A vibrant rainbow arches across a clear blue sky with scattered white clouds. Below the sky is a lush green field with a line of trees and bushes in the distance. The overall scene is bright and positive.

Mental and Emotional Health Needs Assessment of the LGBT (Lesbian, Gay, Bisexual and Transgender) populations of NHS South of Tyne and Wear: Gateshead, South Tyneside and Sunderland

November 2010

**Marcia Ash
Catherine Mackereth**

Membership of the Advisory Group

Marcia Ash, Consultant
Julie Connaughton, Involvement Officer, NHS SoTW
Dean Falcus, Gay and Lesbian Supported Housing Sunderland
Jeannie Fraser – MESMAC North East
Dianne Graham – Gateshead Council
Alison Griniezakis – Gateshead Health Foundation Trust
Judith Hindess – Gateshead Council
Marjorie Hunter – North East Counselling service
Colleen Knox – Gateshead Health NHS Foundation Trust
Lynne Lane, Equalities and Diversity Manger, NHS SoTW
Mish Lorraine – Gateshead Mental Health User Forum
Catherine Mackereth, Public Health Lead – Emotional Health and Wellbeing, NHS SoTW
David Messenger, NECA
Jackie Nixon, DRE/CDW Manager
Mark Oddy, Sexual Health Services, NHS SoTW
David Scoon, Gay Advice Sunderland
Frankie Williams, Sunderland University

For further information contact:

Catherine Mackereth, Public Health Lead – Emotional Health and Well-being

NHS South of Tyne and Wear

Catherine.mackereth@sotw.nhs.uk

Contents

Part 1: Introduction	5
Aims of the report	5
Policy context	5
Part 2: Epidemiological assessment	6
Geographical setting	6
Demographic data	7
General health of lesbian, gay and bisexual people	8
Lesbian health	8
Gay men's health	9
Bisexual people's health	9
Transgender people's health	10
Lesbian, Gay and Bisexual people's health from Black and Minority Ethnic (BME) communities	10
Disabled LGB people	11
Young LGB people	12
Older LGB people	12
Mental health	12
Sexual health	14
Healthy lifestyles	14
Barriers to healthcare	15
Wider determinants of health	15
Education	15
Employment and Training	16
Housing	17
Community Safety and Crime	17
Culture and Leisure	18
Conclusion	19
Part 3 Consultation	20
Ethos	20
Data Collection	20
Focus Groups	23
One-To-One Interviews	23
LGBT happiness and well-being cake	23
Services	24
Services – the gaps	26
Service provision	28
Service Provision – the gaps	29
Generic versus LGBT specific services and organisations	29
Generic versus LGBT specific services and organisations – the gaps	30
To be 'out' or not to be 'out'	31
To be out or not to be out – the gaps	32
Homophobia	33
Homophobia – the gaps	33
Equality and diversity training and monitoring	34
Equality and diversity training and monitoring – the gaps	34
Domestic Violence	35

Domestic Violence – the gaps	35
Young people and education	36
Young people and education – the gaps	36
Older people	37
Community Development	37
Deaf community	37
Family and friends	37
Faith, belief and spirituality	38
Role models	38
Services and experiences	38
Conclusion	39
Recommendations	40
References	42
Appendix	48

Part 1: Introduction

The need for this report, *Mental and Emotional Health and Well-being Needs Assessment for the lesbian, gay, bisexual and transgender (LGBT) populations within NHS South of Tyne and Wear (SoTW)*, which covers the localities of Gateshead, South Tyneside and Sunderland was, was identified within the *Mental Health Needs Assessment* (Mackereth 2009 available at <http://www.cehi.org.uk/MHNA%20Final.doc>). The complex health needs that LGBT populations experience, particularly around mental and emotional health, and the lack of obvious services available to them indicated a need for a closer examination of the issues.

It is often assumed that LGBT people's health and well-being needs are the same as their heterosexual counterparts, except for specific needs relating to sexual health. However, this group experience discrimination on a wide range of levels, not least in being treated differently by professionals in the healthcare sector. Often in society, they are subject to violence, verbal abuse and bullying and experience social isolation. This can lead to a range of health problems, such as alcohol and drug abuse, depression, suicide and self-harm, as well as problems around housing and employment (DoH 2007 h). Many LGBT people also experience the added disadvantages of low income, and 'dual discrimination', that is, being a member of an ethnic minority group and having a disability (Shewell and Penn 2005).

The report describes the aims of the work, an epidemiological assessment and summary of current research relating to LGBT issues, a report of the consultation with local people and services and recommendations developed by the Advisory Group in response to the findings.

Aims of the report

- To describe the emotional and mental health and well-being needs of the LGBT populations
- To inform and influence commissioners and service providers about services and interventions that will meet these needs and will achieve better emotional and mental health and well-being as identified by LGBT people

Policy context

"The Government believes that there are many barriers to social mobility and equal opportunities in Britain today, with too many children held back because of their social background, and too many people of all ages held back because of their gender, race, religion or sexuality. We need concerted government action to tear down these barriers and help to build a fairer society." (HM Government, 2010, p18)

The Equality Act 2010 came into effect on 1 October 2010 and provides a new cross-cutting legislative framework to protect the rights of individuals and advance equality of opportunity for all; to update, simplify and strengthen the previous legislation; and to deliver a simple, modern and accessible

framework of discrimination law which protects individuals from unfair treatment and promotes a fair and more equal society. For the first time It gives the UK a single Act of Parliament, requiring equal treatment in access to employment as well as private and public services, regardless of age, disability, gender, gender reassignment, marriage or civil partnership, maternity or pregnancy, race, religion or belief and sexual orientation.

From another legal perspective, attacks directed at LGBT people are now being recognised as specific forms of hate crime and this helps encourage victims to support incidents. However a large proportion of victims of hate crime are still reluctant to report such attacks, creating a justice gap (Equality and Human Rights Commission (2010).

Part 2: Epidemiological assessment

This section provides a brief overview of the demographic make-up of the area. It describes the general health of the LGBT populations, and provides a summary of current research on each group's physical and mental health. Groups who may be further disadvantaged, such as Black and Minority Ethnic LGBT, are identified and their needs are identified from the literature. The wider determinants of health are explored in terms of the LGBT population.

Geographical setting

This report covers Gateshead, South Tyneside and Sunderland. Each of these areas has its own unique features and the Mental Health Needs Assessment (Mackereth 2009) gives more detailed statistical information about the make up of the general populations, as well as providing information on a range of the wider determinants of health. Joint Strategic Needs Assessments have been completed within each locality and can be accessed through each council's website, and provide a wide range of information about their particular populations.

Some generalisations can, however, be made about the area as a whole. On most indicators of deprivation, SoTW measures poorly against the rest of the country, as can be seen in Table 1.

Table 1: IMD 2004 Overall deprivation – population in worst 10% and 25% Super Output Area in England (ONS 2008)

Area	Population in worst 10%	% in worst 10%	Population in worst 25%	% in worst 25%	Total population
Gateshead	52,026	27.2%	103,237	54%	191,109
South Tyneside	30,046	19.7%	93,908	61.5%	152,785
Sunderland	75,696	27%	155,643	55.4%	280,749
Tyne and Wear	259,562	24.1%	561,277	52.2%	1,075,850
North East	538,774	21.4%	1,138,306	45.3%	2,515,234

The North East has been a centre for heavy industry in the past and the demise of such work has led to widespread unemployment. In many parts, there has been investment in regeneration, which has produced new work opportunities, such as tourism and IT. However, the area remains one of traditional cultural attitudes, which includes 'higher levels of prejudice than other parts of the country' (Shewell and Penn 2005, p58).

Demographic data

There is a little robust evidence of the size or characteristics of the LGBT population, nor of the prevalence of specific inequalities (Mitchell et al 2008). This is in part due to a lack of understanding of the concept of sexual orientation, lack of clear definitions and difficulties with administering questions (ONS 2008). This is compounded by the concerns of the LGBT population in identifying themselves as such, given the harassment and discrimination many of them experience (Aspinall and Mitton 2008). The Government estimates put the numbers of LGB between 5-7% of the population. This would mean an estimate of between 127,000 – 19,800 LGB people living in the North East (Shewell and Penn 2005). At an approximate rate of 6%, this would equate to the following numbers of LGB in each locality:

Gateshead:	11,466
South Shields:	9,167
Sunderland:	17,250

These figures may be an overestimate, because many move away looking for more inviting cities, where discrimination is less blatant (Shewell and Penn 2005).

The size of the transgender population is even more difficult to estimate than the LGB population. The Home Office identified rates from studies conducted in the Netherlands at 1:11,900 – 1:17,000 men in the population. The ratio of female-to-male is much smaller than male-to-female, one estimate from Scotland being 1:4 (Shewell and Penn 2005). There are no local figures available.

Disability

No statistically significant differences have been found between gay, lesbian and heterosexual respondents around the prevalence of disability (Ellison and Gunstone 2009). However, this is not the case with mental illness: 9% gay men and 14% bisexual men reported a mental health problem, compared with 3% heterosexual men; 16% lesbians and 26% bisexual women reported a mental health condition, compared with 8% heterosexual women (Ellison and Gunstone 2009).

Religious identification and ethnicity

Ellison and Gunstone (2009) found that 53% of their survey reported to belong to a religion, but only 37% of gay men and lesbians. They found a smaller proportion of gay and lesbians to be from an ethnic minority group (1.4% compared to 3.5% of white respondents).

General health of lesbian, gay and bisexual people

There seem to be fewer lesbian, gay and bisexual people with longstanding illnesses, with 42.8% of this population take prescribed medicines compared to 45.4% of the general population (National Centre for Social Research 2006). This may relate to the age profile of the LGB population who describe themselves as LGB being younger. A West Midlands survey (Buckley 2005) found:

- 2% of the LGBT population said they suffered from coronary heart disease compared to 6.5% for men and 4% of women in the general population
- 1% of LGBT people said they suffered from epilepsy compared to 0.7% of the general population
- 13% of the LGBT population said they suffered from asthma compared to 13% of men and 16% of women in the general population.

There is very much less information on transgender people (Meads et al 2009).

Lesbian health

It is often assumed that the health needs of lesbians are similar to that of heterosexual women. However, the Department of Health's briefing paper on Lesbian health (DoH 2007a) identified that this group are less likely to have children and more likely to be overweight, which may increase their risk of breast cancer and cardiovascular disease.

Lifestyle issues

The report goes on to state that their 'limited opportunities for building social networks mean that some lesbians often socialise in bars and pubs.' It suggests that coping mechanisms developed for dealing with discrimination include higher rates of alcohol use, smoking and drug misuse amongst lesbians compared to heterosexual women:

- 90% of lesbian and bisexual women report to drink, of whom 40% drink three times per week compared to one quarter of women in general
- Lesbian and bisexual women are five times more likely to have taken drugs: 10% have taken cocaine, compared to 3% of women in general

Screening and cancer

Despite there being no evidence that lesbian or bisexual women are less at risk of cervical cancer than the general population (Meads et al 2009), Hunt and Fish (2008) found:

- 15% of adult lesbian and bisexual women have never had smear compared to 7% women in general
- 1 in 5 have not had a test have been told they are not at risk;
- 1 in 50 have been refused a test

Being a lesbian is not a risk factor for breast cancer, but some lifestyles issues may increase their risk (DoH 2007a):

- delayed childbearing
- less likely to have children

- seek less gynaecological services
- more likely to be overweight
- more likely to drink alcohol and smoke

Lesbians report antenatal education to be the most negative aspect of their care, particularly finding the non-biological mother being excluded (Wilton and Kaufmann 2001).

Gay men's health

Gay men are less likely to disclose their sexual orientation to their GP than lesbians. Their concerns are about confidentiality, how information is recorded in their notes and adverse reactions (DoH 2007b). Some gay men felt it was not relevant to disclose their sexual orientation within a healthcare setting, even if they had HIV (Neville and Henrickson 2006). Many express dissatisfaction with primary care, particularly around heterocentric and family orientated literature (Keogh et al 2004).

Cancer and screening

Anal cancer is associated with anal-receptive sexual activity, as well as with genital warts, hepatitis B, human papilloma virus, herpes simplex virus, HIV and smoking. The incidence of anal cancer is 20 times more common in gay men than in the general population (Anderson et al 2004).

72-84% of gay and bisexual men report to complete testicular self-examination regularly, compared to 49% of the general male population (Khandra and Oakeshott 2002).

Little is currently known about gay men's engagement in screening programmes such as hepatitis C (Dougan et al. 2007).

Bisexual people's health

Bisexual people can suffer from both homophobia and heterosexism and bisexuality is often not accepted as an identity, because it is assumed they can choose to be either gay/lesbian or heterosexual (DoH 2007c). Many of the health needs of bisexual people relate to their experience of discrimination (Dobinson et al 2003).

In terms of their experience of engaging with health services (King and McKeown 2003):

- Bisexual women are more likely to identify their experience of mental health professionals as more negative than lesbians
- Bisexual men are more likely to say that a causal link between their sexual orientation and their mental health issues was made by mental health professions
- Bisexual women and lesbians experience more negative healthcare treatment than heterosexual women (Banwell et al 2005).

Bisexual people's health has not been researched as a separate issue from lesbians and gays, until recently. However, there is evidence of the following issues:

- Bisexual men are less educated about Sexually Transmitted Infections, less likely to see appropriate literature, use condoms appropriately and have more unsafe sex than gay men (Devlin et al 2003)

- Bisexual men are more likely to have used recreational drugs recently than gay men (King and McKeown 2003)
- Bisexual women are more likely to report smoking and the use of illegal drugs and prescribed antidepressants (Eisenberg and Wechsler 2003)
- Similar rates of drinking are reported, but bisexual women are more likely to report associated problems (McCabe et al 2004).
- Bisexual people are less likely to report being at ease with their sexuality or come out to others than lesbians and gay men (King and McKeown 2003).

Transgender people's health

There is a persistent assumption that one's gender is assigned at birth and is male or female (DoH 2007d). Transgender people face prejudice, particularly in the form of:

- Limited employment opportunities
- Limited personal relationships
- Limited access to goods, services and housing
- Reduced health status
- Limited safety
- Reduced access to health and social care (DoH 2007d).

Despite limited research into transgender people's health, many are at risk of a range of physical health problems, including alcohol and substance abuse, violence and HIV (Lombardi et al 2001, Laird and Aston 2003, Kenagy 2005).

Access to healthcare services

- 17% refused healthcare treatment not related to transgender issues, because the doctor or nurse did not approve of gender reassignment
- 29% reported that being transgender negatively affected their treatment by healthcare professionals
- 21% of GPs did not want to help or refused help with treatment (Whittle et al 2007)
- Transgender men rarely included in breast screening programmes (Eyler and Whittle 2001)
- Transgender women were rarely offered prostate screening (Kitzinger 2000)
- Placement on wards: transgender men put on female wards, transgender women put on male wards (DoH 2007d)
- 30% of transgender people in one study experienced discrimination from professionals (Whittle et al 2007)

Gender reassignment

Transgender people can experience long delays – on average 6 years - in obtaining gender reassignment through the NHS and may resort to expensive private treatment (Mitchell and Howarth 2009).

Lesbian, Gay and Bisexual people's health from Black and Minority Ethnic (BME) communities

Very little research has been conducted in the UK on BME LGB people's health (DoH 2007e). This group are diverse in terms of culture, politics,

economics and religion. They may have particular cultural and social expectations placed on them by their families and the wider BME communities (Greene 1997), though BME lesbians are more likely to maintain family links than their white peers (Cahill et al 2003).

There is no evidence to show any difference between BME and white men as to whether they are likely to have sex with men (Hickson et al 2004). African-Caribbean men who do so are twice as likely as the ethnic majority to be diagnosed with HIV (Keogh et al 2004), but are less likely to use outpatient services (Malebranche et al 2004).

BME lesbian and bisexual women are more likely to be overweight compared to their heterosexual counterparts, and more at risk of colorectal cancer, postmenopausal breast cancer, diabetes, arthritis and cardiovascular disease. They are also less likely to be screened for cervical or breast cancer (Mays et al 2002). This group smoke and drink more alcohol, with the greatest difference being between South Asian lesbians and their heterosexual peers (Evans et al 1998).

BME LGB communities experience a disproportionate amount of homophobic violence, harassment and abuse (Galop 2001). These groups encounter racism and heterosexism in their experience with healthcare workers (DoH 2007e). These women are more likely to question their sexual orientation at a younger age, and disclose more quickly when they decide they are lesbians (Parks et al 2004). There are differences between ethnicities in coming out, with only 27% of South Asians doing so to their mothers, compared to 61% of African-Caribbeans (Galop 2001).

When compared to young white people, young BME LGB people are less involved in gay social activities and are less comfortable with disclosing their sexual identity (Rosario et al 2004).

Disabled LGB people

Disabled people often have difficulty getting their right to sexual relationships acknowledged, regardless of their sexual orientation (National Disability Authority 2005). They may face the double discrimination of being disabled and LGB (Davidson-Paine and Corbett 1995). Many do not have access to sex education or appropriate information around sexual health or fertility (Rainbow Ripples and Butler 2006). Health and social care professionals may fail to recognise or take into account the needs of these groups (Brothers 2003). LGB people with learning disabilities are more likely to come out to a trusted professional than to their family, who they fear may reject them (Abbott and Howarth 2005).

There is little research evidence about disabled LGB people, though one study (Abbott and Howarth 2005) found issues included:

- 'Difficulties in getting to know other LGB people (there are few groups for disabled LGB people);
- Lack of validation for same-sex relationship;

- Lack of acknowledgement of LGB people (eg few images of LGB people displayed in service provision);
- Lack of acceptance in the non-disabled LGB scene;
- Lack of privacy;
- Few policies, meaning that staff do not feel supported to do proactive work' (DoH 2007f).

Young LGB people

Many young people are aware of their sexual orientation from the age of about 11, but do not come out until they are 15 or 16. The 'isolation years' between these ages is a time when targeted support and information is crucial (Leicester Lesbian, Gay and Bisexual Community Strategy 2005).

Homophobia is an increasing problem, with the word 'gay' being the most used term of abuse in playgrounds. Bullying is experienced by 30-50% of LGB young people compared to 10-20% of young people in general (Hunt 2007). Mason and Palmer (1996) found that 78% of LGB under 18 experienced verbal abuse and 23% have been attacked by other pupils.

Adults may dismiss them by claiming the young person is too young to know or that it is a 'passing phase' (DoH 2007h). Only 13% of young people have come out to healthcare professionals (Allen et al 1998).

In terms of lifestyle issues:

- Lesbian and bisexual young women smoke more than their heterosexual counterparts (D'Augelli 2004); they are one and a half times more likely to have engaged in binge drinking in the past year and three times more likely to have consumed their first alcoholic drink before age 12 (Ziyadeh et al 2007)
- Some young gay and bisexual young men are at increased risk of taking illegal drugs (Ziyadeh et al 2007)

Older LGB people

Older people are often assumed to be heterosexual, and the needs of older LGB are frequently overlooked. One study found them to be:

- 'two-and-a-half times as likely to live alone;
- Twice as likely to be single; and
- Four-and-a-half times as likely to have no children to call upon in times of need' (DoH 2007g).

This group may have lived through times when same-sex behaviour was illegal and so have hidden their sexual orientation. They may feel particularly vulnerable to harassment (DoH 2007g). Only 14% of older people are open with healthcare providers about their sexuality (Heaphy et al 2003).

Mental health

Research suggests that LGB people are more at risk of experiencing mental health problems (DoH 2007g).

- Bisexual people have poorer mental health than heterosexuals, gays or lesbians, with higher rates of anxiety, depression and suicidal thoughts (Dobinson et al 2003).
- The largest UK survey of transgender people found that 34% have attempted suicide (Kenagy 2005)
- The prevalence of mental disorders in LGB people is similar across ethnic groups (DoH 2007e)
- In the UK, BME LGB appear less likely to consider suicide, possibly because of cultural and religious taboos (King and McKeown 2003), although young South Asian women are more at risk of self-harm and attempted suicide compared with white and African-Caribbean young women (DoH 2007e); In the US, BME gay and bisexual men report more suicide ideation, possibly because of the distress caused by experiences of homophobia, racism and poverty (Diaz et al 2001)
- Young LGB people are more likely to experience mental health disorders, being four times more likely to experience depression and three times more likely to experience generalised anxiety disorder (McNamee 2006)
- Young gay and bisexual men are seven times more likely to have attempted suicide and three times more likely to have suicide ideation than their heterosexual counterparts (Remafedi et al 1998)
- LGB are more likely to self-harm: gay and bisexual men are five and a half times more likely and lesbian and bisexual women twice as likely (Skeg et al 2003). This may be linked to low self-esteem and high anxiety. Bisexual people are more likely to self-harm than lesbians or gays (Bennett 2004).

Good mental health is associated with high self-esteem. Gay men and lesbians are more likely to be out to their family and to health professionals than their bisexual peers (DoH 2007g).

Poor mental health is associated with experiences of victimisation and perceived discrimination (Mays et al 2001). The LGBT population with mental health problems are more likely to report ongoing discrimination than heterosexual people:

- Bisexual people and gay men are more likely to report to having lost their job due to discrimination (DoH 2007g)
- Lesbians report more verbal and physical abuse than heterosexual women (King and McKeown 2003)
- LGB people are more likely to self-harm as a consequence of discrimination (Meyer 2003)

LGB use mental health services more often than the heterosexual population, but may have more negative experiences. This is the case for one-third of gay men, a quarter of bisexual men and over 40% of lesbians. In one in five cases, mental health professionals may make a causal link between a person's mental health issue and their sexual orientation. Experiences range from lack of empathy to homophobic incidents (King and McKeown 2003).

Sexual health

There is a plethora of research around HIV/AIDS and it is recognised that it is a life-threatening condition which is fast-growing, with 7,450 individuals being newly diagnosed in 2007 in the UK. There has been a stabilising of cases diagnosed and a decline in the number of new diagnoses from migrants. Of people living in the UK with HIV, 52% are white, 43% are black and 5% are of other ethnicities (DoH 2007i).

Gay and bisexual men

- 80% of new HIV infections in the UK are among men who have sex with men
- 59% of people with AIDS are gay and bisexual
- Up to 50% of gay and bisexual men have never been tested for HIV
- 66% gay men do not talk to their GP about safer sex (DoH 2007i).

Lesbian and bisexual women

This group are often thought to be the healthiest adult population group. However, one UK study showed that 85% had previously had sex with men (Bailey et al 2003). Studies have shown that:

- Gonorrhoea and Chlamydia are uncommon in lesbians
- Bacterial vaginosis is more common than in heterosexual women (Bailey et al 2004).
- Less than half lesbian or bisexual women have been screened for STIs (sexually transmitted infections)
- Half of those who have been screened had an STI and one quarter of those with a STI reported only having had sex with women in the last five years (Hunt and Fish 2008).

Healthy lifestyles

It is often assumed that LGBT people lead less healthy lifestyles, including higher rates of alcohol consumption, smoking and drug misuse. This may be due to the need for socialising in venues where these activities are more common (though smoking is now banned in public places). It may also be related to lower self-esteem caused by homophobia, which links with associated poor health habits. However, research identifies some lifestyle issues:

- The ideal gay male body shape is slim and muscular, which may be why gay men are more likely to suffer from eating disorders (Kaminski et al 2005).
- Lesbians on average weigh more than heterosexual women and have a bigger waist circumference
- LGB people are significantly more likely to smoke:
25% of lesbians smoke compared to 15% of heterosexual women
33% of gay men smoke compared to 21% of heterosexual men (Tang et al 2004)
- Lesbian and bisexual young women are more likely to have used alcohol recently, have had binge drinking sessions and consume more alcohol (Ziyadeh et al 2007); Adult lesbian and bisexual women are more likely to report alcohol problems (Gruskin et al 2001)

- No difference has been found between alcohol related behaviours of gay and bisexual men compared to their heterosexual counterparts (Trocki et al 2005)
- One study found that when compared to young heterosexual people, young LGB people are:
 - Three time more likely to use MDMA/ecstasy
 - Eight times more likely to use ketamine
 - 26 times more likely to use crystal methamphetamine (Lampinen et al 2006).

Barriers to healthcare

Attitudes of healthcare professionals

- 25% LGBT people experience negative attitudes from healthcare staff (Beehler 2001)
- Healthcare staff can be judgemental and unsupportive of LGBT service users, who then do not receive appropriate care (Scott 2001)

Obstacles to communication with healthcare providers

- LGBT people fear disclosure will lead to discrimination and poorer care (Bell and Morgan 2003)
- Reasons for non-disclosure include concerns about confidentiality, poorer standards of care and negative responses where a health problem is attributed to their sexual orientation (DoH 2007H)

Health professionals knowledge and understanding

- Lack of knowledge and awareness among healthcare staff about LGBT needs, with little input in training (Pringle 2003)

Negative attitudes, communication and lack of knowledge lead to delayed attendance and lack of screening, including breast and cervical screening for women and late presentation of prostate or anal cancer for men. For transgender people, waiting times for gender reassignment surgery is the biggest barrier (DoH 2007h).

Wider determinants of health

It is widely accepted that social and economic factors have an impact on health (Marmot 2010). Consequently, it is important to recognise these elements as affecting the health and well-being of the LGBT population.

Education

A major review of research in education found that studies focused mainly on homophobic bullying, with limited information on educational attainment (Mitchell et al 2008).

In terms of the content of education, Section 28 of the Local Government Act (1988) limited discussion of sexual orientation within the classroom until it was repealed in 2000. This led to confusion about what it was legitimate for teachers to talk about within schools and enabled many to avoid any

discussion, which may lead to addressing homophobic attitudes (Thorp and Allen 2000).

Despite the repeal of Section 28, Keogh et al (2006) found that heterosexual gender norms still dominate the education system, which serves to marginalize and alienate LGB young people. Furthermore, there is evidence of increasing homophobic bullying in schools (Hunt and Jensen 2006). This has implications for emotional well-being and ability to achieve at school (Warwick et al 2004). Harassment at school has been shown to contribute to:

- Lack of sleep
- Loss of appetite
- Isolation
- Nervousness
- Being upset or angry
- Elevated rates of actual and attempted suicide and self-harm
- Truancy
- Poor achievement
- Low attendance and high absenteeism
- Low self-esteem
- Substance abuse (Mitchell et al 2008)

Despite these disadvantages, Ellison and Gunstone (2009) found that LGB people had higher levels of educational achievement: 39% gay men and 50% lesbians reported qualifications to NVQ4 and above, compared to 31% heterosexual men and 28% heterosexual women.

Employment and Training

As there is no official information on the size of the LGBT population, it is difficult to make meaningful comparisons with the wider population. Estimates are often made on the basis that 5 – 7% of the population is gay or lesbian, which would mean that 1.4 million people working in the UK are gay or lesbian (Mitchell et al 2008). However, despite the effects of the direct discrimination that these groups experience, leading to losing jobs and reduced career progression, and due to the indirect effects of poor educational attainment and high levels of poor mental health, the LGB population is more likely to be in work:

- 75% of gay men are in full-time work, compared to 57% heterosexual men
- 58% lesbians in full-time work, compared to 41% bisexual women and 34% heterosexual women (Ellison and Gunstone 2009).

This could reflect a class-related issue of self-definition: those who are confident enough to identify themselves as LGB are more likely to be in higher paid jobs.

There is a significant body of evidence identifying the discrimination that LGBT people experience in the workplace (for example TUC 2000, Stormbreak 2003). This has a many consequences, including:

- Fear of discrimination preventing being open about sexual orientation
- Homophobic culture at work restricting employment options

- Negative outcomes, such as poor productivity and/or leaving employment due to homophobia (Colgan et al 2006)

Reliable research on the incomes of LGBT people is limited, and findings are limited, though one study found gay men earned less than men in heterosexual relationships (Arabsheibani et al 2006). However, a more recent study (Ellison and Gunstone 2009) found that employed gay men earned significantly higher incomes (48% earning more than £26,000 compared to 37% of heterosexual men). Lesbians earn more than heterosexual women (25% lesbians earning more than £26,000 compared to 13% of heterosexual women). In contrast, transgender people are more likely to work in lower-paid and insecure jobs (Mitchell and Howarth 2009).

Housing

In terms of housing need, this population may not have specific housing needs related to their sexual orientation (Stonewall 2007). Studies tend to focus on the experiences of harassment and discrimination that LGBT people may suffer with regard to housing. For example, although harassment may occur anywhere, it is most often happens around the home, whether from family members, flatmates, landlords or neighbours (Stonewall Cymru 2006). Transgender people seem to be at particular risk (Mitchell and Howarth 2009).

LGB young people are at greater risk of homelessness than their heterosexual counterparts (Creegan et al 2007). Reasons include:

- Family breakdown
- Disruptive parental behaviour
- Physical and sexual abuse
- Leaving care
- Religious and cultural expectations

Research suggests that LGB older people have housing concerns that relate to the loss of independent living. People usually expect care and support in older age from their family, but LGB older people are less likely to have a partner or children to look after them (Heaphy and Yip 2006). They may have fears about having to rely on residential services where they may experience homophobia and subsequent isolation (Mitchell et al 2008).

Community Safety and Crime

Fear of crime

A study in Waltham Forest (2010) found that major concerns of the LGBT population was personal safety and fear of crime, often preventing them being out in their everyday lives. They found:

- Particular fears expressed about going out after dark
- Avoidance of particular areas perceived as unsafe
- Modifying behaviour to appear not obviously LGB
- Less than half of those physically attacked had reported the incident to the police, and of those, less than half were satisfied with the police response

Hate crime

A hate incident is defined as 'any incident, which may or may not constitute a criminal offence, which is perceived by the victim or any other person as being motivated by prejudice or hate' (cited in Dick 2008, p11). Such incidents include:

- Physical assaults
- Threat of violence
- Insults
- Harassment
- Vandalism against home or property
- Unwanted sexual contact

Despite the difficulties in measuring hate crime, research suggests that LGB people experience high levels of hate crime and that this has not changed over the past decade (Stonewall 2008). One study found that one in five lesbian and gay people have been victim to a hate crime or incident within the last three years, and one in eight within the last year. It also found that gay men are two and a half times more likely to experience such an incident involving physical assault than lesbians. LGB people from minority ethnic groups experience twice the number of physical assaults that their white peers do (Dick 2008).

Research suggests that 62 – 73% of transgender people have experienced harassment or violence, particularly if they were poor (Mitchell and Howarth 2009).

Domestic violence

Research into domestic violence has focused on heterosexual relationships, particularly violence towards women by men, and with services predominantly geared towards heterosexual women (Mitchell et al 2008). However, a recent survey (Hunt and Fish 2008) found that a quarter of lesbians and bisexual women experienced domestic violence (similar to the proportion of women in general) and in two-thirds of cases another woman was the perpetrator.

Culture and Leisure

Media

Research shows that LGBT people are portrayed negatively in the media, particularly in perpetrating homophobic and transphobic preconceptions (Stonewall 2003, Mitchell and Haworth 2009).

Sport

There are few role models of sportspeople who are 'out', which has a negative impact on LGB youth participation, particularly among women (Stonewall 2007).

Competing in sports has been a controversial issue for male-to-female people. Transgender people may have issues in participating in sports due problems accessing changing facilities (Mitchell and Haworth 2009).

Arts

Stonewall (2007) identifies a high concentration of gay people working in the arts. However, there are few public figures, and the few there are tend to be

'exaggerated caricatures or are overly concerned with their sexuality' (p6).
There is no information about LGB people's access or participation in the arts.

Leisure

LGB people have found the need to create separate spaces to socialize in and this has had an impact on the economies in particular locations (Purdam et al 2007).

Conclusion

A wide range of factors affecting the health of the LGBT population has been identified. Some of these factors relate to the specific needs of these groups, but the vast majority occur as a result of the discrimination they experience. This affects their health, and the services they receive, their lifestyles and opportunities, and the wider determinants of the environment they live in.

Part 3 Consultation

This section describes a consultation process which took place between March and September 2010. Demographic data is provided on the participants and the findings are presented.

In March 2010 a range of public sector workers, including those from Local Authorities, education establishments and from different parts of the NHS, voluntary sector workers and volunteers, and service users were invited to help shape the consultation element of the LGBT Mental and Emotional Health and Well-being Needs Assessment.

Fifteen people attended this event from a range of organisations:

- NHS SoTW
- Gay and Lesbian Supported Housing
- NECA (North East Council on Addictions)
- Gateshead Health Foundation Trust
- Gateshead Council
- North East Counseling Service
- Mental Health Matters
- Sunderland University

An Advisory Group was drawn from this group to guide and support the consultation process. Most of the direct work regarding the consultation, including contacting, coordinating and collecting data from the focus groups and interviewees, was conducted by an independent consultant. Figure 1 provides an overview of the process of the consultation.

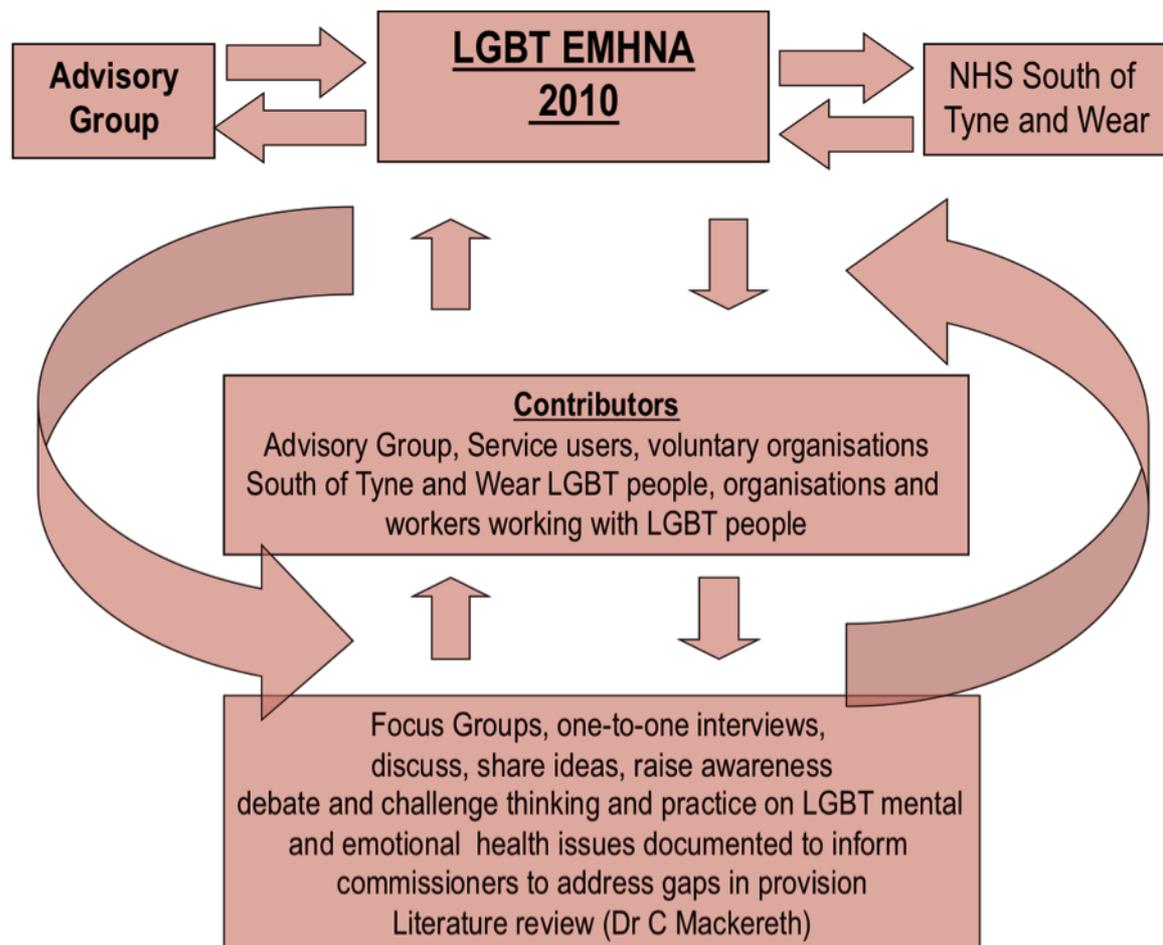
Ethos

Given the nature of the work and the lack of such data in the past, high priority was given to ensure that marginalised voices were heard, recorded, respected, valued and used in this final report. The Advisory Group wanted to ensure this exercise avoided being a 'tick box exercise' and that on completion of the work, commissioners and strategists within the NHS and Local Authorities would be informed about the neglected emotional and mental health and well-being needs of the LGBT population. It is anticipated that this will ensure there is a solution-focused approach, with a positive impact on the future planning and delivery of fully inclusive and welcoming services for LGBT people in the SoTW area.

Data Collection

Data was obtained from one hundred and thirty people, of whom one hundred and seven people completed Equality and Diversity (E&D) Monitoring forms enabling demographic information to be collated. Not all participants completed forms and a full breakdown of the figures can be found in Appendix 1. Please note that numbers do not always add up to 100%, due to some questions not being completed by all respondents.

Figure 1. Overview of consultation process



EMHNA = Emotional and Mental Health Needs Assessment

Geographic areas

The focus of the consultation has been within the South of Tyne and Wear, to include Gateshead, South Tyneside and Sunderland. All but one of the focus groups and two interviews took place in these areas, and some respondents worked or used the services within these areas, even if they lived elsewhere.

Of the consultation participants, 28% came from Gateshead, 12% from South Tyneside and 36.89% from Sunderland.

Age

All age groups have been well represented within the consultation, with 27.18% under twenty-five years and 26.21% over fifties.

Sexual Orientation

The greatest number of participants were gay men, closely followed by straight/heterosexual (all of whom were working within organizations and/or LGBT people).

Consultation participants by sexual orientation:

Lesbian/Gay Woman	21
Gay Man	38
Bisexual	12
Straight/Heterosexual	31
Do not wish to answer	4
Other: Cross Dresser	1

Gender

The gender was almost equal male and female, with one person not wanting to answer and another identifying as intersex.

Transgender

Whilst it was difficult to identify transgendered people within the areas to take part in the consultation, we were able to collect views from four participants who described themselves as transgender.

Consultation participants identifying as transgender:

Yes	4
No	97
Do not wish to answer	6

Disability

Of the 17% of participants that stated that they had a disability, 50% of them also said they had a mental health condition.

Consultation participants reported disability:

Physical Impairment	4
Long-standing illness	4
Mental Health Condition	13
Sensory Impairment	3
Learning Disability	1
Other	1

Faith and belief

Sixty five percent of participants identified as non-Christians, of which Atheism accounted for 24% and Agnosticism accounted for 16% of respondents.

Relationship status

Almost 50% of respondents reported to be single, 27% in a partnership, civil or otherwise, 14% married and 8% divorced.

Ethnicity

Almost 90% of respondents were white British.

Participants with dependents

Only 20% reported to have dependents.

Focus Groups

Sixteen focus groups were held within the SoTW in Gateshead, South

Tyneside and Sunderland. Table 2 identifies the different groups.

Table 2. Focus groups

Gateshead	South Tyneside	Sunderland
<ul style="list-style-type: none"> - Managers (Gateshead Council) - LGB Staff Network (Gateshead Council) - Pride in Mind (Mental Health Matters) - Sexual Health Service - LGBT Youth Forum - Stag Group - Plus Group - NHS SoTW 	<ul style="list-style-type: none"> - Commissioners NHS SoTW - LGBT Youth Group - South Tyneside Council 	<ul style="list-style-type: none"> - Good As You - Tea with Dorothy (Age UK) - Gay & Lesbian Supported Housing - Sunderland IAG (Interagency Group) - Sunderland Council

One-To-One Interviews

Twelve one-to-one interviews were held in various areas around SoTW, Newcastle, either in person, by telephone or by email.

People interviewed:

- British Sign Language Interpreter
- Three Male to Female Transgender People
- Two nurses
- Two service users
- LGBT Police Association
- North East LGBT Domestic Violence Worker
- Tyneside Women's Health
- Parents Enquiry North East

LGBT happiness and well-being cake

As a warm up into the consultation process, all focus group participants and interviewees were asked to discuss the following question. "Imagine that the things that make you happy and feel good are the ingredients of a cake...in an ideal world, what ingredients would go into your happiness cake?"

Participants found it difficult to answer this positive question. They initially focused on what was missing and the gaps in service provision, with respondents needing to off-load many negative experiences, which are captured later in the report.

By far the most repeated answer was 'Being accepted'. This suggests that despite changing legislation and policy development within organisations and institutions, LGBT people find it difficult to feel accepted in a world that stigmatizes and discriminates against difference.

“There is no difference between what the general heterosexual population and LGBT need, we all have needs...love, food, shelter, warmth, self-actualisation, secure finances...‘Maslow’s hierarchy of needs’”

The following summarises the most recurring positive answers from participants:

Being positive	Trust	Love	Freedom of expression	Absolute sense of belonging
Good health	Good body image	Exercise	Fun	Leisure
<p><i>“Friends create a safety net, especially when there is estrangement from the family of origin”</i></p> <p><i>“...access to the support, services and activities for all the needs a heterosexual person has...”</i></p>				
Community involvement	Making a difference in people’s lives	Socialising	Conversation	Holidays
Job	Money	Security	Secure Homes	Family

Transgender issues

“To just be taken as a woman ...to feel part of a ‘club’ having a positive experience of coming out at work and social acceptance”

“...ability to go to family events...weddings, funerals, christenings etc...be an auntie to my nieces, nephews etc...go to the cinema, access female single sex facilities without women saying “look that’s a man entering the women’s toilets”... use a female health spa...weight watching club etc... gain the skills I need to get a well paid job...get my poems and writing work published, only then could I gauge how my work is seen by the public...”

Services

When asked the question ‘What services are meeting the needs of LGBT people?’, many respondents were unable to answer as they knew of few services that were either LGBT focused or were welcoming. Many just stated, “there’s nothing here”. It should be noted here that many of these services are either cover the entire North East and/or based in Newcastle and are identified with an asterisk (*).

LGBT Services used by contributors

Pride In Mind*
Women4Women*
LBG Police Association*
North East Older Lesbian Network*
South Tyneside LGBT Youth Group
LGBT Youth Forum – Gateshead Council
Gateshead Psychology Dept at Sunderland Gender Identity Clinic
South Tyneside College – LGBT Group
LGBT AIGS Sunderland Council
Parents Enquiry North East
Tea with Dorothy
Lesbian Line*
Plus Group
Stag Group
Outpost

“There used to be a designated LGBT Psychiatric Nurse...but no longer”

Generic Services used by contributors

Lifeline*
Headlight
Tranwell Unit
Slimming world
Sunderland Mind
Arts for Well-being
Mental Health Matters*
Mental Health Arts Group for Carers
Occupational Therapy - Dryden Rd Day Hospital
Gateshead Integration Team – one-to one counselling
Primary and Secondary Mental Health Teams
Online services - e.g. Addictions UK
North East Counselling Service
Vantage Database
Art studio
Oasis
NECA
24/7

* Those services based in areas outside SoTW

Issues for which services were contacted

Throughout the consultation many needs and issues were discussed. Participants highlighted that at best stereotypical assumptions were made of needs and at worst they believed that their needs were denied or ignored.

“...straight society thinks that gay people are constantly disco dancing and taking drugs...the biggest percentage are...having problems with their mental health, housing,

sexuality etc., another large section are just getting on with their lives and not accessing services”

There is still a huge stigma attached to mental health issues, compounded when trying to seek help and support if a person identifies as LGBT.

“rejection turns into anger, frustration, paranoia and depression...If your family accepts you it’s usually better all round...so much easier...people don’t like change, my dad didn’t accept me and it turned into a real mental health problem...lack of confidence...like you are constantly searching for something...living a lie, always questioning who am I...alcohol, drugs and violent relationships”

The following summarises the most recurring negative answers from participants:

Loneliness	Unhappiness	Isolation	Depression	Suicide
Low Confidence	Anxiety	Domestic Violence	Sexual Abuse	Stress
Low Self Esteem	Dual Diagnosis With Alcoholism/Addiction And Mental Health Issues	Mental Health Issues	Alcohol/Substance Misuse	Poor Body Image
Self-Harm	Physical Activity	Sexual Health	Healthy Eating	Smoking

“There is a problem of visibility, nothing says we are valued as part of our and the wider community...”

Services – the gaps

Participants were asked ‘In your real life cake, as an LGBT person or a professional working with LGBT people what ingredients are different or missing?’

“...[I’m] saddening self with how it actually is...the ‘cake’ is lumpy, has holes in it...there’s too much of something not enough of other... no love...no care

“Heterosexuals are represented everywhere [it’s] difficult to know what we need...we’re so overwhelmed by the needs of others...when you’ve never had anything close to equal treatment, it’s hard to envisage or imagine what it could look like...[it’s] difficult to analyse the needs [of LGBT people] because they have never been met and there is nothing to compare to”

“Never being ‘tolerated’ as this implies that it is an irritation to put up with...never being an after thought”

Limited Services

Respondents reported that across SoTW there are a few specific services, with good examples of real community engagement, despite the lack of resources and capacity. However, others struggle, through lack of support or experience, which is reflected in the service they do provide.

Many generic services seem incapable of reaching out to meet the needs of the LGBT populations, resulting in those services being perceived as ‘straight services’, which are unknown and unwelcoming to LGBT people. Of those generic services making an effort, lack of awareness can result in well-meaning heterosexual workers being insensitive to LGBT issues.

LGBT people report to be so accustomed to services being inadequate in providing help, advice and support, that they do not seek it. They may spend many years denying their sexuality, or accepting that there is an issue, but continuing to self-medicate with alcohol, recreational and pharmaceutical drugs, and become more isolated, which can exacerbate the problems.

There is a small gay scene in Newcastle. On a Tuesday night in Sunderland is Gay-friendly night in a few of the bars (with a history of ‘gay bashing’). There is nothing comparable in Gateshead or South Tyneside.

“As a council taxpayer...as a gay man I can’t see where my money is being used to serve me and my community...this makes a big statement – ‘I’m not valued or cared for’ “if you take away the bars there’s little to assist people in socialising...creative outlets, there isn’t a gay centre in Newcastle, Gateshead, Sunderland or South Tyneside the nearest is Gay Advice Darlington, to serve county Durham”

There is little in the way of cultures coming together, such as LGBT and ethnicity, disability or faith.

There is no continuity, with the few projects which have been developed not getting long term funding.

“South Tyneside has had no input, Gateshead has had no mainstream LGBT health input in the last 5 years, development work has stopped and there is no infrastructure...sexual health money is tied up into HIV...questions need to be raised about budget allocation and where the money and taxes are actually going, because they aren’t being equally distributed across the region or services for the actual numbers of LGBT people in the South

of Tyne and Wear...of all the money available and spent on diversity in relation to health...approximately 0.016% is for LGBT...Inequalities start the minute a LGBT person walks in for support from an NHS service, staff are resistant or at best hesitant to ask questions that might give them vital information on sexual orientation, health professionals are not trained to ask questions about sexuality and sexual orientation, even if they were, what would they do with the information, given that there isn't anywhere to signpost them to"

Service provision

Throughout the consultation, participants acknowledged that whilst many organisations provide good services to the general population, they had concerns about the services they provide to the LGBT population. Services do not target LGBT people and are therefore less able to work with them on health priorities, such as physical activity, healthy eating, alcohol and substance misuse, mental health issues, sexual health and smoking cessation.

"LGBT people are invisible or isolated and they are the people who's needs have to be taken in to account"

Respondents felt it essential that services recognise that LGBT people are not a homogenous group. Workers need to be clear that sexual orientation is important. However, a person's sexuality appears to raise fears within workers, which leads to a lack of engagement and a lack of awareness of the issues LGBT people face. It is here that sexual orientation may be by-passed or seen as irrelevant or an over-emphasis placed on LGBT identity.

"If a LGBT person has an issue...goes to a provider, then 'comes out' the provider flaps and contacts LGBT organisations. This means the person gets referred to MESMAC, even if...their problem is around housing...in Sunderland and South Tyneside the attitude is 'we don't want gay people' and again people are sent over to Newcastle. It's as if MESMAC is seen as a colossal giant spreading across the North East and the attitude is 'they deal with gay people'...Once a person goes to MESMAC and find they can't help with the housing they are getting lost in the system and their needs are not being looked after..."

Within service provision, the term 'personalisation' means that services are tailored to an individuals' needs. Respondents reported that whilst many organisations have always used a 'person centred' approach, by treating the person not the problem, many are failing to take this into account.

Whilst a LGBT identity is important and relevant, it appears that such labels are used in a non-person-centred way, which serves to put people in box, resulting in the problems of not being diagnosed properly. Participants felt that far too much focus is placed on sexual orientation, rather than the mental health, housing or education issues. Difference from the heterosexual

population is emphasised and the LGBT person is labelled. The LGBT label starts to be pathologised and treated, rather than dealing with the issue the person may actually be seeking help for.

One participant provided an extreme example within the PCT, claiming that LGBT workers working with LGBT people have been given a guideline of working in pairs, to avoid any accusations of paedophilia.

In the present climate voluntary sector organisations are perceived as being at particular risk. They often have a real commitment to the well-being of their clients and are better suited to working with LGBT people, because of their flexibility. However, their workers and senior managers are reported to be funding-fatigued, anxious and filled with uncertainties about the future.

Service Provision – the gaps

Participants reported that there are few services or groups that come close to meeting the needs of LGBT people. What there is, is based on social activities and do not address health needs. There is nothing to help deal with emotional and mental health issues.

Like other minority groups who experience disadvantage due to their marginalised position in society, LGBT people report having to cope with prejudice in the form of homophobia, which has a huge impact on emotional and mental health and well-being.

Inequalities are apparent from the minute a LGBT person walks in for support from an NHS service. It was reported that staff are resistant or at best hesitant to ask questions about sexual orientation.

There are many services and organisations to address the health needs of the general population and their social and emotional needs, but they do not reach out or make themselves accessible or welcoming to LGBT people.

There are many services with a remit to address mental health issues, alcoholism, addiction and relationship issues, but the perception is that they are for heterosexuals. Additionally, it is not enough to say 'we are working with LGBT people', if few actually use the service. It is about whether they are doing it well and working in partnership with other organisations. Often it is down to the skills a worker has, and participants' experiences of services either as service users or health professionals reveal that few providers of services have such skills.

Generic versus LGBT specific services and organisations

It is evident from the consultation process that there are few, if any services and organisations, specifically dealing with LGBT mental and emotional health and well-being. Participants referred to the importance of generic services being able to address these needs, but most were not perceived as capable of doing this for LGBT people in a person-centred and sensitive manner. It was widely agreed both options should be available: to attend a generic, or an LGBT specific service. However, some participants were opposed to

segregated services, because it could further ghettoise LGBT people and does not address the lack of inclusivity.

Overwhelmingly, participants stated they were fully supportive of an LGBT centre being created as a one-stop shop to deal with issues, including counselling, confidence building, creative pursuits, housing, legal matters, joblessness and provide training to organisations. This would enable signposting to reputable organisations beyond the remit of a centre. There were concerns that fully accessible and welcoming LGBT specific services could mean that non-specialist services lose their accountability. Additionally, if services are to be set up this must be done in consultation with LGBT people (even if those views are very difficult to collect due to many LGBT people being invisible or isolated) and the workers to come from the LGBT community.

“...more LGBT people are needed in posts providing services to the LGBT community”

Whilst participants appreciated the progress some generic services have made, for the most part there is no service provision for LGBT people and their needs have been over-looked. It was also highlighted that well-meaning workers (mostly heterosexual) and their organisations could be doing more harm than good, having an inability to deal with homophobia and transphobia in either their own workforce's attitudes or of other service users.

There is little in the way of LGBT-friendly images on flyers, posters or information booklets in waiting rooms or on information outlets. LGBT people struggle to find information about LGBT specific services, as information is limited to the promotion of gay nightclubs, events and bars.

Generic versus LGBT specific services and organisations – the gaps

Respondents felt there was no reason why generic organisations could not support or deal with LGBT people. However, it appears that they are ill equipped, unskilled and at worst unwelcoming. LGBT people feel excluded have concerns that their needs are not being met, so they stop trying.

“...we wouldn't need specific services if generic services could treat people as individuals, with whatever their issue is, rather than the LGBT label, paralysing ordinarily effective and confident workers...that invisible wall comes up...‘agh... what do I with them... where do I send them...agh... there isn't anywhere’...the cycle of paralysis”

There are few, if any, LGBT workers facilitating groups and this extends to those groups set up to deal specifically with LGBT people.

“Any service using group work must endeavour to provide LGBT specific groups due to the prevalence of homophobia and the experiences of individuals having been to generic

groups continually report the difficulty [they have] in truly being themselves and the ‘therapy’ is then limited...”

Gay participants with mental health issues stated that they want to be with other gay men to talk about their issues and not in a heterosexual arena. They went on to discuss the great distrust they have with generic services and the vulnerability they felt, particularly how difficult it can be to be on ‘the scene’ when you have mental health problems.

“We shouldn’t have to go to a ‘special’ group we should be accepted by all groups but...they don’t accept us...”

Some participants felt that services, groups and activities that claim to cater for the LGBT population, predominantly cater for gay and/or bisexual men. Lesbian sexual and general health needs are ignored and generic services give poor or inappropriate advice. This gives a strong message that lesbians do not need or deserve a service. The feeling was that if there is an organisation that specifically caters for gay and bisexual men’s health, as there is for the whole of the North East, there ought to be an equivalent organisation to address the emotional and general health needs of lesbians/bi-women.

A huge lack of empathy within the medical professionals was expressed, despite LGBT people’s increased need for psychological therapies for depression, anxiety and relationship support. Specific advice sessions and groups are needed to support people in their ‘coming out’ process or for legal advice, housing and mentoring/buddying.

“...the fear then is that we create LGBT health ghettos, we recommend that there should be specific services and work towards integrated services where good experience and practice will have been gained and will fully inform such integrated services”

Participants felt that transgender issues need to be high on the agenda, particularly regarding emotional and mental health support. Whilst Gateshead Psychology Department and Sunderland Gender Identity Clinic are supporting and assisting transgender people in the process of change, there is only one group for people working out options, awaiting or going through surgery. If the transgender-person has taken the option of not pursuing surgery, there is very little help and support available.

To be ‘out’ or not to be ‘out’

There can be many issues regarding the relevance and possible consequences of coming out.

“Whilst most gay people aren’t rejected by their family/friends, are treated with respect from their employers, there are issues around the expectation of rejection... even the most ‘out’ of people maybe ‘in’ in certain elements of their life...if you don’t

have a stereotyped identity, it results in having to come out on a regular basis ...awaiting a reaction of acceptance [or] rejection... on a deep level an LGBT person's intuition and possible paranoia... is highly tuned and can sometimes result in self-destructive behaviour, including regular or binge use of alcohol, drugs, self-harm or going through bouts [or long-term] of depression..."

"being in the closet creates emotional health problems [it's] hard to be open and talk openly without the feeling of retribution, persecution, direct or indirect homophobia..."

"...Straight people don't have to think about acceptance in the same way LGBT people do..."

Even in reasonably progressive organisations, such as Gateshead Council, where a sexual orientation question has recently been included on their E&D monitoring form, figures collected show a much lower rate of LGBT workers than would be anticipated:

"...people are fearful of monitoring, will it be used against me...help or hinder me"

An LGBT group for workers at South Tyneside Council have had real difficulty engaging:

"...if 6% of the population were likely to be gay...only 1% of NHS staff are comfortable enough to come out at work"

For a short period of time within NHS SoTW, a LGBT network for employees was set up. It was reported that it did not feel like a safe group as it was run and attended by non-LGBT people.

"...healthcare professionals are scared to come out at work due to [it] potentially affecting their career...there is institutionalised homophobia"

"How can you have good honest relationships in the NHS if you aren't honest with NHS people...in the NHS [you] don't feel safe to be out"

If the fear of 'coming out' within institutions and organisations is so great, then teachers, doctors, dentists, nurses, practitioners and other workers will continue to hide their sexual orientation and will continue to be unable to provide effective role models.

To be out or not to be out – the gaps

When a prospective service user walks through the door, sexual orientation may not always be important. However, participants felt that it may influence

the signposting a worker may offer, which may then have a profound effect on an individual's life.

“There aren't many services or groups that can actually meet the needs of LGBT people, what there is [is] based on social groups and don't address health...As soon as the LGBT person 'comes out' the issue becomes about sexual orientation not about the issue...panicked workers refer...to a social group or MESMAC, Gay/bi are better catered there is nothing for lesbians/bi-women”

Homophobia

Throughout the consultation the experiences of homophobia, the fear of homophobia and internalised homophobia were said to be one of the main contributors to mental health problems for LGBT people.

“...homophobia is the 'invisible wall'...like 'the glass ceiling' ...before we can even think of our happiness this 'invisible wall' comes up and you can't get through it...”

Participants reported that whilst Gateshead, South Tyneside and Sunderland Councils have committed themselves to such awareness raising events including IDAHO Day (International Day Against Homophobia, May 17th each year) and the building of Community Safety Partnerships (with housing, police, victims and perpetrators) to support people to report hate crime attacks and the introduction of a twenty four hour helpline (in Gateshead), homophobic attacks continue.

Homophobia leads to fear, that leads to mental health Issues...when a victim of attack [you're] more vulnerable...”

Young people are the most vulnerable group. In schools homophobic bullying is not challenged as frequently or taken anywhere as seriously as racist bullying.

“internalised homophobia...homophobia...bi-phobia...and transphobia [results in]...many issues for those living alternative lifestyles, that don't fit into conventional ideals”

Homophobia – the gaps

At present within SoTW there are no real intervention strategies to deal with homophobic abuse and attacks

“People need help with the conditioning that 'being gay is wrong'... no one's picking up the picture...schools do challenge more...[they] have been effective in challenging racism and sexism only... homophobia isn't being challenged”

Equality and diversity training and monitoring

At present services are not monitored for sexual orientation, so data on how many LGBT people are using services is not being collected. People noted that the 2011 Census will not be collecting statistical data on sexual orientation. Participants complained that of the organisations they came across (mostly in the voluntary sector), most were only 'ticking boxes'. No mechanism for accurate recording was identified, as there is with other minority groups and Equality Impact Assessments are not properly understood.

"...LGBT people aren't represented in the world...when you don't see who you are in the world [you] don't have anything to identify yourself with...[you] feel alone...like you don't exist...it's like, if you are black and all you see is white...but a great deal has been done on race..."

If NHS staff are not asking about sexual orientation, LGBT people will continue to be hard to reach and invisible within mainstream services.

"...in the past there was a wave of anti-racist campaigning, there is now a need for anti-homophobia training provided by members of the LGBT community"

Across SoTW, many participants stated that they were aware that more money and resources are put into BME projects. None thought this commitment should to be reduced, but they wanted an equal commitment for LGBT people, with the same level of campaigning, awareness raising and capacity building.

Equality and diversity training and monitoring – the gaps

Workers described the NHS and other service providers as being 'Caught in a chicken and egg situation'. To justify the argument for more tailored or LGBT specific services they are told to 'show us the need'. However, there are no recorded statistics, monitoring, targets, or outcomes about the generic services and any LGBT specific work that may have been done. The need cannot therefore possibly be demonstrated in simple statistical terms.

Given the great progress that has been made in relation to monitoring ethnicity, faith and disability, similar gains could be obtained for LGBT people, which would then show the need for staff training.

Domestic Violence

Participants stated that it is now being widely recognised that domestic violence is more common within LGBT relationships.

"There is also the issue of domestic violence...the external force of homophobia being internalised and brought into

relationships...domestic violence happens, goes unreported and then has a huge impact on the person's mental health..."

Although there have been improvements, services and organisations have been slow to address same-sex domestic violence.

"LGBT domestic violence needs a campaign...analogy the smoking ban [it] did shift a culture, made the acceptable unacceptable...change the shift of acceptability and then [you] can change the mind set"

Domestic Violence – the gaps

Respondents felt that domestic violence service provision has been set up from a heterosexual mindset, including the use of posters and leaflets showing women or violent men. Domestic violence is often seen as male violence towards women.

It was reported that there is little in the way of psychological support for LGBT people experiencing domestic violence. As women tend to operate from a more emotional place, relationship issues become more difficult to overcome and many women in lesbian or bi-sexual relationships are totally unaware of the psychological domestic violence they experience.

People reported that there have been no regional or sub-regional campaigns, which are needed to create more awareness of same sex domestic violence. LGBT people can find support difficult or impossible to access.

Whilst the police have become better in their responses, it was felt that more could be done to address the full extent of the problem. They have done a lot of work to build trust to ensure domestic violence is reported. Additionally, the Probation Service seems to be moving forward with their use of risk assessments, but again much more speedy progress is required to spread through the region.

It was reported that a post of Regional LGBT domestic violence worker has been recently set up to encourage inclusivity, raise awareness and increase confidence in staff to be able to deal with same-sex relationships in potential service users. No one was aware of any current services within the North East offering specialist services. Although MESMAC and Victim Support do provide some support and help, there are no real services to signpost on to. Housing departments and the probation service are not equipped to deal with LGBT domestic violence. Whilst it should not matter that there are no LGBT specific services, with all services being able to support each individual as they arrive for help, the reality is very different. It appears that as soon as a worker learns that the person is LGBT, this becomes a stumbling block. Workers seem to lack confidence, stating that 'they aren't an expert', even if their daily job involves working with domestic violence.

Young people and education

Regardless of sexual orientation, participants felt that young people are very vulnerable. Being LGB is more acceptable than ever before, but younger transgender people can face extreme prejudice. It was felt that life can be particularly difficult for young LGBT people if they do not have parental support or guidance. They may struggle to develop coping skills.

Being LGBT can be an extra burden within the pubs and nightclubs, where violence is often an issue, whether that be through homophobic attacks or violence between LGBT people.

Homophobia in schools is having a huge impact on LGBT young people. Of the limited workers within SoTW working with young people and schools they report:

“Real trouble engaging schools”

Respondents felt that if attitudes in general are to change towards LGBT people, this needs to start with young people in schools, where much of the unreported homophobia occurs and is sometimes condoned.

Within youth worker training, participants reported that there is very little in the way of E&D. There is nothing about facilitating groups to be inclusive to LGBT people or how to deal with individuals' and a worker's own emotions. There appear to be few places for young LGBT people to attend. However, one group in each of the areas, Gateshead (Plus Group), South Tyneside (South Shields LGBT Youth Group) and Sunderland (Good As you), have recently started.

Young people and education – the gaps

Participants reported a disparity between service provision and the needs of young LGBT people. There are very few opportunities for 14-18 year olds to make friends, resulting in isolation or early entry in to the Newcastle or Sunderland 'Gay Scenes', exposing them to alcohol, drugs and predatory behaviour. This raises LGBT issues which are addressed elsewhere in this report.

Homophobic bullying in schools is not being addressed and having a devastating effect on some of the young people in this consultation. Young people's groups catering for the 'hetero-sexual norm' are not welcoming to LGBT young people. Additionally it is difficult to publicise the LGBT groups, due to fear of homophobic attacks.

Little in the way of supported housing is available for young homeless people, within SoTW. Outpost, for young people up to 25, is Newcastle based, but does work across the region. However, they have limited resources and capacity.

Older people

There was no awareness of any care/day centres for LGBT people when they get older within SoTW. It was suggested that LGBT people are five times more likely to need services and five times less likely to ask, making the assumption that there could not be anything that could possibly meet their needs. Additionally, people felt that they are less likely to have social networks and more likely to become isolated.

Community Development

If some designated services with specialist workers are to be a reality, participants felt that there will need to be a development phase, with capacity building, strategic and operational planning and implementation. This work will need to be fully supported by LGBT people, who need to be integral to the process, from consultation and planning, to a finished and continuing project, to ensure LGBT issues can be embedded fully to develop inclusive services in the future.

“Visitors to Sunderland wouldn’t necessarily see or experience as being LGBT friendly...I don’t think Sunderland is an attractive city for LGBT people, it’s...a tough city to be Gay in...it’s limited to 4 straight bars open on a Tuesday...therefore the message really is...you can be gay in Sunderland on a Tuesday night...this would be great if it was totally safe, but it has been known that some people actively go out on a Tuesday night for ‘gay bashing’”

There is a lack of networks and the visible LGBT community are not necessarily representative of the rest of the community.

There is little in the way of meaningful activity other than the ‘scene’ bars in Newcastle and on a Tuesday night in Sunderland. There is a real lack of free or low cost, creative or sports activities in the evenings and weekends

Deaf community

There are no services specifically catering for deaf LGBT people. This community is very small in SoTW. Few organisations and NHS workers are effective or efficient in working with LGBT deaf people. It is often impossible to effectively book BSL interpreters and there are no BSL deaf counsellors.

“Where small groups have formed or been created there is acceptance...[there is] difficulty in finding a deaf LGBT group...”

Family and friends

Participants reported that friendships and the networks and sense of community they provide are very important for LGBT people, especially where there is estrangement or geographical distance from family. The whole notion of family can be very different for LGBT people.

PENE (Parents Enquiry North East) deal with and support the parents of LGBT people. They report that when a son or daughter 'comes out' as LGBT, they have nobody to talk to and can feel alone with their concerns, which can lead to depression. GPs are overstretched and LGBT issues or those of their parents dealing with a son or daughter, are not considered a priority. Parents can see the 'coming out' as a death sentence, accompanied by worries and fears of sexually transmitted diseases.

For those wishing to pursue adoption, It was reported that the adoption process could be very off-putting and challenging, even for the most stable and loving couples.

Faith, belief and spirituality

Many conventional religions conform to 'the heterosexist-norm', most being oppressive to LGBT people. If LGBT people feel rejected and isolated, there may be few places to go to find spiritual solace or refuge. Participants discussed increased mental health problems for people from Catholic backgrounds who discussed problems around sexual orientation. As the interest in conventional religion wanes, the data collected about faith and belief from this consultation, would suggest that more LGBT people are exploring other avenues of spirituality.

Role models

Respondents reported that positive self-esteem can come from having good role models within organisations and institutions, including the media. Realities are very different from the general population's stereotypes, for LGBT people who are constantly 'self-checking' in a hetero-sexualised world and asking the questions "do I fit in here?", "Will I be accepted or rejected?"

In a world, particularly in SoTW, where LGBT visibility is low, it cannot be underestimated how much of a powerful life-affirming experience it can be for an LGBT person, when there is an empowering self-identified LGBT worker.

Services and experiences

LGBT people, as with the general population, have to consult with services to address their needs. Overall, participants reported very few services that LGBT people could speak of and offer praise. On the whole there are two very different scenarios that LGBT people will need help and support with: an LGBT issue or an LGBT person with an issue. The majority of experiences involve LGBT people being treated like '*hot potatoes*' and being passed on '*from pillar to post*'.

The following are a collection of those experiences by LGBT service users and health professionals and workers within organisations working with LGBT people.

" I found it hard to fit in, older generation of GP's don't take Trans issues seriously..."

“...‘We’ve got a bisexual’ shouted down the corridor in a family planning clinic...I was mortified...”

“...not the right condoms in stock, suitable for gay men in a sexual health clinic”

“Whilst doin’ my teacher training, I was told that I would never make it in the profession because I was camp...I was singled out for humiliation in front of class on numerous occasions...”

“...I feel vulnerable socialising...nearly every city has a scene, it can become ghettoised, but there is nothing in Gateshead, Sunderland and South Tyneside that come anywhere close to anything that could be or become a ghetto, because there isn’t anything there...but the hate we see...and how that shows itself is truly shocking...”

“...I was declined my first smear by female GP because I was lesbian”

“The problem really, is actually getting the individual to accept that they have a mental health problem, if you add a mental health problem with being gay...upbringing, a mental health trigger and a multi layer cake of life events and experiences those problems may add to a catastrophic problem”

Conclusion

The consultation showed that LGBT people experience a wide range of problems arising from different sources. Despite the increased awareness of the existence LGBT people in the general population, they still experience high levels of stigma and harassment as both individuals and as groups. This extends into their experience of trying to address their health needs, whether physical, mental or emotional. Services are consistently failing to recognize those needs.

Recommendations

It is recognized that in an ideal world, separate services would not be required for the LGBT population. The aim of commissioners and providers is to ensure that mainstream services are sensitive to the needs of all users, from whatever background, regardless of age, gender, sexual orientation, religion and belief, disability or race.

The findings of the consultation of LGBT people and from exploring the literature led to a long list of areas of concern that need to be addressed. Many of these overlap or are interdependent on each other. The following recommendations are not comprehensive, but aim to highlight the main areas that need to be addressed in order to improve the mental and emotional health of the LGBT population in SoTW.

1. Promoting visibility

Mainstream services need to be aware of the LGBT population and be sensitive to their needs.

- Training in LGBT issues needs to be developed and promoted across all mainstream services, especially around attitudes
- Services should target the LGBT population to ensure equal access to those services
- Appropriate sign-posting, possibly supported by a directory of local services, should be promoted across all services
- Appropriate images of LGBT people should be included in all literature produced by services, such as including pictures of same sex couples

2. Generic versus specialist services

There are a limited number of specialist services for the LGBT population and most LGBT people are expected to attend generic services. These services are rarely sensitive to the needs of the LGBT populations and can result in users being sent directly to inappropriate specialist services or being treated with little or no understanding of the particular needs of this group, as identified within the current report. It was identified that there were many more specialist services for gay men than lesbians.

- Some targeted specialist services should be developed and promoted, particularly around mental and emotional health and well-being
- Some specialist services should be targeted to lesbian and bisexual women.

3. Tackling discrimination

Harassment and discrimination are major themes in the experiences of the LGBT population and in the literature.

- ARCH (hate crime reporting system) should be promoted across SoTW and responses reviewed on a regular e.g. quarterly basis to inform action
- Training around discrimination against the LGBT population should be part of any equality training and regularly undergone by staff. It is not adequate to do this as an on line exercise.

4. Capacity building

Community development is an ideal approach to engaging groups who do not have access to mainstream services.

- Community development should be funded to promote LGBT work, including self-help groups, drop-ins, phone-ins.
- Public health, particularly mental health promotion, should be aware of the particular needs of the LGBT population when developing programmes such as smoking cessation, weight reduction and well-being services.

5. Partnership working

The current report is a result of working in partnership across the statutory and non-statutory sectors, as well as engaging the public. This often works well at a local level with individuals, but not always at an organizational level.

- Partnership working should involve as wide a range of key stakeholders as necessary
- Best practice around the country should be explored to learn lessons for new developments locally

6. Monitoring

Despite the requirements of Equality Impact Assessments, it is clear that many services do not gather information about who uses services generally, and this is particularly the case for LGBT people.

- Recognizing the need for sensitivity, services should be monitoring their use by LGBT people, identifying gaps in provision and taking action to remedy this.

7. Commissioning

Commissioning should be informed of the needs of the different populations.

- Current findings should be disseminated widely and particularly to commissioners
- Commissioners should be collecting and reviewing monitoring figures from services to ensure that LGBT people receive the appropriate services

8. Young people

Although the current report relates to adults, it is recognized that many young LGBT suffer particular difficulties, from bullying at school, relationship problems at home, and feeling unsafe on the streets.

- Current findings should be disseminated to the commissioners and providers of children's services, particularly the CAMHS (Child and Adolescent Mental Health Services)

9. Double discrimination

Some people suffer the double discrimination of being LGBT and being older, disabled, come from a minority ethnic background or have mental health problems.

- People suffering from double discrimination need extra support, both mainstream and specialist.

10. Transgender

Participants in the consultation suggest that Transgender people suffer more discrimination than LGB people and more attention to detail in service provision is required to provide inclusivity. It is recognized that there is a regional lack of services both in the statutory and voluntary sector. In part due to that and also to the limited time available for this research there is a clear need for more work to be done in this area in order to support any recommendations.

References

- Abbott D., Howarth J. (2005) *Secret loves, hidden lives: Exploring issues for people with learning difficulties who are gay, lesbian or bisexual*. Bristol: Policy Press.
- Allen L.B., Glick A.D., Beach R.K., Naylor K.E. (1998) Adolescent health care experience of gay, lesbian and bisexual young adults. *Journal of Adolescent Health*, vol 23, pp 212-20.
- Anderson J.S., Vajdic C., Grulich A.E. (2004) Is screening for anal cancer warranted in homosexual men? *Sexual Health*, vol 1, no 3, pp 137-40.
- Arabsheibani, R., Marin, A. and Wadsworth, J.(2005) Gay pay in the UK. *Economia*, vol 72, no 286, pp 333-347.
- Aspinall, P.J. and Mitton, L. (2008) 'Kinds of people' and equality monitoring in the UK. *Policy and Politics*, vol 36, no 1, pp 55-74.
- Bailey, J.V., Farquhar, C., Owen, C. and Whittaker, D. (2003) Sexual behaviour of lesbians and bisexual women. *Sexually Transmitted Infections*, vol 79, no 2, pp 147 – 50.
- Bailey, J.V., Farquhar, C., Owen, C. and Mangtani, P. (2004) Sexually transmitted infection in women who have sex with women. *Sexually Transmitted Infections*, vol 80, no 3, pp 244-6.
- Banwell C., Bammer G., Gifford S., O'Brien M. (2005) Australian lesbian and bisexual women's health and social experiences of living with hepatitis C. *Health Care for Women International*, vol 26, no 4, pp 340-54.
- Beehler G.P. (2001) Confronting the culture of medicine: Gay men's experiences with primary care physicians. *Journal of the Gay and Lesbian Medical Association*, vol 5, no 4, pp 135-41.
- Bell N. and Morgan L. (2003) *First out: Report of the Beyond Barriers survey of lesbian, gay, bisexual and transgender people in Scotland*. Glasgow: Beyond Barriers.
- Bennett J. (2004) *Emotional well-being and social support study: An overview*. Glasgow: University of Strathclyde.
- Brothers M. (2003) Not just ramps and Braille: Disability and sexual orientation. *Re-thinking identity: The challenge of diversity*. London: Disability Rights Commission.
- Buckley E. (2005) *Measure for Measure 2: Needs assessment of services for lesbian, gay and bisexual individuals in West Midlands*. Stoke on Trent: Staffordshire University.
- Cahill S., Battle J., Meyer D. (2003) Partnering, parenting, and policy: Family issues affecting Black lesbian, gay, bisexual and transgender (LGBT) people. *Race and Society*, vol 6, pp 85-98.
- Colgan, F., Creegan, C., McKearney, A. and Wright, T. (2006) Lesbian, gay and bisexual workers equality, diversity and inclusion in the workplace: a qualitative research study. London: Comparative Organisation and Equality Research Centre, London Metropolitan University.
- Creegan, C., Lee, S. and Reynolds, E. (2007) *Sexuality – the new agenda: a guide for local authorities on engaging with lesbian, gay and bisexual communities*. London: IDeA.
- D'Augelli A. (2004) High tobacco use among lesbian, gay and bisexual youth: Mounting evidence about a hidden population's health risk behaviour. *Archives of Pediatric and Adolescent medicine*, vol 158, no 4, pp 309-10.

Davidson-Paine C. and Corbett J. (1995) A double coming out: Gay men with learning disabilities. *British Journal of Learning Difficulties*, vol 23, pp 147-51.

Department of Health (DoH) (2007a) *Lesbian health*. London: DoH.

DoH (2007b) *Gay men's health*. London: DoH.

DoH (2007c) *Bisexual people's health*. London: DoH.

DoH (2007d) *Trans people's health*. London: DoH.

DoH (2007e) *Lesbian, gay and bisexual (LGB) people from Black and minority ethnic communities*. London: DoH.

DoH (2007f) *Disabled lesbian, gay and bisexual (LGB) people*. London: DoH.

DoH (2007g) *Mental health issues within lesbian, gay and bisexual (LGB) communities*. London: DoH.

DoH (2007h) *Working with lesbian, gay, bisexual and trans (LGBT) people*. London: DoH.

DoH (2007i) *Sexual health*. London: DoH.

Devlin W., Keogh P., Nutland W, Weatherburn P. (2003) *The field guide: Applying Making it count to health promotion activity with homosexually active men*. London: Terence Higgins Trust/Sigma Research.

Diaz R.M., Ayala G., Bein D.E. et al (2001) The impact of homophobia, poverty, and racism on the mental health of gay and bisexual Latino men: Findings from 3 US cities. *American Journal of Public Health*, vol 91, no 6, pp 927-32.

Dick, S. (2008) *Homophobic hate crime: the gay British crime survey 2008*. London: Stonewall.

Dobinson C., MacDonnell J., Hampson E., Clipsham J., Chow K. (2003) *Improving the access and quality of public health services for bisexuals*. Toronto: Ontario Public Health Association.

Dougan S., Balogun M.A., Elford J., Brant L., Sinka K. Evans B., Ramsay M. (2007) Current National Surveillance Systems in England and Wales monitor sexual transmission of hepatitis C among HIV-infected men who have sex with men? *BMC Public Health*, vol 7, no 1, p7.

Eisenberg M.A. and Wechsler H. (2003) Social influences on substance-use behaviours of gay, lesbian and bisexual college students: Findings from a national study. *Social Science and Medicine*, vol 57, no 10, pp 1913-23.

Ellison, G. and Gunstone, B. (2009) *Sexual orientation explore: A study of identity, attraction, behaviour and attitudes in 2009*. London: Equality and Human Rights Commission.

Evans B., Kell P., Bond R., MacRae K. (1998) Racial origin, sexual lifestyle, and genital infection among women attending a genitourinary medicine clinic in London. *Sexually Transmitted Infections*, vol 74, no 1, pp 45-9.

Equality and Human Rights Commission (2010) *Triennial Review 2010 – How Fair is Britain?* www.equalityhumanrights.com

Eyler E.A., Whittle S. (2001) *FTM breast cancer: Community awareness and illustrative cases*. Paper presented at the XVII Harry Benjamin International Gender Dysphoria Association Symposium, 31 October – 4 November 2001, Galveston, Texas, USA

Galop (2001) *The low down: Black lesbians, gay men and bisexual people talk about their experiences and needs*. London: Galop.

Greene B. (1997) Ethnic minority lesbians and gay men: Mental health and treatment issues. In Greene B. (ed) *Ethnic and cultural diversity among lesbians and gay men*. Thousands Oaks: Sage Publications.

- Gruskin E.P., Hart S., Gordon N., Ackerson L. (2001) Patterns of cigarette smoking and alcohol use among lesbians and bisexual women enrolled in a large health maintenance organisation. *American Journal of Public Health*, vol 91, no 6, pp 976-9.
- Heaphy B., Yip A., Thompson D. (2003) *Lesbian, gay and bisexual lives over 50: A report on the project 'The Social and Policy Implications of Non-heterosexual Ageing'*. Nottingham: Nottingham Trent University and York House Publications.
- Heaphy, B., Yip, A. (2006) Policy implications of ageing sexualities, *Social Policy and Society*, vol 5, no 4, pp 443-451.
- Hickson F.C., Reid D., Weatherburn P., et al (2004) HIV, sexual risk and ethnicity among men in England who have sex with men. *Sexually Transmitted Infections*, vol 80, pp 443-50.
- HMGovernment. (May 2010) *The Coalition: our programme for government. Fairness, freedom, responsibility*. London: Cabinet Office.
- Hunt R. (2007) *Speak out*. London: Stonewall.
- Hunt R and Fish J. *Prescription for change*. (2008) Lesbian and bisexual health check. London: Stonewall.
- Hunt, R. and Jensen, J. (2006) *The school report: the experiences of young gay people in Britain's schools*. Stonewall Housing Association and Schools Health Education Unit
- Kaminski, P.L., Chapmen, B.J., Haynes, S.D. and Own, L. (2005) Body image, eating behaviours, and attitudes toward exercise among gay and straight men. *Eating Behaviours*, vol 6, no 3, pp 179-87.
- Kenagy G.P. (2005) Transgender health: findings from two needs assessment studies in Philadelphia. *Health & Social Work*, vol 31, no 1, pp19-26.
- Keogh P., Henderson L., Dodds C. (2004) *Ethnic minority gay men: Redefining community, restoring identity*. Portsmouth: Sigma Research, University of Portsmouth.
- Keogh, P., Reid, R and Weatherburn, PI (2006) *Lambeth LGBT matters: the needs and experiences of lesbians, gay men, bisexual and trans men and women in Lambeth*. London: Sigma Research and Lambeth Borough Council.
- Keogh P., Weatherburn P., Henderson L., Reid D., Dodds C., Hickson F. (2004) *Doctoring gay men: Exploring the contribution of General Practice*. Portsmouth: Sigma Research.
- khandra A. and Oakeshott P. (2002) Pilot study of testicular self-examination in men attending two South London general practices. *Family Practice*, vol 19, no 3, pp 294-296.
- King M. and McKeown E. (2003) *Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales: A summary of findings*. London: Mind.
- Kitzinger C (2000) Women with androgen insensitivity syndrome (AIS) in J.M. Ussher (ed) *Women's health: Contemporary international perspectives*. Leicester: BPS Books.
- Laird N., Aston L. (2003) Participatory Appraisal Transgender Research. www.stonewall.org.uk/documents/Transgender_Research_Report.pdf
- Lampinen, T.M., McGhee, D., and Martin, I. (2006) Increased risk of 'club' drug use among gay and bisexual high school students in British Columbia. *Journal of Adolescent Health*, vol 38, no 4, pp458-61.

Leicester Lesbian, Gay and Bisexual Community Strategy (2005) *Sexuality matters: Sexuality Matters Community Strategy. A strategy for improving the lives of LGBT in Leicester*. Leicester: LLGBC.

Lombardi E.L., Wilchins R.A., Priesing D., Malouf D. (2001) Gender violence: transgender experiences with violence and discrimination. *Journal of Homosexuality*, vol 42, no 1, pp 89-101.

Mackereth, C.J. (2009) *Mental Health Needs Assessment*. NHS South of Tyne and Wear. Available at <http://www.cehi.org.uk/MHNA%20Final.doc>

Malebranche D.J., Peterson J.L., Fullilove R.E., Stackhouse, R.W. (2004) Race and sexual identity: Perceptions about medical culture and healthcare among Black men who have sex with men. *Journal of the National Medical Association*, vol 96, no 1, pp 97-107.

Marmot, M. (2010) *Fair society, healthy lives*. London: The Marmot review, University College London. <http://www.marmotreview.org/>

Mason A., Palmer A. (1996) *Queer bashing: A national survey of hate crimes against lesbians and gay men*. London: Stonewall.

Mays V.M., Cochran S.D. (2001) Mental health correlates of perceived discrimination among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health*, vol 91, no 11, pp 1869-76.

Mays V.M., Yancey A.K., Cochran S.D. et al (2002) Heterogeneity of health disparities among African American, Hispanic, and Asian American women: Unrecognised influences of sexual orientation. *American Journal of Public Health*, vol 92, no 4, pp 632-9.

McCabe S.E., Hughes T.L. and Boyd C.J. (2004) substance use and misuse: Are bisexual women at greater risk: *Journal of Psychoactive Drugs*, vol 36, no 2, pp 217-25.

McNamee H. (2006) *Out on your own: An examination of the mental health of young same-sex attracted men*. Belfast: The Rainbow Project.

Meads C., Pennant M., McManus J. and Bayliss S. (2009) *A systematic review of lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research*. West Midlands Health Technology Assessment Collaboration, Unit of Public Health, Epidemiology & Biostatistics, University of Birmingham.

Meyer I.H. (2003) Prejudice, social stress and mental health in lesbian, gay and bisexual populations: Conceptual issues and research evidence. *Psychological bulletin*, vol 129, pp 674-97.

Mitchell, M. and Howarth, C. (2009) *Trans research review. Equality and Human Rights Commission Research report 27*. London: Equality and Human Rights Commission

Mitchell, M., Howarth, C., Kotecha, M. and Creegan, C. (2008) *Sexual orientation research review 2008*. Manchester: Equality and Human Rights Commission.

Mitchell, M. and Howarth, C. (2009) *Trans research review. Equality and Human Rights Commission Research report 27*. London: Equality and Human Rights Commission.

National Centre for Social Research. (2008) *Health Survey for England 2006 Latest trends*. London: The Information Centre.

National Disability Authority (2005) *Disability and sexual orientation: A discussion paper*. Dublin: National Disability Authority.

Neville S, Henrickson M. (2006) Perceptions of lesbian, gay and bisexual people of Primary Healthcare Services. *Journal of Advanced Nursing*, vol 55, no 4, pp 407-15.

ONS (Office for National Statistics) (2008) ONS' sexual identity project – progress update January 2008.
http://www.statistics.gov.uk/about/data/measuring-equality/sexual-identity/downloads/Sexual_Identity_Progress_report_Jan_2008.pdf

Parks C.A., Hughes T.L., Matthews A.K. (2004) Race/ethnicity and sexual orientation: Intersecting identities. *Cultural Diversity and Ethnic Minority Psychology*, vol 10, no 3, pp 241-54.

Pringle A. (2003) *Towards a healthier LGBT Scotland*. Glasgow: Stonewall Scotland and NHS Scotland.

Purdam, K., Wilson, A.R., Afkhami, R. and Olsen, W. (2007) Surveying sexual orientation: asking difficult questions and providing useful answers.

Rainbow Ripples and Butler R. (2006) *The Rainbow Ripples Report: lesbian, gay and bisexual disabled people's experiences of service provision in Leeds*. Leeds: Rainbow Ripples.

Remafedi G., French S., Story M. et al (1998) The relationship between suicide risk and sexual orientation: Results of a population-based study. *American Journal of Public Health*, vol 88, no 1, pp 57-60.

Rosario M., Schrimshaw E.W., Hunter J. (2004) Ethnic/racial differences in the coming out process of lesbian, gay and bisexual youths: A comparison of sexual identity development over time. *Cultural Diversity and Ethnic Minority Psychology*. Vol 10, no 3, pp 215-28.

Scott P. (2001) *Small effort, big change – a general practice guide to working with gay and bisexual men*. Swindon/Salisbury: Gay Men's Health Wiltshire and Swindon.

Shewell, D. and Penn, D. (2005) *Equality and diversity in the North East region of England: a baseline study*. Newcastle upon Tyne: NERIP.

Skeg K., Nada-Raja S., Dickson N. et al (2003) Sexual orientation and self-harm in men and women. *American Journal of Psychiatry*, vol 160, no 3, pp 541-6.

Sigma Research (2010) *Waltham LGBT Matters*. Waltham: Waltham Forest Council.

Stonewall (2003) *Profile of prejudice*. London: Stonewall.

Stonewall (2007) *The equalities review: sexual orientation research review*. London: Stonewall Housing Association.

Stonewall Cymru (2006) *The housing needs of lesbian, gay and bisexual (LGB) people in Wales*. Wales: Stonewall Cymru and Triangle Wales.

Tang H., Greenwood G.L., Cowling D.W., Lloyd J.C., Roseseler A.G., Bal D.G. (2004) Cigarette smoking among lesbians, gays, and bisexuals: How serious a problem? *Cancer Causes and Control*, vol 15, no 8, pp 797-803.

Stormbreak (2003) *Sexual discrimination in the workplace*. London: Stormbreak.

Thorp, A. and Allen, G. (2000) *The Local Government bill: the 'Section' debate*. London: House of Commons Research Paper 00/47, 6 April.

Trocki K.F., Drabble L., Midanik L. (2005) Use of heavier drinking contexts among heterosexuals, homosexuals and bisexuals: Results from a National Household Probability Survey. *Journal of Studies on Alcohol*, vol 66, no 1, pp 105-10.

TUC (2000) *Straight up! Why the law should protect lesbian and gay workers.* London: TUC

Warwick, I., Chase, e. and Aggleton, P. (2004) *Homophobia, sexual orientation and schools: a review and implications for action.* London: Thomas Coram Research Unit, Institute of Education, University of London with Schools Out

Whittle S., Turner L., Al-almi M. (2007) *Engendered Penalties: Transgender and transsexual people's experiences of inequality and discrimination.*

Wilton T, Kaufmann T. (2001) Lesbian mothers' experiences of maternity care in the UK, *Midwifery*, vol 17, no 3, pp 203-211.

Ziyadeh N.J., Prokop L.A., Fisher L.B., Rosario M., Field A.E., Carmargo J., Carlos A., Bryn Austin S. (2007) Sexual orientation, gender and alcohol use in a cohort study of US adolescent girls and boys. *Drug and Alcohol Dependence*, vol 87, no 2-3, pp 119-30.

Appendix 1

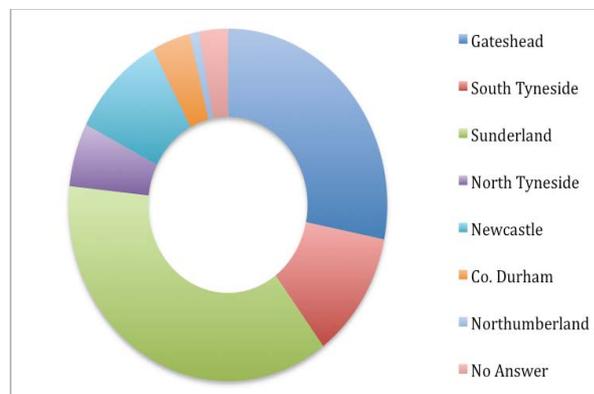
Data Collection

Data was obtained from one hundred and thirty people, of which one hundred and seven people filled out Equality and Diversity (E&D) Monitoring forms enabling us to determine demographic information. Not all participants completed all parts of forms.

Geographic areas

Whilst the focus of the consultation has obviously been within the South of Tyne and Wear, to include Gateshead, South Tyneside and Sunderland all but one focus group and two interviews took place in these areas. Whilst people attended the interviews/focus groups from the designated areas, they may have worked or used the services within these areas, even if they lived elsewhere.

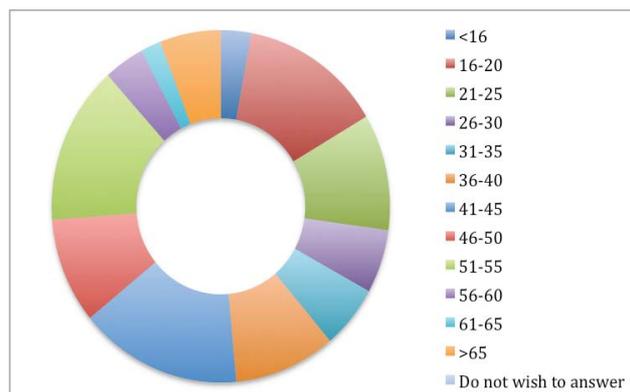
Consultation participants came from:
Gateshead (28%)
South Tyneside (12%)
Sunderland (37%)
North Tyneside (6%)
Newcastle (9%)
Co. Durham (4%)
Northumberland (1%)
No Answer (3%)



Age

All age groups have been well represented within the consultation, with 27.18% under twenty-five years and 26.21% over fifties.

Consultation participants were aged:
<16 3
16-20 14
21-25 11
26-30 6
31-35 6
36-40 10
41-45 16
46-50 10
51-55 15
56-60 4
61-65 2
>65 6

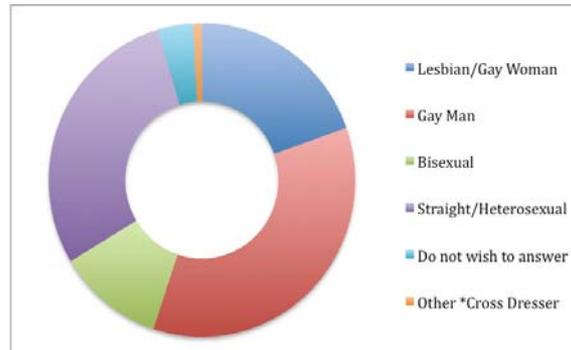


Sexual Orientation

Due to the ambiguity for some and nature of declaring one's sexuality – it appears that some participants ticked more than one box (the figures below are the number who ticked the box for each category); one also confused the nature of cross-dressing as a sexual orientation. However, the greatest number of participants were gay men, closely followed by

straight/heterosexual (all of whom would have been those working within organizations and/or LGBT people).

Lesbian/Gay Woman	21
Gay Man	38
Bisexual	12
Straight/Heterosexual	31
Do not wish to answer	4
Other * Cross Dresser	1



Gender

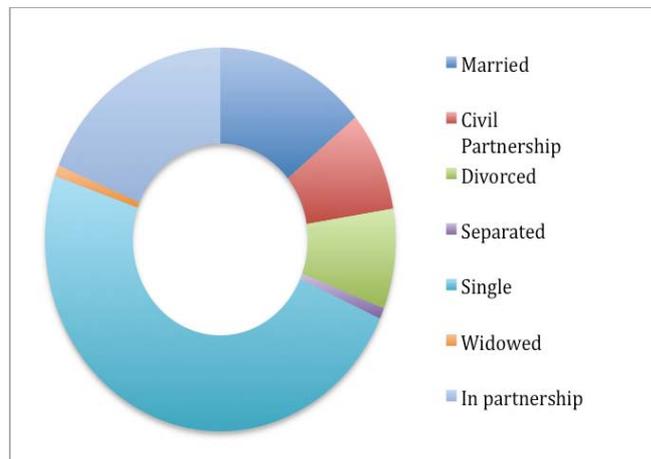
The gender was almost equal male and female, although there were a slightly larger number of males (52) than females (46) participating in the consultation, with one person not wanting to answer and another identifying as intersex.

Transgender

In answer to the question 'Do you consider yourself to be transgender?', 4 people said yes, 97 said no, and 6 did not wish to answer.

Relationship status

Married	15
Civil Partnership	9
Divorced	9
Separated	1
Single	52
Widowed	1
In partnership	20

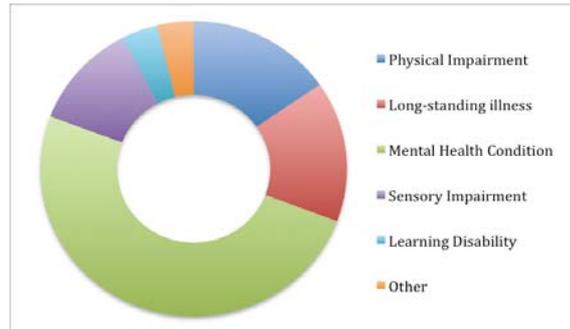


Disability

Of the 18 participants that stated that they had a disability, 13 said they also had a mental health condition.

Type of impairment

Physical Impairment	4
Long-standing illness	4
Mental Health Condition	13
Sensory Impairment	3
Learning Disability	1
Other	1

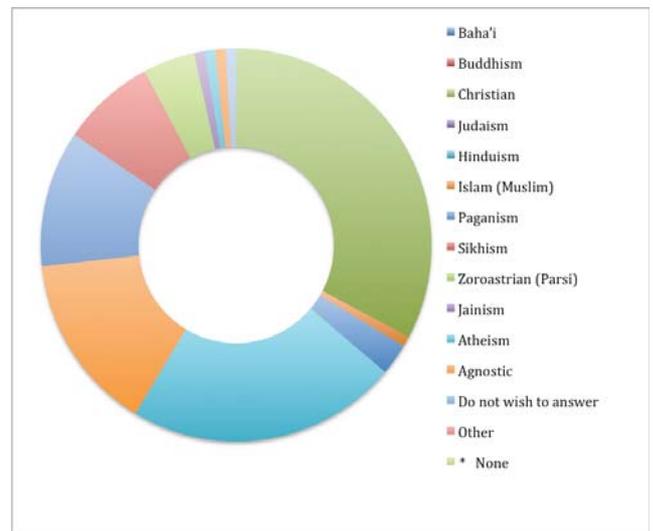


Faith and belief

64.49% participants identified as non-Christians.

Christian	38
Islam (Muslim)	1
Paganism	3
Atheism	26
Agnostic	17
Do not wish to answer	13

(Baha'i, Buddhism, Judaism, Hinduism, Sikhism, Zoroastrian (Parsi), Jainism
No participants followed these faiths)



Ethnicity

Black or Black British – African	1
Do not wish to answer	1
Mixed – White and Asian	1
Mixed – Other	2
White – British	94
White – Irish	1
* White Scottish	1
* Asian British Kashmiri	1
* South African	1
* Black British African Caribbean	1
* Welsh	1
* Middle Eastern	1

(White or Other are marked with '*')

