Written submission from the National LGB&T Partnership (HSC0033)

Introduction

1. LGBTQ people experience worse outcomes than the general population in most, if not all, areas of health and care. The reasons for this are multiple: lack of provision of appropriate services, difficulty and resistance to accessing, and discrimination within, services, and lack of knowledge and understanding of the specific health needs of and risks for LGBTQ people. There are significant evidence gaps due to a lack in data collection and research, but where evidence exists it paints a stark picture of LGBTQ people's unmet needs.
2. We know even less about the way these needs differ between LGBTQ people based on their other protected characteristics, but it can be assumed that these groups will face double disadvantage[1,2].
3. Below we outline and give reasons for some of the experiences and needs of LGBTQ people in relation to health and social care and point to good practice and recommendations for addressing these.

The National LGB&T Partnership

4. The National LGB&T Partnership was established in 2010 to reduce health inequalities and challenge homophobia, biphobia and transphobia within public services. It combines the expertise of eleven key LGB&T organisations across England[3].
5. The partners have a long history of service delivery, working with LGBTQ people locally and nationally. The intelligence gathered from this frontline work, paired with the Partnership's position as a member of The Health and Wellbeing Alliance[4] enables us to act as a catalyst and connector, putting LGBT people and their issues firmly on the agenda of decision makers.

General:

Access

6. Findings from Pride in Practice and Out Loud[5] are that LGBTQ people still too often face hostility and are inappropriately treated because of their gender identity, trans status and/or sexual orientation.
7. Additional barriers in secondary care include single sex accommodation, where trans and gender non-conforming LGB patients may be made to feel uncomfortable and discriminated against by staff and other service users.

Data collection

8. Progress in advocating for LGBTQ people's specific needs in health and social care is stymied by the lack of evidence to support what we know from experience providing support to LGBTQ service users and communities. While reports such as Improving the health and wellbeing of lesbian and bisexual women and other women who have sex with women[6], Promoting the health and wellbeing of gay, bisexual and other men who have sex with men[7] and The Public Health Outcomes Framework LGBT Companion Document[8] evidence inequalities in health outcomes in a range of areas, the evidence upon which these conclusions are drawn is limited, and doesn't exist for some areas of healthcare. This is due to incredibly poor uptake of sexual orientation monitoring across the health and social care system, non-inclusive gender monitoring and a lack of trans status monitoring[9].

9. It is additionally difficult for comparisons to be drawn with non-LGBTQ populations due to a lack of accurate population statistics either for sexual orientation or trans status. While we commend the efforts of ONS to introduce a question on sexual orientation in the 2020 census, efforts to develop a question on trans status and make the gender question inclusive leave much to be desired and in their current format will not succeed in either intention.
10. The ASCOF LGB&T companion[10] found that 73% of respondents said that the service they provide/commission does not collect data for LGB&T users. A fifth said this was collected, and a further 7% were unsure.

Inclusion Health Groups

Gypsy, Roma, Travellers (GRT)

11. GRT organisations report severe and widespread homophobia and transphobia in their communities, which when combined with discrimination against GRT communities results in feelings of isolation and fear and contributes to poor mental and physical health outcomes.

Homelessness

12. LGBTQ people, particularly young people, are more likely to become homeless, and less likely to receive appropriate support when they do[11]. Homelessness raises specific issues around health, particularly around access to healthcare. In response to this need, recommendations have been drawn up[12][13]. London will soon open first homeless shelter only for LGBT+ people.

Sex workers

13. Sex workers have specific health needs and are particularly disadvantaged due to stigma, discrimination and criminalisation. LGBTQ sex workers face additional barriers due to multiple intersecting marginalisations. Projects such as Trans-Actions and SWARM provide recommendations for addressing these.

Vulnerable migrants

14. Stonewall's No Safe Refuge[14] highlights issues for detained LGBT refugees: harassment and discrimination from other detainees and staff, lack of privacy, inappropriate/insufficient medical treatment and difficulty settling back into society after being released.

Criminal Justice system

15. Access to healthcare, particularly transition related medicine and sexual healthcare, is a particular difficulty in custodial settings. Information about the health needs of people transitioning are outlined in the Inside Gender Identity[15] report.

Whole Systems Approaches

16. Learning from our WSA project[16] showed that bringing all parts of local systems together to tackle complex issues created new energy for change. Shared learning can be drawn from each community, allowing the system to take a more holistic approach.

Ageing:

17. LGBT people are more likely to experience life-limiting disease than non-LGBT people, as well as more likely to be childless, live on their own and experience damaging mental health conditions.

Dementia

18. A lack of traditional models of support leads to an increased need to use social care services. However, research by Stonewall[17] has shown that some older LGB people feel that mainstream services would not be able or willing to meet or understand their needs. Recommendations can be found in the report Dementia, Equity & Rights[18].

End of Life Care

19. Research recognising the barriers to end of life care for LGBTQ people established agreed recommendations[19] to improve provision.

Cancer:

20. Evidence suggests higher rates of some cancers for LGBQ women, and lower participation in gendered cancer screening[20]. A third of gay/bisexual men check their testicles monthly as recommended as a preventative measure against testicular cancer[21] . 10% gay/bisexual men have ever discussed prostate or bowel cancer with a healthcare professional and 3% have ever discussed lung cancer[22].
21. Systems do not currently separate screening need from recorded gender, leaving many trans people without invitation to screening. Combined with the gendered nature of many services, low uptake by LGB women[2324] and the fact that some clinicians turn away LGB women from cervical screening[2526], it is vital that access to screening is addressed.
22. PHE has produced guidance on NHS population screening programmes[27] for trans people, but not for practitioners.
23. Macmillan's report[28] shows how little robust data there is on the needs and experiences of LGBTQ people with cancer. The report states that treatment and support are overwhelmingly heterosexist & cissexist, and clinicians don't know how to support LGBTQ people.

Drugs and Alcohol:

24. Research[29] shows significant problematic substance use amongst LGB people, likely to be higher than in the wider population, with high levels of substance dependency and perceptual and structural barriers to accessing information, advice or help.
25. The Impact of Drugs on LGBT Communities[30] found that despite higher levels of use there was lower uptake of support and treatment. This was largely due to the perception by LGBT people that services would not meet their needs, or that they lacked understanding of the drugs more frequently used by LGBT people, and the context of use.

Chemsex

26. A recently emerged pattern of drug use by gay, bisexual and other MSM to enhance and prolong sexual activity, Chemsex involves a marked and distinct change in the substances used; context of use; routes of administration; and levels of harm. Chemsex has an association with the transmission of HIV, hepatitis and other STIs, as well as links to psychosis, paranoia, and poor mental health. Observations in sexual health clinics highlight how crystal methamphetamine is especially linked to multiple incidences of harm[31].
27. Emerging research links problematic chemsex with loneliness, boredom, community and wanting to belong[32], underlining the need for interventions that address underlying causes.

Smoking

28. There is a higher prevalence of smoking amongst LGBTQ people[33]. The LGBT Cancer Support Alliance presents recommendations[34] for commissioners, care providers, smoking cessation services and LGBT organisations.

Mental Health:

Conversion therapy

29. Data from the Government's LGBT Survey[35] suggests that 2% of LGBTQ people have undergone conversion therapy and a further 5% offered it.
30. There is agreement from the UK counselling and psychotherapy professional bodies condemning conversion therapy. However, this doesn't prevent practice, nor were the majority of those offering this kind of intervention health professionals.

Eating disorders

31. Gay and bi men are over-represented among people seeking treatment for eating disorders, and inconclusive evidence on LGB women[36]. Research[37] found 5% trans respondents had received an ED diagnosis, while 19% believed they had one without diagnosis. In US-based research[38], trans people were four times more likely to have a diagnosis than cisgender heterosexual women.

Inpatient support

32. Very little evidence exists about the needs and experiences of LGBTQ people in mental health inpatient settings or under the Mental Health Act, due to lack of data collection and research. However, the same issues exist around single sex accommodation as in a secondary care settings above.

Psychological therapies

33. Experiences of or resulting from homophobia, biphobia and transphobia can lead to poor mental health, and evidence regularly points to LGBTQ people having poorer mental health than their straight, cis, counterparts.
34. Access to appropriate, culturally competent support is vital, but restricted by the ongoing closing of specialised provision due to funding cuts in the voluntary sector.

Self harm

35. Research[39] has found that 57.1% of LGB people have self-harmed at least once compared to 38.3% of heterosexual people, and 85.2% of trans young people had self-harmed.

Suicide

36. One Survey[40] found in the last year, 3% of gay men had attempted suicide. This increases to 5% of BME men, 5% of bisexual men and 7% of disabled gay/bisexual men. In the same period, 0.4% of all men attempted suicide.
37. Prescription for Change[41] found in the last year, 5% of lesbians had attempted suicide. This increases to 7% of bisexual women, 7% of BME women and 10% of disabled lesbian/bisexual women.
38. The Trans Mental Health Study[42] found that 11% of trans people had thought about suicide in the last year and 33% had attempted suicide than once in their lifetime, 3% attempting suicide more than 10 times.

Physical Activity:

39. 42% of LGBT people meet the level of physical activity required for good health, compared to 59% of the general population[43]. Recommendations to address this can be found in this report[44].
40. Homophobia is a prevalent problem in professional and amateur sport. A Stonewall survey found 72% of football fans have heard homophobic abuse. The 'Out on the Fields' study[45] found 70% of respondents in the UK did not think that youth sports were a supportive place for LGB people. 84% of respondents had heard homophobic 'jokes' in sporting environments.
41. Transphobia in professional sporting bodies' rules influences amateur sport, resulting in teams ruling against gender non-conforming people's participation. Further information about sports governing bodies and LGBT inclusion, including recommendations, can be found in this report[46].

Sexual and Reproductive Health:

42. BASHH have recently stated that sexual health services are 'at breaking point'. This places unfair burden on the VCSE, which is already under-resourced, to provide specialist services, known to have better take-up and outcomes.

Fertility

43. Forthcoming research from PHE found that 28% of trans respondents would like to have a child in future, and 16% are unsure. Gamete storage is not routinely funded for those undergoing medical transition. The EHRC are bringing a judicial review.
44. There is inconsistent access to fertility treatment for women in same-sex partnerships. NICE recommends[47] that six cycles of Intrauterine Insemination (IUI) should be offered to women in same-sex relationships, but only if they have previously had difficulty conceiving through IUI. In practice, this means that women must pay for at least six cycles of IUI themselves before being able to access it through the NHS. It is unclear how many NHS trusts are currently implementing this guidance.

HIV

45. New diagnoses of HIV among gay/bisexual men decreased by 31% 2015 – 2017. In 2012 late diagnosis was lowest among men who have sex with men: 31% of individuals were diagnosed late, and highest among heterosexual men at 62%[48].
46. Due to the continuing stigma around HIV, late diagnosis remains high, particularly among trans women. Trans people are twice as likely as cis people in the UK to be diagnosed late with HIV[49], and preliminary findings from forthcoming research from PHE suggest that 59% of trans people have never had an HIV test.
47. International evidence shows that trans women are estimated to be 49 times more likely to have HIV compared to the general population[50].
48. Local contracts specifically for work targeting MSM in London are now worth around half what they were four years ago in 2013/14. In the rest of England there was a 21% reduction in MSM contract value between 2015/16 and 2016/17[51].

PREP & PEP

49. LGBTQ people in the UK have inconsistent access to PrEP. Free to anyone who needs it in Scotland, in England and Wales LGBTQ people must apply to be on the Impact Trial/PrEPared trial.
50. Initial reports state that the Impact Trail is oversubscribed by white MSM in major cities and undersubscribed by BAME MSM. The study is also struggling to recruit

women. Overall recruitment is inconsistent, with major flaws in how people sign up to the Impact Trial leaving MSM, trans people and bisexual women disproportionately affected.

STIs

51. Between 2014 – 2015 there was a 10% increase in sexually transmitted infections among gay, bisexual or other men who have sex with men.
52. Despite this, ¼ of gay/bisexual men have never been tested for any sexually transmitted Infection and 3 in ten gay/bisexual men have never had an HIV test[52].
53. Less than half of lesbian/bisexual women have ever been tested for sexually transmitted infections, while over half of lesbian/bisexual women who have been tested for sexually transmitted infections have had an infection[53].

Social Care:

54. Three quarters of respondents to one survey[54] said that the service they provide/commission does not collect sexual orientation or trans status data for admissions to residential and nursing care homes. Only 12% said this was collected, a further 12% were unsure. Those who did not collect the data indicated it was not relevant to the service, indicating a lack of understanding of LGB&T inclusion, further evidenced here.
55. Research has shown many LGB&T people, especially those who are ageing, fear the prospect of using generic mainstream care services where engaging in activities associated with LGB&T identity are not perceived to be possible[55].
56. The ASCOF LGBT Companion Document[56] outlines recommendations, good practice and areas for further research.

Transition:

57. Examples are widespread of GPs refusing to prescribe hormones to trans people, even when instructed by specialists. It is also common that GPs do not appropriately refer trans people to gender identity services, both through lack of knowledge but also due to discrimination. Some GPs are instead referring trans patients to mental health services, not only preventing trans people from receiving treatment, but also reducing the capacity of mental health services and increasing stigma around trans identity.
58. As evidenced by the Public consultation on Gender Identity Services[57], waiting lists, inconsistency of treatment and lack of suitably trained workforce are all significant barriers to accessing medical transition.
59. Further barriers include limits on surgery based on BMI not based on medical evidence, discrimination against movement between private and NHS healthcare, and requiring registration with a GP - particularly difficult for those from inclusion health groups.

Depathologisation

60. There is a growing call for depathologisation gender transition, as evidenced by the calls for an 'informed consent' model for gender identity services from a large number of respondents to the public consultation [58]. The move by WHO to reduce stigma by changing the diagnosis from Gender Identity Disorder to Gender Incongruence and moving it from mental health to a new section under sexual health in the ICD11 also points to an understanding of the need for depathologisation, while recognising that many health systems still require a formal diagnosis for treatment.

Young People:

Access to appropriate RSE

61. The teen pregnancy rate is higher for lesbian/bisexual women than for heterosexuals[59] . While exact reasons for this are not known, one element which must certainly affect this is the lack of appropriate, LGBTQ-inclusive relationships and sex education for young people. Not only do young people not learn what they need to know about sex, they are also marginalised and stigmatised, leading to them engaging in risky activities and in activities to try to 'prove' to themselves or others that they are not LGBTQ.
62. Inappropriate and lacking RSE, stigma around being LGBTQ, and resulting poor mental health also lead young LGBTQ people to be at increased risk of sexual assault[60] .

Access to healthcare

63. Young LGBTQ people, particularly those with unsupportive families or not 'out' to their families have restricted access to healthcare through reduced ability to travel to access LGBTQ specific healthcare (particularly geographically-dispersed transition-related healthcare) and due to concerns around confidentiality. A trans-inclusive review of young people's gendered help-seeking behaviours can be found here[61].

Mental Health

64. Young LGBTQ people have higher rates of poor mental health, self-harm and suicide than their non-LGBTQ counterparts, with LGBTQ people under 35 twice as likely to report a mental health problem[62]. These young people have specific support needs in developing and recovering good mental health which we outlined in a research review[63] .

The National Advisor role

65. The new National Adviser for improving LGBT healthcare must work in collaboration with the LGBT voluntary sector, LGBT Consortium members and the National LGB&T Partnership to address our priorities and the gaps we have identified[64] .
66. The advisor must be objective, inclusive and accessible to our communities. They should be identified through independent recruitment with engagement from sector specialists, and supported by a Multi-Disciplinary Advisory Group who meet regularly.
67. The role should be senior and linked to Executive Directors with access to health leads and the ability to work across government departments.

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