure prophylaxis for HIV following sexual exposure (2011). Available from http://www.bhiva.org/PEPSE.aspx.

Figure 8: Estimated number of people living with HIV (both diagnosed and undiagnosed): UK, 2012



Source: Public Health England

3.13.4 The increase in the number of new diagnoses among older people (500 diagnoses among people aged 50 years and over in 2003 compared to 990 in 2012), and an ageing cohort has led to a disproportionate rise in the number of people accessing HIV-related care aged 50 and over. In 2012, one in four adults (19,120/76,840) who were accessing care were aged 50 and over, compared to one in eight (4,360/35,210) in 2003 (*HIV in the United Kingdom: 2013 report*, Public Health England).

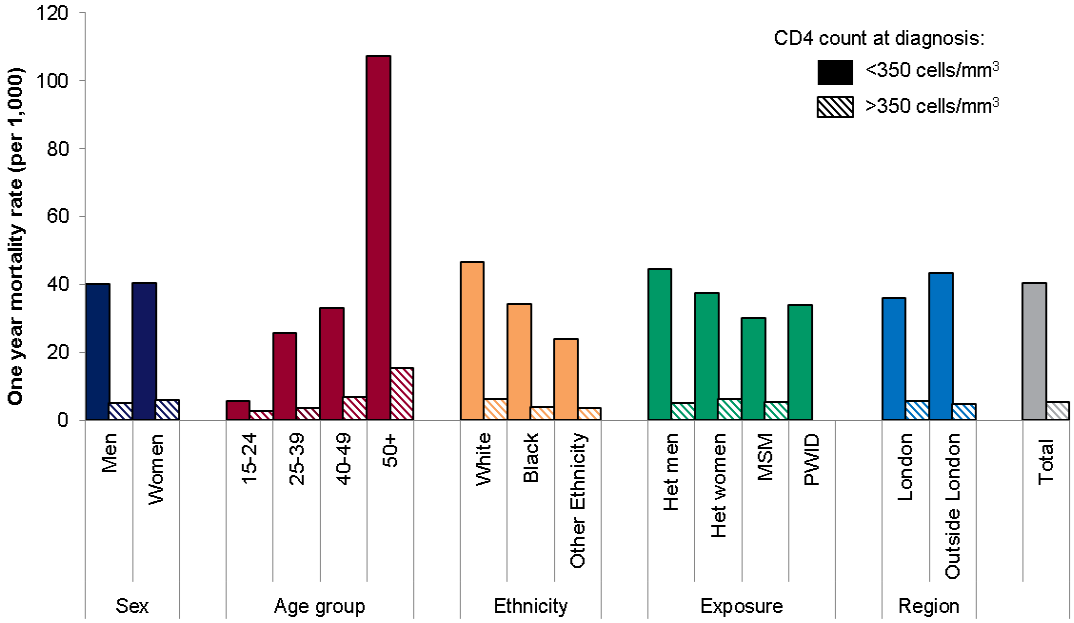
National HIV Testing and Diagnosis

3.14 Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection. People living with HIV can expect a near normal life expectancy and better clinical outcomes if they are diagnosed promptly. In 2012, 47% (2,990) of all HIV diagnoses were made at a late stage of infection (with a CD4 cell count <350 cells/mm^3 within three months of diagnosis) including 28% (1,770) who were severely immunocompromised at diagnosis (CD4 cell count <200 cells/mm^3). In 2012, the lowest proportion of late diagnosis was among MSM, with 34% (1,110/3,250) diagnosed late.

3.14.1 The median age at diagnosis among MSM was 34 years, but one in nine MSM were diagnosed at the age of 50 years or over. (*HIV in the United Kingdom: 2013 report*, Public Health England).

3.14.2 One year mortality is also lower in MSM compared to other exposure groups (figure 9).

Figure 9: One year mortality among adults diagnosed by CD4 count at diagnosis: UK, 2010



3.14.3 Quality of care in the UK is high, with 97% of people diagnosed in 2012 linked to HIV care within three months of diagnosis, regardless of age, gender, ethnicity, sexual orientation, sex and area of residence.

3.14.4 Stonewall found that 30% (35% in the Devon sample) of gay and bisexual men had *never* had an HIV test. Almost 70% (78% in Devon) said this was because they did not think they had put themselves at risk, 33% (17% in Devon) said it was because they had never had any symptoms, and 26% (11% in Devon) said it was because they had never been offered a test, despite being a priority group for testing. Nationally, bisexual men are more likely than gay men to say that have never had an HIV test (60% compared to 30%).

Local HIV Prevalence

3.15 Devon, Torbay and Plymouth are all defined as areas of low HIV prevalence (*in all transmission groups*) at (>2 per 1000 population), as shown in table 8.

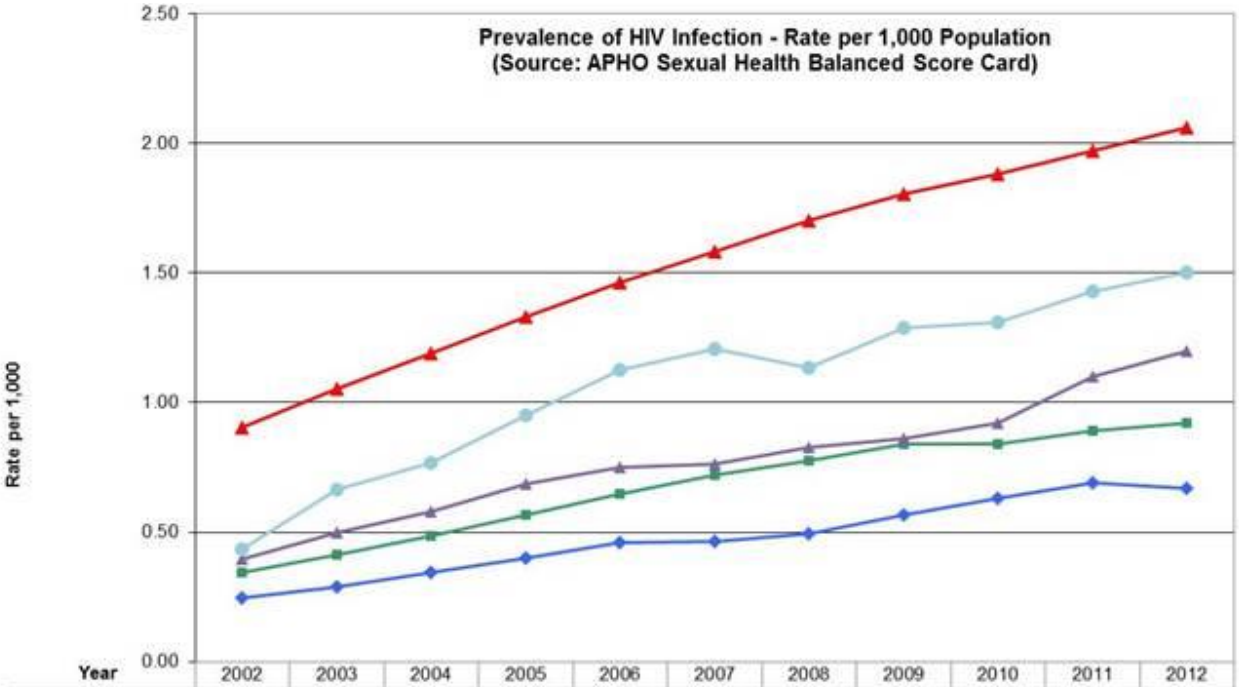
Table 8: Prevalence of diagnosed infection per 1,000 among persons aged 15 to 59 years (2012)

Area	Count	Crude rate – per 1,000
England average	65,541	2.05
South west average	2,822	0.96
Devon	282	0.69
Plymouth	183	1.16
Torbay	103	1.48

Source: Sexual and Reproductive Health Profiles, Public Health England

3.15.1 Figure 10 shows that diagnosis is increasing at a slower rate over time in Devon than in England.

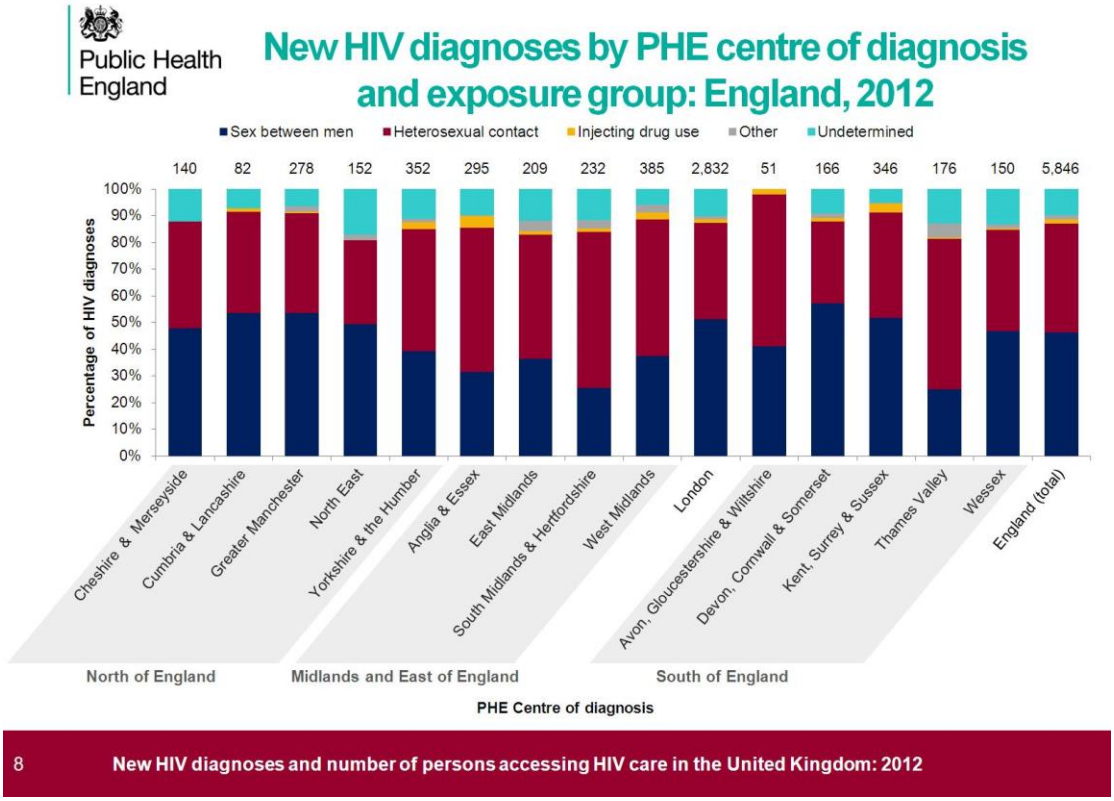
Figure 10: Rate of HIV diagnosis over time, persons aged 15-59



Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
England	0.91	1.05	1.19	1.33	1.47	1.58	1.70	1.81	1.88	1.97	2.06
South West SHA	0.34	0.41	0.49	0.57	0.65	0.72	0.78	0.84	0.84	0.89	0.92
Devon	0.25	0.29	0.35	0.40	0.46	0.47	0.49	0.57	0.63	0.69	0.67
Plymouth	0.40	0.50	0.58	0.69	0.75	0.76	0.83	0.86	0.92	1.10	1.20
Torbay	0.43	0.67	0.77	0.95	1.12	1.21	1.14	1.29	1.31	1.43	1.50

3.15.2 In 2012, Devon, Cornwall and Somerset was the Public Health England Centre area with the highest proportion of newly diagnosed persons who were infected through sex between men (57%; 95/166) (figure 11). Correspondingly, Devon, Cornwall and Somerset was the Public Health England Centre with the highest proportion of persons seen for care who were infected through sex between men (58%; 575/987).

Figure 11: New diagnoses by area and exposure group, 2012



Local HIV Testing

3.16 All patients presenting at sexual health services are routinely tested for HIV in accordance with national guidelines. Routine testing in all men and women registering in GP practice, and all general medical admissions, has been recommended for areas of high diagnosed HIV prevalence (>2 per 1000 population), but Devon, Torbay and Plymouth do not meet this threshold. However, HIV testing should also be offered to certain high-risk groups, including MSM, and this should take place at least annually, or every three months for those having sex with new or unprotected partners (UK National Guidelines for HIV Testing 2008).

3.16.1 Coverage and uptake of HIV testing is better than or similar to the national average across Devon, Plymouth and Torbay (table 9).

Table 9: Coverage* and uptake^ of HIV testing among MSM, measured in GUM clinics (all ages, 2013).

Area	% MSM coverage HIV test	% MSM uptake for HIV
England average	86.1	94.8
South west average	86.0	94.3
Devon	87.6	97.4
Plymouth	94.7	98.1
Torbay	90.5	95.4

Source: Sexual and Reproductive Health Profiles, Public Health England
Red = worse than national average
Amber = similar to national average
Green = better than national average
* Coverage is defined as the proportion of eligible new GUM attendees in whom an HIV test was accepted.
^ Uptake is defined as the number of eligible new GUM episodes where an HIV test was accepted as a proportion of those where an HIV test was offered.

Late Diagnoses

3.17 Table 10 shows the percentage of all new diagnoses of HIV (not just MSM) with a CD4 cell count <350 between 2010 and 2012.

Table 10: Percentage of adults (aged 15 and above) newly diagnosed with a CD4 count less than 350 cells cubic millimetre (2010-12).

Area	% <350 (of CD4)
England average	48.3
South west average	49.3
Devon	50.0
Plymouth	39.1
Torbay	27.3

Source: Sexual and Reproductive Health Profiles, Public Health England

3.17.1 In Devon, HIV cases that could have been diagnosed earlier are reported via the Datex system which enables clinicians to consider the case and identify learning to influence future practice.

3.18.1 Stonewall found that bisexual men were more likely than gay men to report they have never been tested for STIs (38% compared to 25%) (Guasp and Taylor 2012).

Women Who Have Sex with Women

3.19 Stonewall found that less than half of lesbians and bisexual respondents had ever been tested for STIs or vaginal conditions. Over half of respondents who *had* been tested for STIs have had an infection (a quarter of all respondents) (Hunt 2008). Of those who had not been tested, three quarters had not been tested because they thought they were not at risk, one in ten because they were 'too scared', and 4% had been told by healthcare workers that they did not need a test.

3.19.1 20% of respondents had had thrush, and 5% had had Bacterial Vaginosis, both of which can be passed on to a partner through oral and penetrative sex. 25% of those who had been diagnosed with an STI had only had sex with women in the last five years. Of those who had not been tested, 20% had had sex with men in the last five years.

3.19.2 Lesbians and bisexual women have both oral and penetrative sex and can share fluids through hands, mouth and sex toys. Bailey (2004) found a majority of women who have sex with women reported sexual histories with men (82%). Bacterial vaginosis and candida species were commonly diagnosed (31.4% and 18.4% respectively). Genital warts, genital herpes, and trichomoniasis were infrequently diagnosed (1.6%, 1.1%, and 1.3% respectively). Chlamydia, pelvic inflammatory disease, and gonorrhoea infections were rare (0.6%, 0.3%, and 0.3% respectively) and diagnosed only in women who had histories of sex with men.

Trans Sexual Health

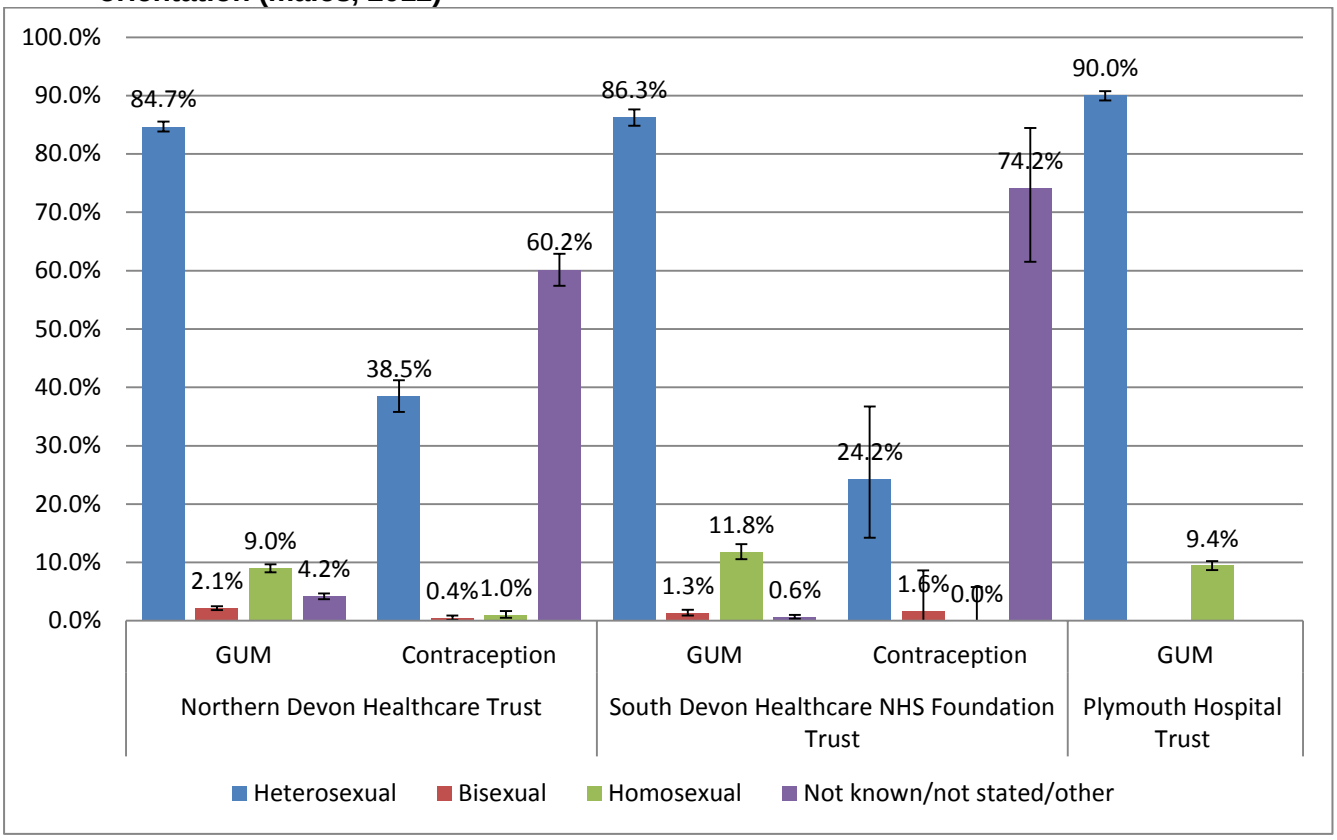
3.20 There is a paucity of evidence about the sexual health and access to services of trans individuals in the UK. Gender identity is not routinely recorded. Services need to be sensitive and responsive to provide advice to trans people at whatever stage of transition they are at. Few sexual health information portals include sexual health for trans people. The Terence Higgins Trust have produced guides for trans women and transmen on sexual health issues.[9]

Service Use

3.21 Figures 12 and 13 show attendances at genitourinary medicine (GUM) clinics across Devon. There is significant under-reporting and missing data, but reporting is better for GUM services than contraception services. Lesbian and bisexual women appear to be significantly underrepresented.

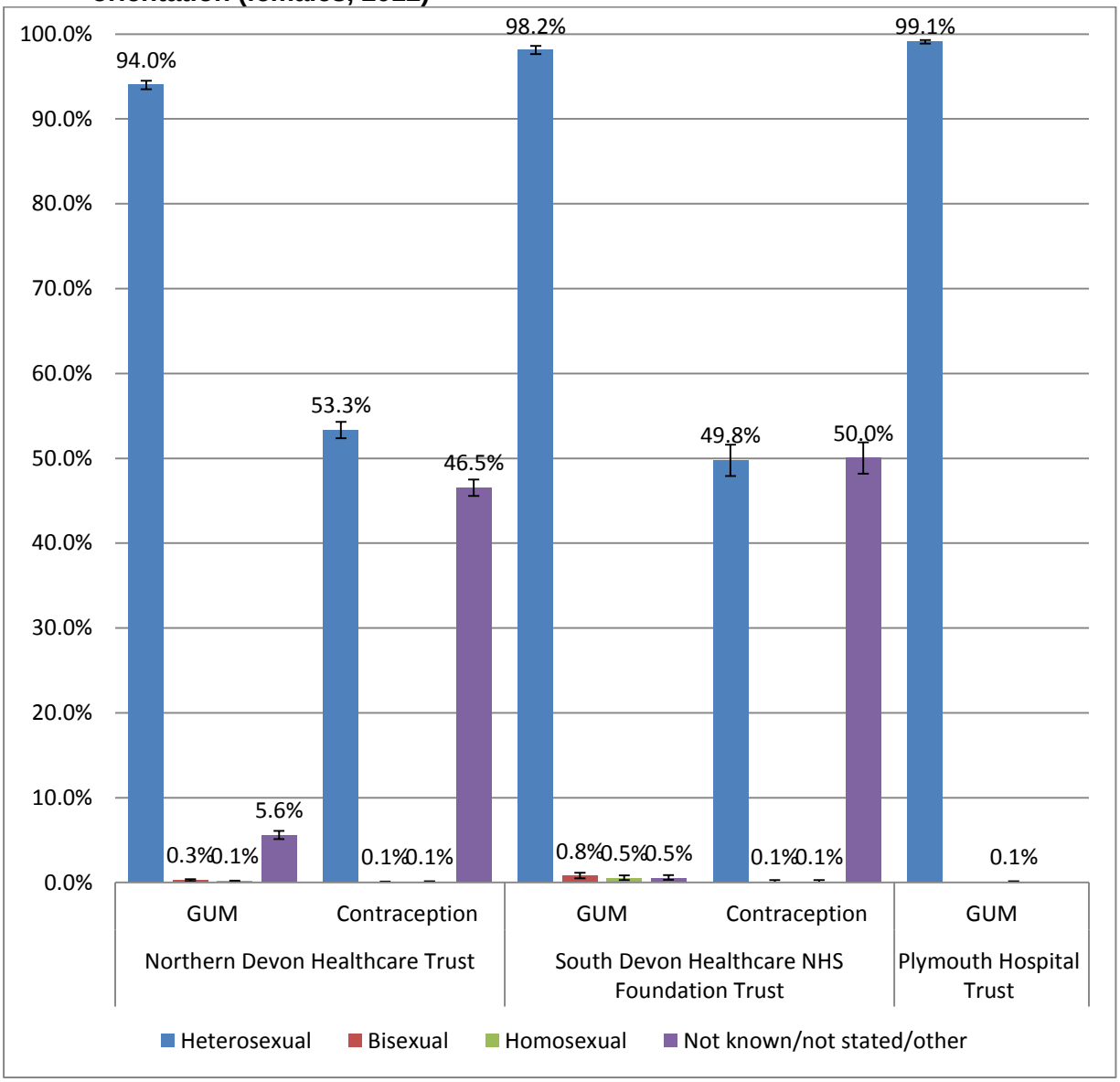
[9] Advice for transwomen: http://www.tht.org.uk/sexual-health/Sex,-reproduction-and-gender/Transwomen
Advice for transmen: http://www.tht.org.uk/sexual-health/Sex,-reproduction-and-gender/Transmen

Figure 12: New episodes of care at sexual health services by sexual orientation (males, 2012)



** Plymouth Hospital Trust provides a GUM specific service. Contraception services are provided in a separate service, provided by Plymouth Community Healthcare CCASH service. Data represent GUM attendances only (contraception is offered if identified as a need at the time). Plymouth use a different coding system to the other two areas, recording sexual orientation as:*
Heterosexual ***(blue column)***
MSM ***(green column)***

Figure 13: New episodes of care at sexual health services by sexual orientation (females, 2012)



** Plymouth Hospital Trust provides a GUM specific service. Contraception services are provided in a separate service, provided by Plymouth Community Healthcare CCASH service. Data represent GUM attendances only (contraception is offered if identified as a need at the time). Plymouth use a different coding system to the other two areas, recording sexual orientation as:*
*Heterosexual **(blue column)***
*Women who have sex with women **(green column)***

Smoking

3.22 Smoking remains the leading cause of health inequalities and preventable morbidity and mortality in the UK. Although smoking rates overall have steadily declined and are now at 20% of the adult population, they are still high in certain population groups, including LGB&T people.

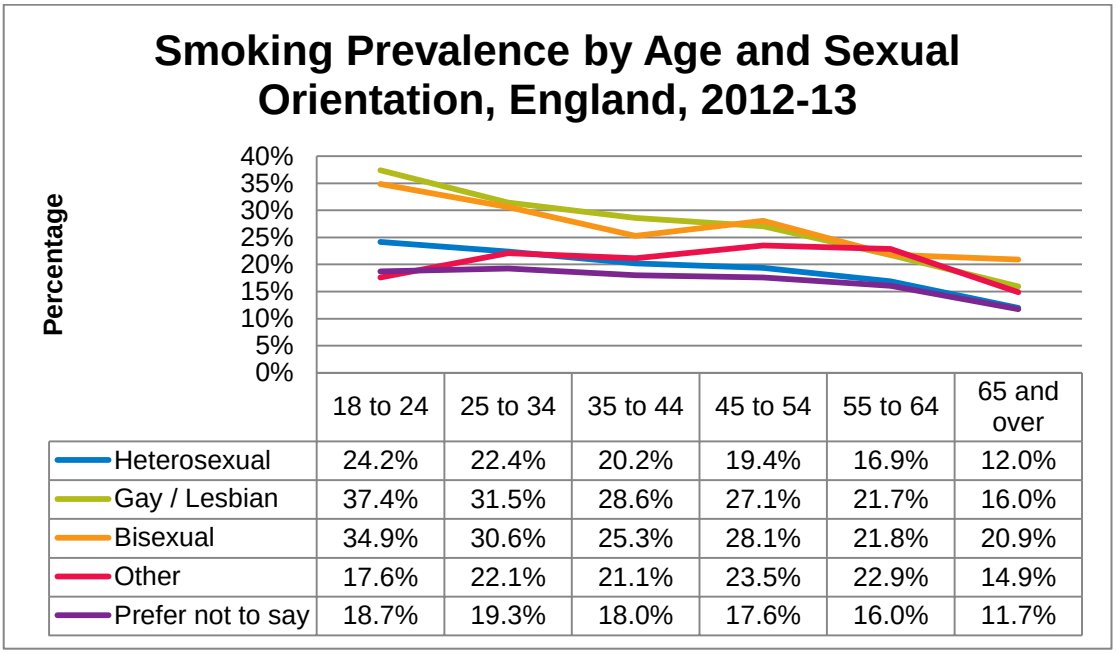
3.22.1 There is strong evidence from a large US systematic review that there are higher levels of smoking in the LGB population, with odds ratios between 1.5 and 2.0 for sexual minority women compared to heterosexual women, and

odds ratios between 2.0 and 2.5 for sexual minority men compared to heterosexual men (overall odds ratios of between 1.5 and 2.5 for men and women combined, confidence intervals not supplied) (Lee 2009).

3.22.2 Another US systematic review, has examined the risk factors/correlates of smoking among LGB people. It identified risk factors that could be considered unique to sexual minorities, including internalised homophobia and negative reactions to disclosure, as well as common smoking risk factors experienced at higher levels among sexual minorities, including stress, depression, alcohol use and victimisation (Blosnich 2013).

3.22.3 The GP Patient Survey includes a question about smoking status. Figure 14 shows that smoking rates are higher in LGB than heterosexual respondents across age groups, with particularly high disparity in younger age groups.

Figure 14: Smoking prevalence by age and sexual orientation, England 2012-13



	18 to 24	25 to 34	35 to 44	45 to 54	55 to 64	65 and over
Heterosexual	24.2%	22.4%	20.2%	19.4%	16.9%	12.0%
Gay / Lesbian	37.4%	31.5%	28.6%	27.1%	21.7%	16.0%
Bisexual	34.9%	30.6%	25.3%	28.1%	21.8%	20.9%
Other	17.6%	22.1%	21.1%	23.5%	22.9%	14.9%
Prefer not to say	18.7%	19.3%	18.0%	17.6%	16.0%	11.7%

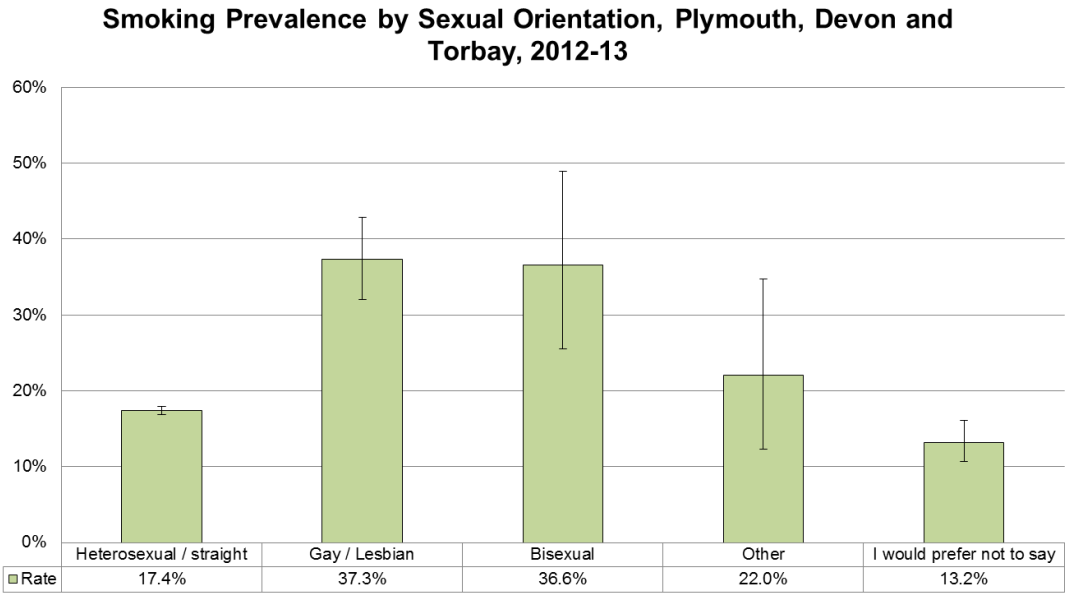
Source: GP Patient Survey

3.22.4 Stonewall found that nationally, 26% (23% in Devon) of male respondents, and 29% (33% in Devon) of female respondents were current smokers. Another survey found even higher rates; 35% smoked cigarettes, including 48% of those who were HIV positive (Hickson 2007).

3.22.5 There is a lack of data on levels of smoking in the trans population. One survey found that 32% of trans people smoked regularly, though the sample may not be generalisable to Devon (Rooney 2012). *The Trans Mental Health Survey 2012* found that 19% of respondents were current smokers, a similar level to the general population.

3.22.6 The adult smoking prevalence in the general Devon population is 20.2%. The GP Patient Survey found 37.3% of gay and lesbian people in Devon, and 36.6% of bisexual people were current smokers, compared to only 17.4% of heterosexual people (figure 15).

Figure 15: Smoking prevalence by sexual orientation



Alcohol and Substance Misuse

3.23 A substantial body of research has found higher levels of alcohol substance misuse in the LGB&T population. Prevalence of alcohol dependence is twice as high in the LGB population than the general population. Prevalence is particularly high in women (King 2008).

Table 11: Alcohol dependence in LGB people compared to heterosexual people (King 2008)

Outcome	Risk ratio (95% confidence intervals)
Alcohol dependence (12 month prevalence) in men and women	2.22 (1.78-2.77)
Alcohol dependence (12 month prevalence) in men only	1.51 (1.13-2.02)
Alcohol dependence (12 month prevalence) in women only	4.00 (2.05-5.61)

3.23.1 Stonewall found that 41% of lesbian and bisexual women (37% in the Devon sample) had a drink on three or more days in the last week compared to 36% of women in general. 42% of gay and bisexual men had had a drink on three or more days in the last week (also 42% in the Devon sample), compared to 35% of men in general. The statistical significance of these comparisons is not provided.

3.23.2 UK research has found lesbians and bisexual women are more likely to drink alcohol excessively (King 2003). Another large survey found that binge drinking is high across all genders, sexual orientations and age groups in the LGB community, with 34% of males and 29% of females reporting binge drinking at least once or twice a week (Buffin 2012). Available comparable data (from the ONS General Lifestyle Survey 2010) suggests that binge drinking is around twice as common in gay and bisexual men, and almost

twice as common in lesbian, gay and bisexual women, when compared to men and women in the wider population.

3.23.3 UK research has found lesbians and bisexual women have higher levels of substance use disorders and that bisexual men are more likely than gay men to have recently used recreational drugs (King 2003).

Table 12: Recreational drug use in the UK by sexual orientation and gender (King 2003)

	Heterosexual men	**Gay/bisexual men**	**Heterosexual women**	**Lesbian/bisexual**
Recreational drugs used in last month	45% (223/498)	52% (327/626)*	33% (194/583)	44% (185/422)***
Recreational drugs used ever	72% (361/499)	77% (480/627)	60% (350/586)	79% (334/424)***
Significance level: * p≤0.05, ** p≤0.01, *** p≤0.001				

3.23.4 The British Crime Survey found that 32.8% of LGB respondents had taken any drug in the last year, compared to 10% of heterosexual respondents. They are also more likely to have taken a Class A drug (11.1% compared to 3.6%). The higher prevalence of last year drug use was found across most drug types: powder cocaine, ecstasy, hallucinogens, amphetamines, cannabis, tranquilisers, ketamine and amyl nitrite. Higher rates remained even after adjusting for age (Hoare 2010).

3.23.5 Similar results were found in Buffin 2012, which found that LGB people across all age groups were more likely to take drugs than their heterosexual counterparts. 35% of LGB people had taken a drug (excluding alcohol) in the last year. Buffin also found that LGB people were more likely to be substance dependent, with between four and 13% of drug users scoring as dependent.

3.23.6 *The Big Community Survey* (The Intercom Trust 2014) found that 7% of male respondents and 3% of female respondents said they had experienced a (self-reported) drug and/or alcohol problem in the previous two years.

> *"I had issues with loss and abandonment and started to use hard drugs and heavier sex to 'escape' which lead to dangerous situations"*
> (*The Big Community Survey*, *The Intercom Trust 2014*)

3.23.7 Some surveys in parts of England have found that LGB&T people may have different patterns of substance use to other drug users, such as using drugs in a club environment, combination drug taking (poly-drug use) and using a wider range of illicit drugs or club drugs such as Gamma-hydroxybutrate (GHB) (Buffin 2009, Measham 2011 and Browne 2009). Recent research in London has identified a growing trend for 'chemsex', a term commonly used by gay or bisexual men to describe sex that occurs under the influence of drugs, which are taken immediately preceding and/or during the sexual session. The drugs most commonly associated with chemsex are crystal methamphetamine, GHB/GBL, mephedrone and, to a lesser extent, cocaine and ketamine. Although chemsex was reported to increase sexual arousal and facilitate more adventurous sex, many men were using drugs to mask

self-esteem or self-confidence issues. The majority of men were not happy with their sex lives and wanted a long-term partner for more intimate and emotionally connected sex. Chemsex was also associated with having unprotected sex with high risk of HIV/STI transmission (Bourne 2014).

3.23.8 A report by the UK Drug Policy Commission (2010) found that the LGB&T community tend to be early users of new drugs and says improving links between such minorities and health officials would identify risks before drug use became widespread.

3.23.9 Buffin (2012) found that LGB people experienced barriers both in recognising that they may have a substance problem, and in accessing services to help them. The internet was the most popular source of information and advice. Participants feared prejudice or lack of understanding from mainstream services around their sexual orientation.

3.23.10 There is less evidence about drug use in trans people, but *The Trans Mental Health Study 2012* found that 24% of trans people have used drugs within the last 12 months, the most common being cannabis, poppers and ecstasy. Rooney found 10% of trans people indicated signs of severe drug abuse using the Drug Abuse Screening Test (Rooney 2012).

3.23.11 There are specific considerations around drug use in trans people. A healthy lifestyle is important for trans people undergoing hormone treatment. Drug taking, excessive alcohol consumption and obesity are all factors that can undermine the efficacy of hormone treatment and increase the risk of complications. Due to long waiting times for gender reassignment, some trans people may order their own medication via the internet, which may not be safe (Reed 2009).

3.23.12 Sexual orientation of drug and alcohol clients has been recorded by the HALO system in Devon since 1st April 2013 (table 13). The fact that 2.2% of drug service clients are reported as LGB (despite significant lack of completion in the data) suggests that there are at least as many LGB clients in the drug service as there are LGB people in the general population (see table 2).

Table 13: Alcohol and drug service clients by sexual orientation - Devon and Torbay (Plymouth data is incomplete)

	LGB or other	Heterosexual	Blank or unrecorded	Total
Alcohol Service	0.7% (-)	38.9% (118)	60.4% (183)	303
Drug Service	2.2% (27)	81.8% (984)	16.0% (192)	1203

Other Lifestyle Factors

3.24 UK research is lacking in this area, and national datasets do not record sexual orientation and gender identity. US research has found that lesbians are more likely to be overweight or obese than heterosexual or bisexual women (Conron 2010, Jun 2012). Gay men were less likely to be overweight (odds ratio 0.5; 95% confidence interval: 0.4-0.7) or obese (OR 0.5; 95% CI: 0.3-0.6) than heterosexual men, whereas lesbians were more likely to be obese (OR 2.1; 95% CI: 1.6-2.7) than heterosexual women. Weight did not differ between bisexuals and heterosexuals.

3.24.1 Stonewall found that gay and bisexual men are less likely to be overweight or obese than comparable data for men in general (44% compared to 70% of men in general) (Guasp 2012), and similar levels of overweight and obesity as in women in general.

3.24.2 Stonewall found that 25% of gay and bisexual men (28% in the Devon sample) said they meet recommended physical activity levels, compared to 40% of men in general. 50% of lesbian and bisexual women said they meet recommended physical activity levels, compared to 28% of women in general. Statistical significance was not provided for these comparisons.

3.24.3 A US study found that sexual minority women are at increased risk for cardiovascular disease (CVD) compared with heterosexual women. Family history of CVD and history of drug use was unrelated to increased CVD risk, and the risk was not fully explained by either risky drinking or smoking. The findings suggest that sexual minority status may confer additional CVD risk beyond that of smoking and excessive alcohol use (Farmer 2013).

3.24.4 Trans individuals may face particular barriers to participation in facilitated or venue-based physical activity because of open changing rooms and gendered facilities. *The Trans Mental Health Study 2012* found that 50% of respondents avoided public toilets and gyms, and 25% avoided other leisure facilities, clubs or social groups (McNeil 2012).

Domestic Abuse

3.25 Domestic abuse and sexual assault services do not routinely ask about sexual orientation or gender identity. One national survey (not fully representative due to sampling) found that 38% of respondents reported experiencing domestic abuse in a same sex relationship (40% of women and 35% of men) (Donovan 2006). LGB&T populations may experience unique forms of abuse, based on their sexual orientation and/or gender identity.

3.25.1 Stonewall found that 25% (23% in the Devon sample) of lesbian and bisexual women have experienced domestic abuse in a relationship, which is similar to the rate for women in general. Of those who had experienced domestic violence from a female partner, 62% had experienced some form of violence from a female partner, 6% had been forced to have unwanted sex, and 9% had their sexual orientation used against them (Guasp 2012).

3.25.2 Stonewall found that 49% (55% of the Devon sample) of gay and bisexual men reported experiencing at least one incidence of domestic abuse from a family member or partner since the age of 16, compared to 17% of men in general). Of those who had experienced domestic violence from a male partner, 9% of gay and bisexual men reported being forced to have unwanted sex, and 7% reported that they had had their sexual orientation used against them (Guasp 2012).

3.25.3 A recent systematic review (with some limitations) found that men who have sex with men who are victims of Intimate Partner Violence (IPV) are more likely to engage in substance abuse (odds ratio = 1.88, 95% CI 1.59–2.22), suffer from depressive symptoms (OR = 1.52, 95% CI 1.24–1.86), be HIV positive (OR = 1.46, 95% CI 1.26–1.69), and engage in unprotected anal sex (OR = 1.72, 95% CI 1.44–2.05). Men who have sex with men who are

perpetrators of IPV are more likely to engage in substance use (OR = 1.99, 95% CI 1.33–2.99) (Buller 2014).

3.25.3 *The Big Community Survey* (Intercom Trust 2014) asked "In the past two years have you experienced any physical or emotional violence - or threats of violence - in your home or from your partner or family?"
14% said "Yes", 84% said "No". (2% gave no answer.)

3.25.4 The *Trans Mental Health Study 2012* found that 17% of respondents had experienced domestic abuse because of being trans. Another survey (though not fully representative) by the Scottish Transgender Alliance found that transgender people had high levels of transphobic domestic abuse. 80% of respondents said that they had experienced emotionally, sexually or physically abusive behaviour by a partner or ex-partner, the most frequent of which was transphobic emotional abuse at 73%. High risk points for abuse include when trans people are coming out for the first time to existing partners, and when they reveal plans to transition. This has a compounding effect on poor mental health and can make the complex process of transition even more difficult. Respondents also expressed apprehension about seeking help from mainstream services, due to fear of being outed, misunderstood or experiencing transphobic reactions (Roche 2010). Research into the lives of LGB&T people in Brighton and Hove found that 64% of trans respondents had experienced domestic abuse, often associated with a rejection of their trans identities (Browne 2008). This compared to 29% of the non-trans respondents in the same survey. Trans people are also at risk of abuse from other family members (Whittle 2007).

3.25.5 Low numbers of LGB&T clients (less than 1% LGB and no recorded cases of transgender clients in both 2011-12 and 2012-13) are recorded as using domestic abuse services in Devon. However, 13% of adults and 23% of young people using The Intercom Trust's help and advocacy services (between 2009 and 2013) disclosed domestic violence and abuse (The Intercom Trust 2013).

Homelessness and Housing

3.26 There is strong evidence that there are high levels of homelessness amongst LGB&T youth (see section 3.34 on youth). For homeless adults, sexual orientation and gender identity can remain invisible (Roche 2005). Homeless people often experience multiple and complex health and social needs, which may mean issues of sexual and gender identity become marginalised.

3.26.1 *The Trans Mental Health Study 2012* found that 19% of trans people had been homeless at some point.

3.26.2 Stonewall research has found that one in five lesbian and gay people expect to receive worse treatment because of their sexual orientation when applying for social housing, this proportion rises to one in four among young (18-24) and older (over 55) gay people (Stonewall 2011).

3.26.3 Devon Home Choice record both sexual orientation and gender identity, but the fields are significantly underreported (tables 14 and 15).

Table 14: Applications to Devon Home Choice by gender identity (Devon, Plymouth and Torbay)

Gender	Total	Percentage
Not recorded	6	0.02%
Female	21,571	61.71%
Male	13,353	38.20%
Transgender	26	0.07%
Grand Total	34,956	100.00%

Table 15: Applications to Devon Home Choice by sexual orientation (Devon, Plymouth and Torbay)

Sexual orientation	Total	Percentage
Not recorded	13,995	40.04%
Bisexual	176	0.50%
Gay man	127	0.36%
Gay woman/lesbian	90	0.26%
Heterosexual	17,380	49.72%
Other	211	0.60%
Prefer not to say	2,977	8.52%
Total	34,956	100.00%

Employment/Deprivation

3.27 Data on employment rates is limited. *An Anatomy of Economic Inequality in the UK* found that there was no significant difference between the employment rates and salaries of same-sex couples and heterosexual couples, once levels of qualifications and parental status were controlled for (the findings of the *Labour Force Survey* had previously implied that people in same-sex couples were *more* likely to be employed and earn higher salaries, but this was due to bias in the sample). This survey does not give a picture of the wider LGB population who are *not* in a same-sex couple, and gives no information about transgender employment.

3.27.1 However, Stonewall has found that LGB people face significant barriers at work. Nearly one in five lesbian and gay people have experienced bullying from their colleagues because of their sexual orientation (Hunt 2007). Another survey found even higher levels – one in three experienced verbal bullying and discrimination (Lesbian and Gay Foundation 2012).

3.27.2 *The Trans Mental Health Study 2012* found that 52% of the participants had experienced problems with work due to being trans or having a trans history. The most common issue was harassment or discrimination, with 19% experiencing this. 18% believed that they had been unfairly turned down for a job due to being trans, whereas 16% had not applied for one due to fears of harassment and discrimination. 9% had not provided references because of their gender history, whilst 7% had left a job due to harassment or discrimination even though they had no other job to go to. *Engendered Penalties* (Whittle 2007) found that the main trigger point for inequality or discrimination was the point of transition in the workplace.

> *"Never knowing how people are reading me/ forever being misgendered/ not having an identity that is generally recognised as valid... (the list goes on) this causes a lot of anxiety and does effect my mental health/ depression. I have been out of work…"*
> *(The Big Community Survey, Intercom Trust 2014)*

Minorities within Minorities

3.28 *Minorities within Minorities*, a supporting document to the *Lesbian, Gay, Bisexual and Transgender Companion to the Public Health Outcomes Framework*, has summarised the evidence on the compounding effect of belonging to multiple minority groups (Varney 2013). The strength of the research so far is limited by small sample sizes but some differences can be drawn out.

Black and Minority Ethnic Groups (BME)

3.29 *Minorities within Minorities* (Varney 2013) found that growing up within different minority groups may create additional pressures for a person from a minority sexual orientation or gender identity. For example ethnicity, religion and sexual orientation interact differently in different ethnic contexts.

3.29.1 The report highlights that:

- Migrant gay men are particularly vulnerable because of their socio-economic circumstances, with higher risk of mental ill health and sexual risk taking.

- The picture on mental health is complex; ethnic minority gay men living with HIV are prone to more psychological stress related to their gay lifestyle than Caucasian gay HIV positive men, but King (2003) found that BME LGB respondents were less likely than white LGB respondents to have considered suicide, possibly because of cultural and religious taboos around suicide.

- BME LGB people are more likely to smoke than heterosexual BME people, but less likely to smoke than white LGB people.

- BME LGB people may be more likely to experience physical abuse and more likely to experience harassment from a stranger than white LGB people.

3.29.2 Stonewall (Guasp and Taylor 2012) found:

- Even higher levels of suicidal ideation among BME gay and bisexual boys aged 11-19 than white gay and bisexual boys, and higher levels of self-harm in BME lesbian and bisexual girls than white lesbian and bisexual girls.

- Higher levels of domestic abuse from a family member since the age of 16: 43% of black gay and bisexual men, 32% of Asian men and 34% of other ethnicity men compared to 22% of white gay and bisexual men.

- Higher levels of drug use in BME lesbian and bisexual women (46% compared to 34% white lesbian and bisexual women).

3.29.3 There is a lack of evidence on the health needs of trans BME people. There is no local data on the health of black and minority ethnic LGB&T people.

Disabled people

3.30 Stonewall (Guasp and Taylor 2012)[10] found that, compared to lesbians and bisexual women who are not disabled:

- Lesbians and bisexual women who are disabled are more likely to have experienced domestic abuse in a relationship – 39% compared to 24%.

- Lesbians and bisexual women who are disabled are more likely to have attempted to take their own life in the last year (10% compared to 4%) and are more likely to have deliberately harmed themselves (31% compared to 18%).

- Lesbians and bisexual women who are disabled are less likely to drink more than three or more days a week (30% compared to 44%) and less likely to have taken illegal drugs in the last year (30% compared to 36%).

- 35% are not out to their GP, compared to 49% of the general sample.

3.30.1 Stonewall (Guasp and Taylor 2012)[11] found that, compared to gay and bisexual men who are not disabled:

- Gay and bisexual men who are disabled are more likely to have experienced domestic abuse from a family member or partner since the age of 16 (63% compared to 47%).

- Gay and bisexual men who are disabled are more likely to have had problems with their weight or eating in the last year (23% compared to 11%).

- Gay and bisexual men who are disabled are more likely to have attempted to take their own life in the last year (7% compared to 2%) and are more likely to have deliberately harmed themselves in the last year (15% compared to 5%).

3.30.2 Stonewall found that disabled LGB people were less likely to be accessing the services they needed (source of comparator not provided):

- 37% of disabled LGB people did not access health services they felt they needed in the last year compared to 28% of heterosexual non-disabled people.

- 23% of disabled LGB people did not access mental health services they felt they needed in the last year compared to 6% of heterosexual non-disabled people.

[10] Statistically significance not available.
[11] Statistically significance not available.

- 19% of disabled LGB people did not access social care services they felt they needed in the last year compared to 10% of non-disabled heterosexual people.

3.30.3 *The Trans Mental Health Study 2012* found that 58% of respondents reported that they had a disability or a long term health condition, but there may be underlying complexities to this self-reporting, as some respondents may be identifying gender dysphoria itself as a form of disability (Whittle 2007). Whittle (2007) found a similar level of impairment in the respondents to *Engendered Penalties* as in the general population (15% compared to 14.4%). Transmen have been found to have more autistic traits than non-trans females, non-trans males and transwomen, but lower than individuals with Asperger's Syndrome (Jones 2011). There is a general lack of evidence on the health needs of disabled trans people. There is no local data on the health of disabled LGB&T people.

Young LGB&T People

3.31 A recent large representative survey of LGBTQ young people in the UK (n=6,514) found that found that 53% of LGBQ respondents knew they were LGBQ by the age of 13, and 58% of trans respondents knew they were trans by the same age (METRO Youth Chances 2014).

Education and Schools

3.32 Stonewall undertook a survey of 1,600 British pupils in 2012 (*The School Report*). Levels of homophobic bullying had fallen by 10% since their previous survey, but remain high, with 55% of pupils saying they had experienced this. 99% of pupils hear the term 'gay' used derogatorily or hear other homophobic language. 44% of respondents skipped school because of homophobic bullying, and 32% of those who were bullied had changed their plans for future education as a result of it.

3.32.1 King (2003) found that among men, bullying at school was reported no more often by gay than heterosexual men, but those gay men who had been bullied regarded their sexual orientation as the main provocation.

3.32.2 There is little evidence on the experience of young trans people at school, but *Engendered Penalties* (2007) found that 64% of young trans men and 44% of young trans women had experienced harassment or bullying at school, from teachers as well as pupils. GIRES has produced guidance on combating transphobic bullying in schools, including case study examples.[12]

3.32.3 The boundaries of homophobic and transphobic bullying are often blurred, since it is often based on *perception* of sexual orientation or gender identity, regardless of whether a young person is actually out or not. Teachers say that boys who behave 'like girls', girls who behave 'like boys', young people with gay parents, friends or family members, and young people merely perceived to be gay can all victims of homophobic bullying (Guasp 2009). Gender non-conformity may be a stronger predictor of psychological distress than sexual orientation or biological sex (Rieger 2012).

[12] Available online at http://www.gires.org.uk/transbullying.php [accessed 02.09.14].

> *"It has to start with kids and schools. I've suffered from severe depression since an early age and have contemplated suicide since I was a little boy. I did attempt it once - and it is ALL directly related to treatment I have suffered by bullies at school and my dad ... at college and even uni), due to my perceived sexuality. I say perceived ... even though I was being called it whilst being punched in the face at school, at the age of six I had no idea I was gay."*
> (*Pride, Progress and Transformation, Equality South West 2012*)

3.32.4 Relationships and Sex Education (RSE) does not consistently address the needs of young LGB people. The Department of Education's *Sex and Relationship Education Guidance* makes clear that schools must meet the needs of all pupils, whatever their developing sexual orientation, and that homophobic bullying should not be tolerated. However this guidance has not been updated since 2000 and its implementation is inconsistent and unclear. The Stonewall School Report found that 85% of pupils had never been taught in school about the biological or physical aspects of same-sex relationships.

> *"... earlier teaching to children that being gay is as acceptable as being straight. This would help with a lot of the reasons why gay people get depressed (acceptance to themselves, their families, friends etc). Earlier knowledge would help overcome these feelings of loneliness and isolation."*
> (*Pride, Progress and Transformation, Equality South West 2012*)

3.32.5 Healthwatch Torbay have produced a Torbay Young People's Emotional Health and Wellbeing Report (July 2013), which included consultation with LGB&T young people. Emotional wellbeing and bullying was highlighted as a priority across the participation groups, and for LGB&T young people (as expected), homophobic bullying was an ongoing issue, by adults as well as peers.

Young LGB&T Mental Health and Substance Misuse

3.33 A US systematic review (Marshal 2008) found that the odds of substance misuse in LGB youth, on average, were 190% higher than in their heterosexual peers and substantially higher within some subgroups ($p<0.0001$). The effect was strongest for a) self-identified LGB youth (as opposed to studies which included same-sex attraction and behaviour), b) females (400% higher odds) and c) those who identified as bisexual (340% higher odds). The effects were also stronger for 'harder drugs', (cocaine, injection drugs) rather than 'softer drugs' (marijuana, heavy alcohol use) where use is already common in the general adolescent population. The exception was cigarettes, where LGB use was significantly higher.

3.33.1 The review found that the strongest risk factors for substance misuse were victimisation, lack of supportive environments, psychological stress, internalizing/externalizing problem behaviour, negative disclosure reactions, and housing status. Adolescent coping mechanisms are often less developed than in adults, making them more vulnerable and likely to turn to unhealthy

and risky ways of coping. Peer victimisation related to sexual orientation and gender identity or expression is associated with disruption to education, traumatic stress, and alcohol and substance use (Collier 2013). LGB youth are almost twice as likely to report sex while intoxicated (OR 1.91, p<0.0001) (Herrick 2011).

3.33.2 A recent analysis of the Longitudinal Study of Young People in England (LYSPE) also found that LGB young people (aged 18/19) were more likely to have a smoking history, drink alcohol, and with risky single occasion drinking (RSOD) (Hagger-Johnson 2013). This study also found that acceptability of recording sexual orientation is very high in young people, with only a 0.1% refusal rate, which strengthens the feasibility of future research and monitoring in LGB youth.

3.33.3 King (2008) found higher levels of self-harm in LGB people, and levels were particularly high in young people. Stonewall found that 56% of LGB young people had deliberately harmed themselves, with girls more than twice as likely to as boys (72% compared to 36%) (Guasp 2012). In comparison, the NSPCC estimates that 7-10% of youth in general self-harm. Girls were also more likely to attempt to take their own life (29% compared to 16% of gay and bisexual boys). Samaritans estimate that 7% of young people in general have ever attempted to take their life.

3.33.4 A US systematic review (Marshal 2011) found significantly higher rates of suicidal ideation or attempts in sexual minority young people (odds ratio 2.92, confidence interval: 2.11-4.03, p<0.0001), with the strongest effects in bisexual young people (OR 4.92, CI: 2.82-8.59, p<0.0001). The review also found significantly higher levels of depression in sexual minority young people.

3.33.5 There is less evidence on the mental health of young trans people. One study found that 52% of gender clinic clients aged 12-18 were depressed, 30% had general anxiety, 75% had relationship difficulties with their parent/carer, 50% had relationship difficulties with their peers, 39% had been victims of harassment, and 23% had self-harmed (De Ceglie 2002). METRO Youth Chances (2014), which included trans respondents, found that 42% of LGBTQ respondents had been treated for depression or anxiety, compared to 29% of heterosexual, non-trans respondents and 52% reported self-harming (current or past) compared to 35% heterosexual and non-trans.

3.33.6 METRO Youth Chances (2014) found that trans young people faced the greatest levels of disadvantage and discrimination and reported lower overall satisfaction with their lives. 36% of trans respondents agreed with the statement *'In most ways my life is close to my ideal'*, compared to 47% of LGBQ respondents and 51% of heterosexual non-trans respondents.

3.33.7 There is some evidence to suggest that family rejection of minority sexual orientation or gender identity is significantly associated with poorer health outcomes, including mental health problems, substance abuse and risky sexual behaviour (Ryan 2009, Bouris 2010).

> *"Isolating myself because I didn't understand fully that I'm trans. Suffered stress/anxiety at college when coming out and depression from rejection at home."*
> *(The Big Community Survey, The Intercom Trust 2014)*

Young LGB&T and Homelessness

3.34 METRO Youth Chances (2014) found that 8% of respondents had had to leave home for reasons relating to their sexual orientation or gender identity.

3.34.1 Some studies have found that as many as 1 in 3 homeless youth in urban centres could be LGB (Roche 2005), though there are no estimates that are generalisable to Devon. Homeless LGB youth have often left home as a result of rejection and intolerance from family or friends, and then may face ongoing difficulties while rough sleeping or in temporary accommodation. Youth may migrate to urban centres where they are exposed to new situations of potential risk and exploitation (Roche 2005). It is reasonable to expect that young trans people would be vulnerable to homelessness for the same reasons.

Older LGB&T People

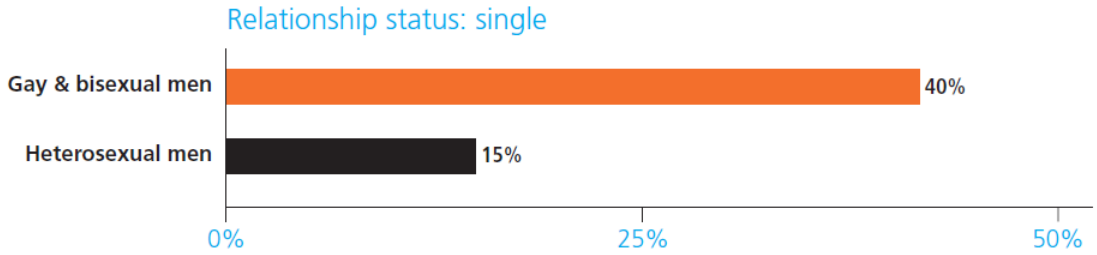
3.35 Understanding of the health needs of older LGB&T people is limited and research in this area is scarce. The existing research often uses small and unrepresentative sample sizes (Addis 2009). However, a Stonewall survey into older LGB people in the UK (Guasp 2010) provides good insights.

Social Isolation in Older LGB&T

3.36 Stonewall commissioned YouGov to conduct a survey of 1,050 heterosexual and 1,036 lesbian, gay and bisexual participants over the age of 55 to find out more about their expectations and experiences of growing older (Guasp 2010). The research found that LGB respondents were:

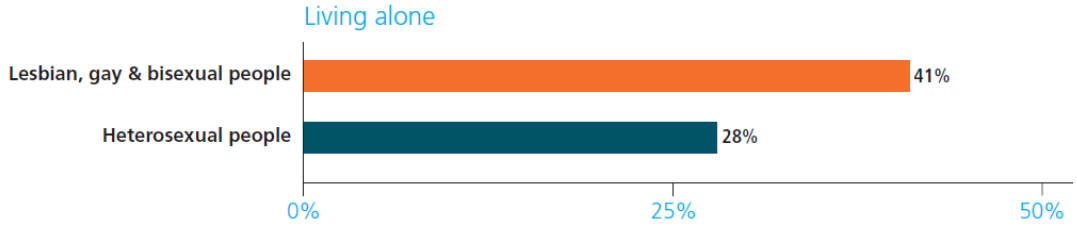
- More likely to be single. 40% of gay and bisexual men were single compared to 15% of heterosexual men.

Figure 16: Relationship status



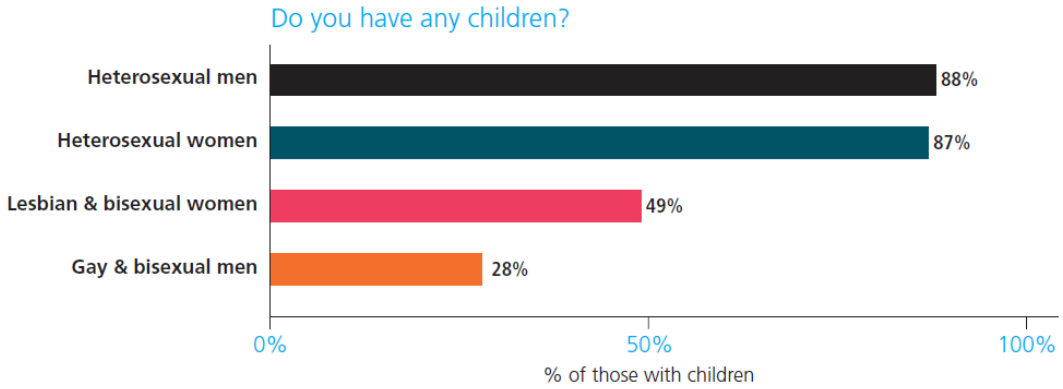
- More likely to live alone. 41% of lesbian, gay and bisexual people live alone compared to 28% of heterosexual people.

Figure 17: Living alone



- Less likely to have children. 28% of gay and bisexual men and 49% of lesbian and bisexual women have children compared to almost 90% of heterosexual men and women.

Figure 18: Do you have any children?



- Less likely to see biological family members on a regular basis. Less than a quarter of lesbian, gay and bisexual people see their biological family members at least once a week compared to more than half of heterosexual people.

3.36.1 While there is a lack of evidence in relation to older trans people, it is reasonable to expect similar patterns of increased isolation and vulnerability. 65% of participants in the *Trans Mental Health Study 2012* say they have worried about growing old alone because of being trans.

3.36.2 There is no data that shows the difference between older LGB&T and heterosexual people in terms of health outcomes, but it is possible that older LGB&T people are at risk of poorer outcomes connected to social isolation and loneliness, such as falls, unplanned hospital admission, fuel poverty and depression.

3.36.3 Social isolation has been identified as a priority in the Devon Joint Strategic Needs Assessment. 41% of adult social care users surveyed in Devon in 2012-13 reported being satisfied with their social situation, which is slightly below the South West and national response. Responses are not available by sexual orientation or gender identity, but commissioners and providers should bear in mind the needs of LGB&T people in relation to this indicator.

Older LGB&T and Health

3.37 Stonewall (Guasp 2010) found that in LGB people aged over 55:

- 45% reported drinking alcohol at least 'three or four days' a week compared to just 31% of heterosexual people.

- 9% reported having taken drugs within the last year compared to 2% of heterosexual people.

- 40% of lesbian and bisexual women have ever been diagnosed with depression, compared to 33% of heterosexual women. 34% of gay and bisexual men have ever been diagnosed with depression, compared to 17% of heterosexual men.

- 49% reported worrying about their mental health compared to 37% of heterosexual people.

- Although research on older adults living with HIV is limited (Paparini 2009), the *50 Plus* report found that older people with HIV are financially disadvantaged compared with their peers and have serious worries about money, poor health, housing and social care (Power 2010).

- There is a lack of information on the health status of older trans people.

Older LGB&T and Access to Health and Social Care Services

3.38 Many older LGB people will have grown up in a time when homosexuality was illegal (until 1966) and for a significant proportion of their lives would have been classified as a mental illness (until 1990). Transgender people only gained full legal recognition in 2004. This historical context needs to be remembered when providing an environment where older LGB&T people feel comfortable and reassured that they can be themselves.

3.38.1 A systematic review into the needs and preferences of LGB patients for end-of-life and palliative care states that the existing research is consistent in showing that services need to avoid heterosexist assumptions about patients, and treat same-sex partners with the same respect and consideration as heterosexual partners (Harding 2010).

3.38.2 NICE has highlighted a lack of UK evidence related to promoting mental wellbeing in certain vulnerable older groups, including LGB&T people (NICE PH16 2008). They do not provide specific recommendations due to this lack of research, but they state that commissioners and managers need to consider in the meantime how proposed interventions can be effectively delivered to these target groups, and monitor and evaluate progress.

3.38.3 Stonewall (Guasp 2010) found that in LGB people aged over 55:

- They are nearly twice as likely as their heterosexual peers to *expect* to rely on a range of external services (due to less family and social support), including GPs, health and social care services and paid help.

- Half of older lesbian, gay and bisexual people felt that their sexual orientation has, or will have, a negative effect on getting older.

- Three in five were not confident that social care and support services would be able to understand and meet their needs. Nearly half would feel uncomfortable being out to care home staff and a third would feel uncomfortable being out to a housing provider, hospital staff or paid carer.

- Two in five were not confident that mental health services would be able to understand and meet their needs.

- One in six were not confident that their GP and other health services would be able to understand and meet their needs. One in five would not be comfortable discussing their sexual orientation with their GP.

- There is a lack of information on older trans people and access to services.

- Further insights are available in a survey run by Age of Diversity and Polari (River 2011).

> *"Worry that I will suffer from dementia or similar as I get older and will get confused about my identity which will cause problems with the respect and dignity that I will require as a human right."*
> *(Pride, Progress and Transformation, Equality South West 2012)*

LGB&T Access to Health and Social Care Services

3.39 It should be noted that there are many examples of healthcare professionals providing excellent care to LGB&T people. One South West survey found that 86% of contributors said that they were treated with respect all, or most of the time when using health services, and less than 3% said that they were rarely or never treated with respect.

> *"With medical staff I am quite open and I have been impressed that their reaction is a non-reaction (it would have been no different if I was telling them about my husband)"*
> *(Pride, Progress and Transformation, Equality South West 2012)*

3.39.1 However, the literature consistently highlights a need for education, awareness and training, so that health and care professionals are as inclusive and sensitive as possible and do not use language that assumes a heterosexual identity or non-trans identity.

3.39.2 A qualitative research study recognised that it may be hard for professionals to find the right balance of attention to a patient's sexual orientation; they may be considered insensitive if they *do not* address sexual orientation in a clinical setting, or insensitive if they *do* (King 2003).

3.39.3 The Stonewall surveys (Hunt 2008 and Guasp 2012) found that in Devon:[13]

[13] Results are not statistically significantly different to national sample.

- 31% of gay and bisexual men in Devon reported at least one negative experience related to their sexual orientation when accessing healthcare in the last year.

- 36% of lesbian and bisexual women and 15% of gay and bisexual men in Devon reported experiencing a healthcare worker assuming they are heterosexual.

- 18% of lesbian and bisexual women and 13% of gay and bisexual men in Devon reported feeling that they have had no opportunity to discuss sexual orientation in a healthcare setting.

- 31% of gay and bisexual men in Devon responded 'few or none' to the question 'what proportion of GPs or healthcare professionals know you are gay or bisexual?' They were more likely to report being out to their manager, work colleagues, family and friends then their GP or healthcare professionals.

- 10% of lesbian and bisexual women and 4% of gay and bisexual men in Devon reported that they were unsure of their GP surgery's confidentiality policy.

- 20% of lesbian and bisexual women and 17% of gay and bisexual men in Devon reported that they had experienced a healthcare worker welcoming their partner into a consultation.

3.39.4 A report on the experiences of transgender people in the South West showed that transgender people frequently encountered barriers in health service provision. A systemic lack of appropriate health care provision was identified, along with a lack of awareness about the effects of gender dysphoria, and the health needs that arise (Equality South West 2009).

> *"My GP is actually quite good - but there is general ignorance about trans issues in NHS and total disregard of obligations to protect information as required ..."*
> *(Pride, Progress and Transformation, Equality South West 2012*)

3.39.5 The response to the inquiry at Mid-Staffordshire NHS Foundation Trust, *Hard truths: The Journey to Putting Patients First*, includes an Equality Analysis which acknowledges that LGB&T people may face barriers and discrimination in accessing healthcare and that the recommendations should address this (Department of Health 2013).

> *"I was assigned to a counsellor who immediately terminated the session when I told her that I was gay."*
> *(The Big Community Survey, Intercom 2014*)

3.39.6 Sexual orientation is recorded in the Adult Social Care Survey and Carers survey, however response rate is too small to be meaningful, so it is not possible to compare LGB satisfaction with heterosexual satisfaction with services.

3.39.7 The Big Community Survey (The Intercom Trust 2014) found that 22 respondents (12%) had had contact with social care services in the past two years. The survey then asked "Did the Social Care service(s) adequately meet your needs and expectations as an LGB or Trans person?", and "Did you feel that — as an LGB or Trans person — the service(s) provided were positive and non-discriminatory?" There were 12 positive responses and four negative. Examples of respondents' experience included:

- *"Trying to get relevant treatment for PTSD through the [local] services, and so far, failing dismally to get an adequate response. Noticed a strong tendency among psychiatric assessors to assume that mental health problems are automatically related to being LGBT."*
- *"I have attended an LGBT information evening about adoption organised by [my local] Council. It was excellent and we were made to feel very welcome and confident in the Council's positivity about LGBT adopters."*
- *"I have on the whole received very sensitive and respectful treatment through the NHS, except in the area I mentioned above [regarding PTSD as mentioned above]. I'd like to see psychiatric staff better trained in relating to trans people with mental health issues."*
- *"To be honest I think it was just the team that were involved with us, but they did break my confidentiality."*
- *"It should not be the first question you are asked, it should be about you as a person not just because your [sic] Gay."*

3.39.8 "Is there anything that could have been done to have given you more confidence in any of these services?" Comments included:

- *"a standard or a mark that says staff have been trained and equally value and believe in that training. That would give me confidence (in the same way that counsellors adhere to the BACP Ethics Board)."*
- *"In spite of a strong desire to end my life a year ago, mental health services said I was fine. I sought counselling privately in the end."*
- *"I have experienced a lack of communication between services in relation to health care. Also, there has been lack of local support when I don't live within a catchment area for a particular health care service…"*
- *"Homosexual individuals that really can relate rather than heterosexual ones."*
- *"I don't know whether my GP surgery is fully LGBT-friendly or not."*
- *"Straight people, no matter how well meaning, should not assume they know what it's like to grow up gay, or that it makes no difference at all."*

- *"I have used the GUM clinic twice for testing, found them to be throughly helpful. Any trouble I have had with alcohol and drugs were not intrinsically linked with my being a gay man."*

- *"GPs could be better informed LGBT about identities, equality and generally improve their interpersonal skills."*

Cancer and Screening

3.40 High levels of risk factors, such as smoking, alcohol and drug use mean it would be reasonable to expect higher incidence of cancer in the LGB&T population. However, sexual orientation and gender identity are not monitored by the national cancer registry and cancer cohort studies, so there is no clear picture of whether there are inequalities in this area. Research has tended to focus on breast cancer and screening.

3.40.1 There is a lack of evidence on the incidence of breast cancer in lesbian and bisexual women, despite considerable interest in this area. In a systematic review, Meads states that the research so far suggests a higher incidence, but it is poor quality and scarce. The only way to increase certainty would be to collect sexual orientation within routine statistics, including Cancer Registry data or from large cohort studies (Meads 2013).

3.40.2 Although cervical abnormalities are more common in lesbian and bisexual women who have been sexually active with men, they have also been found in those who had only ever had sex with women, as the HPV virus can be transmitted through a lesbian partner who has previously had heterosexual sex (Bailey 2000). The same study found that 85% of participants had previously had heterosexual sex.

3.40.3 Despite this risk, there is a common misconception among both patients and health professionals that lesbians are not at risk, leading to significantly lower attendance rates (Fish 2009). Stonewall found that 15% of lesbian and bisexual respondents over the age of 25 had never had a cervical smear test compared to 7% of women in general (Hunt 2008). Of those who had never been tested, one in five had been told by a health worker that they were not at risk. 2% had been refused a test. 70% have had a smear test in the last three years, which is comparable with national data.

> *"...refused a smear test by GP as (I am a) lesbian, despite previously insisting (this is) necessary. When (I) disclosed (my) sexuality (I was) told more likely to be Thrush...As a nurse myself, (I knew this to be) completely unrealistic and potentially dangerous advice."*
> *(Pride, Progress and Transformation, Equality South West 2012*)

3.40.4 Screening presents particular barriers for transgender individuals. Trans women on hormone therapy are at risk of breast cancer and should be invited for screening. Trans women do not need to attend smear tests as they have no womb or cervix. However, they will continue to need to attend prostate screening (though they will be at lower risk for prostate cancer than men due to oestrogen therapy). Similarly, trans men will need to attend breast and

cervical screening, as they will still be at risk.[14] However, services need to consider how to fulfil these clinical needs sensitively and without discrimination. For instance, if a trans woman is summoned to a men's health clinic for prostate examination, or if a trans man is sent to a gynaecological unit for a smear test, the individual would have grounds for complaints of discrimination and/or violation of their privacy (Department of Health 2008). There are also complexities around ensuring that trans people are on the appropriate register in the first place, without compromising their privacy, and also ensuring sensitivity over examining parts of the body that they may not normally wish to draw attention to.

Cancer Awareness, Help-Seeking and Patient Experience

3.41 Although some differences have been found in LGB people in terms of awareness of cancer symptoms and help-seeking behaviour, the similarities outweighed the differences (Gunstone 2010). Gay and bisexual men were more aware of symptoms and more likely to seek help than their heterosexual counterparts, whereas older lesbian and bisexual women were less likely to recognise the importance of lifestyle risk factors and less likely to seek help than their heterosexual counterparts. Overall, age and gender play a more important role in cancer awareness and help-seeking than sexual orientation.

3.41.1 The Cancer Patient Experience Survey (Department of Health 2010) suggested that LGB cancer service users had less positive experiences (in terms of respect and dignity) than heterosexual patients. Out of the questions on which LGB people reported less positive views on cancer treatment than heterosexual respondents, 11/16 related to communication and the respect and dignity with which the patient was treated. There were no measures for trans patient experiences.

LGB&T Local Stakeholder Viewpoints

3.42 The stakeholder workshop discussions largely identified priorities in line with the literature.

3.42.1 Top Priority Areas Identified By Stakeholders:

1. Early intervention/prevention work with younger LGB&T people
2. Mental health and wellbeing across the life-course
3. Access to and experience of health and social care services, especially primary care and mental health

Emerging Themes and Priorities

3.43 A number of cross-cutting themes emerged through discussion and were recorded on flipcharts and post-it notes. The themes are summarised below and include recommendations, insights, challenges and examples of 'what works' to improve the health of LGB&T people.

- **Early intervention and prevention**. Get to the root cause of the health inequalities – discrimination, bullying and intolerance from a young age. Work with parents, e.g. through sure start centres, to help them support an LGB or T child and to respond positively to gender and sexual diversity.

[14] Screening needs for trans people may also depend on other factors including type of drug therapy and sexual activity, therefore clinical judgement needs to be used in each case.

Work with schools to stamp out bullying and strengthen Relationships and Sex Education. Early intervention and prevention also needs to be an approach taken across the life course.

- Services need to build **trust** with LGB&T people by demonstrating that they are 'worthy of trust', by building skills and knowledge and then consistently putting them into practice. Don't just tick a box – show that you mean it and really do care. Trust is a highly valuable but fragile commodity.

- Having **visible** policies, statements, literature and evidence of skills and knowledge can reassure LGB&T patients that they are welcome and go some way to **alleviating apprehension** or avoidance of services due to an expectation of poor treatment. This also means that if poor treatment is experienced, a patient can point out that the service promised (i.e. LGB&T friendly) did not match up to the service delivered. Comments, suggestions and complaints systems need to be easy to use and transparent.

- **Compassion** in healthcare and treating all people equally and with respect should be the default – but there needs to be **accountability** in the meantime for services which are not doing well enough.

- **Communication** has a huge role to play in improving the health and wellbeing of LGB&T people and the services they can access. Communication is not a one-off – it is an on-going process across professionals, partners, patients and public, through as many different channels as possible. Repetition and variety will help get the message across to as many different audiences as possible.

- Ongoing **training and education** is really important to increase knowledge and understanding among professionals. But again – it needs to be more than just a box-ticking exercise, it needs to be regular, mandatory, creative and use people's stories to make it as engaging as possible.

- Sharing **best practice** – there are examples of good practice already out there, e.g. Nottinghamshire Healthcare Trust, Devon and Cornwall Police 'Local Heroes', celebrating diversity and anti-bullying. Herts Valley CCG has won an award for its engagement with the trans community.

- Use real people's **stories and voices** to share good news, what's working well, make LGB&T issues 'real' (remembering that many LGB&T people, especially trans, wish to remain hidden and anonymous).

- **Building capacity** in the LGB&T **community**. LGB&T groups are a support and advocacy resource for LGB&T people, as well as being a resource for commissioners to engage with and learn from. **Consultation and engagement** throughout. Ensure that trans voices are equally represented.

- LGB&T people need to be able to trust that their **data** will be held confidentially, safely and is being collected for a purpose. Be clear about why information is being collected and how it will help. **Confidentiality** can

feel even more crucial in Devon where many communities are small and people who are 'different' may stand out even more.[15]

- **Link to the broader equality and diversity agenda** wherever possible to reinforce the message and strengthen understanding. Raise awareness of cross-cutting 'minorities within minorities' to tackle issues of multiple disadvantage.

- Specific challenges for Devon – **rurality** and a dispersed LGB&T population – may be less 'visible' than other places. How are **older LGB&T people and their carers** being cared for and treated?

4. Summary and Considerations for Next Steps

Summary

4.1 LGB&T people should not be considered as a homogenous group with regards to health needs; sexual orientation and gender identity are just two aspects of identity, and LGB&T people are found across society, just as heterosexual people are. A number of different LGB&T 'communities' exist in the form of social groups and online networking, but the individuals within this community are diverse and not solely defined by their sexual orientation and/or gender identity, and many other LGB&T individuals are not linked to these 'communities'.

4.2 The lack of routinely recorded data presents challenges for assessing the health needs of LGB&T people in the local population, in particular for the transgender population. Developing sensitive and appropriate monitoring of sexual monitoring and gender identity will improve the picture, but it is also necessary to use other methods to ensure that LGB&T needs are being met, including ongoing engagement and input from LGB&T individuals and groups.

4.3 LGB&T people have significantly higher levels of depression, anxiety, self-harm and suicidal ideation. LGB&T people who also have other minority/protected characteristics are at even greater risk.

4.4 Men who have sex with men remain a priority group for HIV prevention and early diagnosis. Devon is an area of low prevalence but this presents its own challenges. Sexual health for lesbian women and trans people is often an invisible and poorly addressed area of need.

4.5 Rates of smoking in LGB people in Devon are significantly higher than in the general population.

4.6 Levels of drug and alcohol abuse are significantly higher in LGB&T people.

4.7 Lesbian and bisexual women are as likely to, and gay and bisexual men are more likely to, experience domestic abuse as their heterosexual counterparts. LGB&T youth may face rejection and abuse from their families.

[15] The 2004 Gender Recognition Act, and 1999 Data Protection Act make it illegal to reveal a trans person's status without their permission.

4.7 Young LGB&T people are more likely to suffer from depression, anxiety, self-harm, suicidal ideation and have higher levels of smoking, alcohol and substance abuse. This is likely to be linked to stress from isolation, bullying and harassment. Homophobic and transphobic bullying is common in schools and can be aimed at anyone who does not conform to a gender or sexual identity norm (whether they are 'out' or not).

4.8 Older LGB&T people are not confident that health and care services are able to provide for their needs in a culturally sensitive way. Older LGB&T people are less likely to have children and more likely to live alone.

Recommendations for Next Steps[16]

	Recommendation	**Responsibility**
1.	Joint Strategic Needs Assessments to include the needs of LGB&T people.	Devon, Plymouth and Torbay Health and Wellbeing Boards and Directors of Public Health
2.	Health and Wellbeing Board Strategy implementation plans to consider actions to reduce health inequalities affecting LGB&T people.	Devon, Plymouth and Torbay Health and Wellbeing Boards
3.	Seek agreement for a Devon-wide LGB&T Best Practice Charter to improve LGB&T access to and experience of services.	Seek agreement from leaders within: • NEW Devon CCG • South Devon and Torbay CCG • Devon County Council • Plymouth City Council • Torbay Council • Devon, Cornwall and Somerset Public Health England Centre • NHS England Local Area Team - Devon, Cornwall and Isles of Scilly
3.	Devon, Plymouth and Torbay to take forward other areas of work as appropriate locally. In Devon, this should consist of a three-year LGB&T Health Improvement strategy, implementation plan and steering group to address the themes from this health needs assessment. The strategy should be developed in collaboration with the HNA stakeholder reference group and should address: 1. Programme Leadership, Strategy Implementation and Governance; 2. Monitoring and Surveillance (see Appendix 1 for sample guidance) 3. LGB&T Mental Health and Wellbeing (including social isolation) 4. Lifestyle/Risk-taking health behaviours in the LGB&T community	Devon, Plymouth and Torbay Health and Wellbeing Boards and Directors of Public Health

[16] Further overarching recommendations can be found in *The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document* (Williams 2013).

	5. LGB&T Children and Young people 6. LGB&T Access to, and Experience of, Health and Social Care Services	
4.	If commissioning needs are identified, identify opportunities for pooled budget and joint commissioning	Local authorities, Joint Commissioning Coordinating Group
5.	Explore the possibility of developing a Peninsula-wide LGB&T Health Network	Authors of this report, Public Health England

5. References

Addis, S. et al., 'The health, social care and housing needs of lesbian, gay, bisexual and transgender older people: a review of the literature', Cardiff University, 2009.

Al-Alami, M, Turner, L and Whittle, S. 'Engendered Penalties: Transgender and transsexual people's experiences of inequality and discrimination', London 2007.

Albeda, R. et al., 'Poverty in the Lesbian, Gay and Bisexual Community', The Williams Institute, 2009.

Aspinall, P. 'Estimating the size and composition of the lesbian, gay, and bisexual population in Britain', Equality and Human Rights Commission Research report 37
University of Kent, 2009.

Austin, S.B. et al 'Eating disorder symptoms and obesity at the intersections of gender ethnicity and sexual orientation in US high school students, *American Journal of Public Health*, February 2013, vol 103/2(e16-22).

Bailey, J. et al 'Lesbians and Cervical Screening' *British Journal of General Practice* 2000, 50 (455) 481 – 482.

Bailey, J. et al 'Sexually transmitted infections in women who have sex with women' *Sexually Transmitted Infections* 2004;80:244-246.

Blosnich, J., Lee, J.G., Horn, K., 'A systematic review of the aetiology of tobacco disparities for sexual minorities', *Tobacco Control*, 2013; 22:66-73.

Bouris, A. et al, 'A systematic review of parental influences on the health and well-being of lesbian, gay, and bisexual youth: time for a new public health research and practice agenda', *Journal of Primary Prevention*, 2010 Dec;31(5-6):273-309.

Bourne, A. et al, *The Chemsex Study: drug use in sexual settings among gay and bisexual men in Lambeth, Southwark and Lewisham.* Sigma Research, London School of Hygiene & Tropical Medicine, 2014.

Browne, K. et al., 'Drugs and alcohol – Additional Findings Report: Count me in to LGBT lives in Brighton and Hove', Brighton: Spectrum, 2009.

Browne, K., and Lim, J., 'Trans people: additional findings report. Count Me In Too: LGBT Lives in Brighton and Hove', Brighton 2008.

Buffin, J et al. 'Part of the Picture: lesbian, gay and bisexual people's alcohol and drug use in England (2009-2011)', Manchester, LGF, 2012.

Buffin, J. and Mirza, I, 'Outing Notts: A study into the substance misuse needs and experiences of LGBT people across Nottinghamshire' University of Central Lancashire with Safer Nottingham Drug and Alcohol Team, 2009.

Buller, A.M. et al 'Associations between Intimate Partner Violence and Health among Men Who have Sex with Men: A Systematic Review and Meta-Analysis' PLOS Medicine March 04, 2014.

Cavanagh, S., Chadwick, K., *Health needs assessment. A practical guide.* National Institute for Health and Clinical Excellence, 2005.

Chakraborty, A. 'Mental health of the non-heterosexual population of England', *British Journal of Psychiatry*, 2011; 198: (143-148).

Collier K.L. et al., 'Sexual Orientation and gender identity/expression related peer victimization in adolescence: a systematic review of associated psychosocial and health outcomes', *Journal of Sex Research*, 2013; 50 (3-4): (299-317).

Conron, K.J. et al., 'A Population-Based Study of Sexual Orientation Identity and Gender Differences in Adult Health', *American Journal of Public Health*, Oct 2010, Vol 100, No 10.

De Ceglie, D. et al. 'Children and Adolescents Referred to a Specialist Gender Identity Development Service: Clinical Features and Demographic Characteristics' *The International Journal of Transgenderism*, Vol 6, Number 1, Jan-Mar 2002.

Department of Health, *Trans: A Practical Guide for the NHS*, Department of Health, London, 2008.

Department of Health, 'National Cancer Patient Experience Survey Programme', Department of Health, London, 2010.

Department of Health, *Hard Truths: The Journey to Putting Patients First*, Department of Health, London 2013.

Department of Trade and Industry, Final Regulatory Impact Assessment: Civil Partnership Act, London 2004

Donovan, C. et al. *Comparing domestic abuse in same sex and heterosexual relationships*. Bristol: University of Bristol, 2006.

Equality and Human Rights Commission 'Collecting Information on Gender Identity' Manchester 2012.

Equality South West 'Transgender: Dimensions of Inequality in the South West' 2009.

Equality South West 'Pride, Progress and Transformation: Health and Wellbeing' 2012.

Farmer, G.W. et al, 'A Population-Based Study of Cardiovascular Disease Risk in Sexual Minority Women', *American Journal of Public Health*, Oct 2013, Vol 103, No. 10, pp.1845-1850.

Fish, J. 'Cervical screening in lesbian and bisexual women: a review of the worldwide literature using systematic methods', Leicester, De Montfort University, 2009.

Gilbert, N., *Researching Social Life – 1st Edition,* Sage Publications, 1993.

GIRES, *Monitoring Gender Nonconformity – A Quick Guide*, GIRES, London, 2012.

Guasp, A., 'The Teacher's Report'. Stonewall, London, 2009.

Guasp, A., ‘Lesbian, gay and bisexual people in later life’ Stonewall, London, 2010.

Guasp, A. ‘The Gay and Bisexual Men’s Health Survey 2012’, Stonewall, London, 2012.

Guasp, A. ‘The School Report’, Stonewall, London, 2012.

Guasp, A. and Taylor, J., ‘Disability: Stonewall health briefing’, Stonewall, London, 2012.

Guasp, A. and Taylor, J., ‘Domestic abuse: Stonewall health briefing’, Stonewall, London, 2012.

Guasp, A. and Taylor, J., ‘Bisexuality: Stonewall health briefing’, Stonewall, London, 2012.

Gunstone, B. ‘Cancer Awareness: The Impact of Sexual Orientation’, Department of Health 2010.

Hagger-Johnson, G. et al. ‘Sexual orientation identity in relation to smoking history and alcohol use at age 18/19: cross-sectional associations from the Longitudinal Study of Young People in England (LSYPE)’, *British Medical Journal Open*, 2013.

Harding, R. et al ‘Needs, experiences, and preferences of sexual minorities for end-of-life care and palliative care: a systematic review’ Journal of Palliative Medicine, 2012 May;15(5):602-11.

Haseldon, L. and Joloza, T., ‘Measuring Sexual Identity: A Guide for Researchers’, London, Office for National Statistics 2009.

Heffernan, K., ‘Eating disorders and weight concern among lesbians’, *International Journal of Eating Disorders*, March 1996, vol 19/2(127-138).

Herrick A.L. et al., ‘Sex while intoxicated: a meta-analysis comparing heterosexual and sexual minority youth’ Journal of Adolescent Health, 2011 Mar; 48(3):306-9.

Hickson F, Weatherburn P, Reid D et al. (2007) ‘Consuming passions: findings from the United Kingdom gay men's health survey’ 2005

Hills, J. ‘An Anatomy of Economic Inequality in the UK: Report of the National Equality Panel’ Government Equalities Office and London School of Economics, 2010.

Hoare, J and Moon, D. ‘Drug Misuse Declared: Findings from the 2009/10 British Crime Survey: England and Wales’ Home Office Statistical Bulletin 2010.

Hunt, R. and Dick, S., ‘Serves You Right’, London, Stonewall, 2007

Hunt, R. and Fish, J. ‘Prescription for Change: Lesbian and Bisexual Women’s Health Survey 2008’, London, Stonewall, 2008.

Johnson W.D., Diaz R.M., Flanders W.D., Goodman M., Hill A.N., Holtgrave D., Malow R., McClellan W.M. ‘Behavioral interventions to reduce risk for sexual transmission of HIV among men who have sex with men’, *Cochrane Database of Systematic Reviews* 2008, Issue 3.

Jones, R.J. et al. ‘Brief Report: Female-to-Male Transsexual People and Autistic Traits’ *Journal of Autism and Developmental Disorders*, February 2012, Volume 42, Issue 2, pp 301-306.

Jun, H.J. et al. ‘Adult Body Mass Index Trajectories and Sexual Orientation: the Nurses’ Health Study II’, American Journal of Preventative Medicine April 2012.

King, M. and McKeown, E., 'Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales', London, MIND, 2003.

King, M., Semlyen, J., See Tai, S., Killaspy, H., Osborn, D., Popelyuk, D., et al. 'Mental disorders, suicide, and deliberate self-harm in lesbian, gay and bisexual people', *BMC Psychiatry*, 8:70, 2008.

Lee, J.G.L, Griffin G.K., and Melvin C.L., 'Tobacco use among sexual minorities in the USA, 1987 to May 2007: a systematic review', Tobacco Control, 2009; 18:275-282.

Lesbian and Gay Foundation, 'Sexual Orientation Monitoring', Lesbian and Gay Foundation, London 2011.

Lesbian and Gay Foundation, 'I Exist', London, Lesbian and Gay Foundation, 2012.

Macdowall, W. et al 'Lifetime prevalence, associated factors, and circumstances of non-volitional sex in women and men in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)', *The Lancet* - 30 November 2013, Vol. 382, Issue 9907

Marshal, M.P. et al, 'Sexual orientation and adolescent substance use: a meta-analysis and methodological review', *Addiction* 2008 April; 103(4): 546-556.

Marshal, M.P. et al, 'Suicidality and Depression Disparities between Sexual Minority and Heterosexual Youth: A Meta-Analytic Review', *Journal of Adolescent Health* 2011 August; 49 (2):115-123.

McElroy, J.A., and Jordan, J. 'Disparate Perceptions of Weight Between Sexual Minority and Heterosexual Female College Students', LGBT Health, Vol 00, Number 00, 2014.

McNeil, J, et al. 'Trans Mental Health Study 2012', Edinburgh, Scottish Transgender Alliance, 2012.

Meads, C. et al. 'A systematic review of UK research on lesbian, gay, bisexual and transgender health', Unit of Public Health, Epidemiology & Biostatistics, West Midlands Health Technology Assessment Group, 2009.

Meads, C. and Moore, D. 'Breast cancer in lesbians and bisexual women: systematic review of incidence, prevalence and risk studies', *BMC Public Health*, 13:1127

Measham, F. et al., 'The Rise in Legal Highs: Prevalence and patterns in the use of illegal drugs and first and second generation 'legal highs' in south London gay dance clubs', *Journal of Substance Use* 16(4): 263-272 (2011).

Mercer, C.H. et al 'Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal)', *The Lancet* - 30 November 2013, Vol. 382, Issue 9907

METRO Youth Chances '*Youth Chances Summary of First Findings: the experiences of LGBTQ young people in England' London,* METRO 2014.

Meyer, I.H., 'Why lesbian, gay, bisexual and transgender public health?' American Journal of Public Health, Jun 2001, 91 (6): 856-9.

Meyer, I.H., 'Prejudice, Social Stress, and Mental Health in Lesbian, Gay and Bisexual Populations: Conceptual Issues and Research Evidence' Psychological Bulletin, Vol 129(5), Sep 2003, 674-697.

Millner, R.E., The experience of lesbians who have a history of binge eating disorder: a qualitative investigation,' *Dissertation Abstracts International*, 2004, vol 65/3.

Mitchell, K.R. et al 'Sexual function in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3)', *The Lancet* - 30 November 2013, Vol. 382, Issue 9907

National Institute for Health and Care Excellence, Public Health Guidance 16 *Occupational therapy and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care,* London, 2008.

National Institute for Health and Care Excellence, Public Health Guidance 28 *Looked-after children and young people*, London, 2010.

National Institute for Health and Care Excellence, Public Health Guidance 45 *Tobacco Harm Reduction*, London, 2013.

National Institute for Health and Care Excellence, Quality Standards 43 *Smoking cessation: supporting people to stop smoking*, London, 2013.

Office for National Statistics, 'Psychiatric morbidity among adults living in private households' London, Office for National Statistics, 2000.

Office for National Statistics, 'Trans Data Position Paper', London, Office for National Statistics 2009.

Paparini, S. 'Older adults living with HIV in the UK: A Review of Current Literature and Directions for Future Research', The Terence Higgins Trust, London 2009.

Power, L. et al, 'A National Study of Ageing and HIV (50+)' The Joseph Rowntree Foundation and The Terence Higgins Trust, London 2010.

Press for Change, 'Trans Equality Monitoring', Press for Change, London, 2006.

Reed, B. et al 'Gender Variance in the UK: Prevalence, Incidence, Growth and Geographic Distribution' GIRES, London, 2009.

Rieger, G. et al 'Gender nonconformity, sexual orientation, and psychological wellbeing' *Archives of Sexual Behaviour* 2012 Jun; 41 (3): 611-21.

River, L. 'Appropriate Treatment: older lesbian, gay and bisexual people's experience of general practice', Age of Diversity and Polari 2011.

Roche, B., 'Sexuality and Homelessness', Crisis, London 2005.

Rooney, Eoin. 'All Partied Out? Substance Use in Northern Ireland's Lesbian, Gay, Bisexual and Transgender Community', Belfast, The Rainbow Project, 2012.

Ryan, C. et al, 'Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults' *Pediatrics*, 2009 Jan; 12(1):346-52.

Stonewall, Albert Kennedy Trust and Stonewall Housing, 'The Housing Guide for Lesbian, Gay and Bisexual People', 2011.

Struble, C.B. et al, 'Overweight and obesity in lesbian and bisexual college women', Journal of American College Health 2011;59:51-6.

The Intercom Trust, 'Help and Advocacy service for Cornwall, Devon and Dorset: CASSIA Confidential Casework Analysis Report 2009-2013'

UK Drug Policy Commission 'The Impact of Drugs on Different Minority Groups: A Review of the UK Literature', 2010

Van Kesteren PJ, Gooren LJ, Megans JA, An epidemiological and demographic study of transsexuals in The Netherlands, Archives of Sexual Behaviour, 1996 Dec; 25(6): 589–600.

Varney, J. *Minorities within minorities*, Lesbian and Gay Foundation, London 2013.

Ward, R. et al 'Don't look back? Improving health and social care service delivery for older LGB users' Equality and Human Rights Commission, London 2010.

Whittle, S. and Turner, L. '"Sex Changes"? Paradigm Shifts in 'Sex' and 'Gender' Following the Gender Recognition Act?', *Sociological Research Online*, 12 (1), 2007.

Whittle et al. 'Engendered Penalties: Transgender and Transsexual People's Experiences of Inequality and Discrimination' Press for Change 2007.

Williams, H., Varney, K. et al, *The Lesbian, Gay, Bisexual and Trans Public Health Outcomes Framework Companion Document*, London, Department of Health 2013.

Wilson, P., Sharp, C., Carr, S. 'The prevalence of gender dysphoria in Scotland: a primary care study' British Journal of General Practice, Dec 1999.

Yean, C et al., 'The relationship of sex and sexual orientation to self-esteem, body shape satisfaction, and eating disorder symptomatology', Frontiers in Psychology, 2013, vol 4(887), 1664-1078.

Author:
Sarah Bird
ADVANCED PUBLIC HEALTH PRACTITIONER

Acknowledgements

With thanks to the project reference group including members of:

Stonewall
The Intercom Trust
Devon County Council/NEW Devon LGB&T staff network
The Eddystone Trust
Equality South West
The Diversity Trust
Transgender Information
Proud2Be
The Beaumont Society
Northern, Eastern and Western Devon Clinical Commissioning Group
South Devon and Torbay Clinical Commissioning Group
Devon County Council
Plymouth City Council
Torbay Council
NHS England
Public Health England
Royal Devon and Exeter NHS Foundation Trust
South Devon Healthcare NHS Foundation Trust
Devon Partnership Trust
The Laurels
Plymouth Hospitals NHS Trust

Northern Devon Healthcare Trust
Healthwatch Devon
Healthwatch Torbay
Healthwatch Plymouth

APPENDIX 1

Guidance for Developing Monitoring

(Source: Sexual orientation monitoring, Lesbian and Gay Foundation. Further guidance is available from the Equality and Human Rights Commission)

Monitoring sexual orientation

The Public Sector Equality Duty (part of the Equality Act 2010) requires that all public sector organisations take into account the needs of people with protected characteristics when designing and delivering services. Monitoring sexual orientation is an important part of fulfilling this duty. There are legitimate concerns around privacy, acceptability and sensitivity of monitoring sexual orientation, but the Lesbian and Gay Foundation has published best practice guidance to help:

- Response rates may be low at first but will increase over time as it becomes embedded.
- It is important to find the appropriate time/place to ask about sexual orientation.
- Monitoring needs political will and leadership to be successful.
- A clear and comprehensive confidentiality policy is essential.
- Staff and service users should be told why sexual orientation is being monitored, how it will improve services and how the information will be safeguarded.
- Sexual orientation shouldn't be treated as a special subject; it should be asked alongside other protected characteristics.
- The data can be used to improve outcomes for staff and service users, and compared to existing research on LGB needs and local population data.
- The individual retains the right not to disclose, but by asking the question a culture of openness and acceptability will build up over time. Monitoring of sexual orientation is about self-definition and self-declaration; assumptions should not be made about an individuals' sexual orientation or how likely they are to disclose.
- Allow people to complete monitoring questions in private, confidentially and in their own time, and make sure they know that they are under no obligation to disclose.
- Use caution when analysing data from a small sample.
- If a 'prefer not to say' option is included, it should be included for all protected characteristics questions.

The following can be taken as a suggested example:

Which of the following best describes how you think about yourself?

- ☐ Heterosexual
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual

It can also be valuable to measure the attitudes of all staff. The Intercom Trust suggest asking 'Is your office environment a welcoming place for LGB&T people?'

Figure 1: Guidance for monitoring sexual orientation

Monitoring gender identity

'Gender identity monitoring is highly complex, warranting further thought and investigation. The issue of monitoring is a dividing issue for the trans community; whilst some feel no qualms about disclosing their trans status or history, others feel that questions around gender identity are inappropriate and, ultimately, ineffective. TREC [Trans Resource and Empowerment Centre] advocates the use of monitoring with regards to surveying the attitudes of service providers rather than as a means of surveying gender identity per se, placing emphasis on quality of service in order to avoid personal disclosure.' (Louis Bailey, Trans Resource and Empowerment Centre, as quoted in Lesbian and Gay Foundation *Sexual Orientation Monitoring*, 2011)

From a legal perspective, it is crucial that any research or monitoring does not lead to the identification of individuals as trans. Section 22 of the Gender Recognition Act states it is an offence for a person who has acquired protected information on a person's gender history, in an official capacity, to disclose the information to any other person (Office for National Statistics 2009).

The Equality and Human Rights Commission provides the following guidance on whether public authorities are required to monitor all of the protected characteristics of their staff under the Equality Duty:

'Because the general equality duty requires you to analyse the effect of your organisation's functions on all protected groups, public authorities will not be able to

meet the duty unless they have enough usable information. If public authorities have not yet achieved a culture where employees or service users are ready to be asked about their sexual orientation, gender identity or religion or belief, they should take steps to engender a culture of trust in which this information could be collected. There may be other means of identifying the issues faced. Analysing national or local research and engagement with people from those groups can be useful for identifying potential issues of concern. If this information is collected, it is important to explain why the information is being collected, what it will be used for, and how privacy will be protected.'

According to guidance from GIRES on monitoring gender identity, a supportive culture is an essential prerequisite to monitoring. Organisations should first monitor staff attitudes to transgender people using the following question:

How comfortable would you be working with, or providing services for, a gender nonconforming person?

- Very comfortable
- Comfortable
- Neutral
- Uncomfortable
- Very uncomfortable
- Refuse to work with/provide services for
- Not sure or prefer not to say

Further best practice questions to monitor gender identity, gender nonconformity and gender reassignment can be found here (GIRES 2012) and here (Equality and Human Rights Commission 2012).

APPENDIX 2

Service Mapping

The following summarises the specialist services and groups available to lesbian, gay, bisexual and transgender individuals in Devon.

The Intercom Trust
The Intercom Trust offers a range of services for lesbian, gay, bisexual and transgender people across the south west. Services include:

- Help and advocacy
- Community development
- Training
- Information, including the LGBT collective – directory of community groups and projects
- Consultation, including LGB&T Voices in Action service
- Victim support, funded by Devon, Cornwall, Dorset and Wiltshire Police

From March 2010 to November 2013, The Intercom Trust provided support to 617 individuals through its helpline and face to face support, including approximately 80% from Devon and Cornwall. The support comprised 1,255 face to face meetings and 4,349 helpline activities including phone calls and emails. The issues identified by the caseworkers include internalised homophobia/transphobia and low self-esteem, depression and anxiety, problems with sexual behaviours, suicidal ideation, self-harm, grief and loss, addiction to drugs and alcohol, anger management and eating disorders.

Youth groups

- X-Plore Youth Group – Exeter
- Out Youth Group - Plymouth
- LGBT Youth group - Torbay
- There is no LGB&T youth group in North Devon

The Lesbian, Gay, Bi/Bi-curious and Trans Health project
Run by Northern Devon Healthcare Trust, this project offers a range of practical advice & support on sex, sexuality, sexual health, and wellbeing, based in Exeter at the Department of Genito-urinary Medicine, NHS Walk-in Centre, Sidwell Street. They also offer workshops on diverse issues relating to sex, sexuality, orientation, sexual health, social inclusion, wellbeing and promoting awareness of issues that affect vulnerable groups specifically relating to sexual health, social inclusion and gender issues

The aims are:

- To promote sexual health as a part of physical, emotional and social wellbeing
- To promote safer sex to prevent the spread of STIs & HIV
- To provide clear information on sex & sexuality / sexual health
- To provide a safe and confidential space to promote open dialogue
- Provision of safer sex packs

Proud2Be
Proud2Be is a charity based in South Devon that aims to empower all lesbian, gay, bisexual, trans, questioning and intersex individuals to be proud of who they are and have equal opportunities to reach their full potential. Services offered include:

- Proud2Be campaign offering positive messages and showcasing a diverse mix of proud role models
- Social opportunities in South Devon, including monthly social group and yearly Totnes Pride
- Monthly radio show on Soundart Radio
- Workshops and consultancy, including LGBT awareness workshops, Equality and Diversity Workshops, 1:1 Mentoring

Local Heroes
Local Heroes is project that was piloted by Devon and Cornwall Police in the autumn of 2013 to help schools address issues of intolerance and discrimination As well as providing PSHE education, Local Heroes has three clear objectives:

- Challenge intolerance amongst young people
- Give young people from all backgrounds the power to achieve their full potential
- Inspire young people to become responsible citizens who make a positive contribution to society

The Eddystone Trust – HIV and Sexual Health Services
The Eddystone Trust are commissioned to provide HIV and sexual health services across Devon, Plymouth and Torbay. They offer support around HIV related issues, for example feeling isolated, emotional wellbeing, medication and sexual health. They also support on issues that may not be directly related to HIV status such as financial, housing welfare benefits, education, re-training or employment.

They also run a sexual health outreach service, aimed reducing HIV incidence for men who have sex with men and to keep them safe – sexually, physically, mentally and emotionally. Outreach workers offer advice, support and signposting on safer sex, HIV and sexually acquired infections, GUM clinics, helplines, LGBT venues, personal safety, dealing with police and reporting homophobic crime. Eddystone work in partnership with Devon & Cornwall Police and The Intercom Trust to deliver ‘Safer Cruising’ an initiative is aimed at both reducing levels of crime but also to increase the reporting of crime against this group of men.

Sunrise Group North Devon
North Devon Sunrise is a community support organisation, primarily focusing on the needs of people from Black and Minority Ethnic (BME) and diverse communities. The organisation supports some of the most vulnerable and disadvantaged people living in Northern Devon (and surrounding areas) including: victims of domestic violence, refugees and asylum seekers, as well as elderly BME communities and LGBT communities.