Equal Access
Equal Outcomes

A strategy to improve the health and wellbeing of the Lesbian, Gay, Bisexual and Transgendered communities in Birmingham

February 2013

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1. The Intention of a Strategy

1.1. A strategy becomes important when significant, serious, and/or important issues are identified in relation to particular communities and/or service pathways.

1.2. A strategy aims to identify three aspects:

1.2.1. A description of the current local circumstances;

1.2.2. A collection of the most effective responses or interventions identified by quality research that should be included in a description of a future local circumstance; and

1.2.3. An indication of actions or steps required to transform the current into the future description of local circumstances.

2. The Context of the Strategy

2.1. The strategy has drawn on the 'Marmot Framework' because of its lifecourse approach to understanding how inequality is constituted over individual biographies. The Marmot framework has five key outcomes and when Birmingham reviewed it they included a sixth, which is also addressed here:

2.1.1. **Start well** – from conception through birth to early years, get the best possible start in life;

2.1.2. **Develop well** – from childhood into adulthood, develop in a way which supports maximum health and flourishing;

2.1.3. **Live well** – enjoy good quality of life and the conditions for good quality of life and health;

2.1.4. **Work well** – have good quality work opportunities which help you maintain a high quality of life. Work should support better health not damage health; and

2.1.5. **Age well** – make the best of ageing, remaining as independent and active as possible, and be valued for your contribution.

2.2. Birmingham has also added a sixth outcome to the Framework:

2.2.1. **Die well** – die with dignity, and with well managed pain and symptoms, in the place and manner of your choosing.

2.3. This framework recognises the importance of optimal personal and social conditions for human health and wellbeing across the lifespan, from conception to death. It therefore provides an opportunity to address the conditions for better health across the lifespan for Lesbian, Gay, Bisexual, and Transgendered (LGBT) people. The growing interest in the life course approach to LGBT identity emphasises the need to:

2.3.1. develop strong identities throughout their lives, recognising that developing and being comfortable with LGBT identity is a process, and

2.3.2. ensure that community services for LGBT people understand and are configured to support this.

3. The Current Position

3.1. There have been several recent research exercises on the health and wellbeing of the LGBT communities of Birmingham. This work has highlighted significant inequities in health status and health outcomes experienced by LGBT people in Birmingham and the West Midlands.

3.2. In addition there are high levels of homophobic bullying in schools, hate crimes and other forms of discrimination such as workplace bullying reported by this community. There is evidence to link discrimination against LGBT people to poorer mental health within this community.

3.3. The findings are described in Birmingham's Joint Strategic Needs Assessment (JSNA) and summarised in *Unequal Access; Worse Outcomes,* a companion report to this Strategy and attached as Appendix One.

4. The Strategic Direction

4.1. Following the logic of this research-informed approach, a lifecourse approach to LGBT identity would be one which seeks to ensure LGBT people can develop:

- 4.1.1. free from the hindrance and obstacles which discrimination causes; and
- 4.1.2. in an environment of services which encourages that development.

4.2. The developments for LGBT people across their life course are:

- 4.2.1. understanding their sexual identity and its implications without internalising trans or homophobia;
- 4.2.2. identifying their aspirations and hopes for life; and
- 4.2.3. being who they are and relating to others for their mutual development.

4.3. The tasks for public services in supporting this are to:

- 4.3.1. understand their LGBT populations and their needs;
- 4.3.2. provide service environments which are free from discrimination and sensitive to the particular needs of LGBT people; and
- 4.3.3. encourage positive health & wellbeing through targeted or universal services (e.g. integrating and accepting LGBT identity, or need to survive experience of hate crime or homophobia).

4.4. Research suggests that these service qualities are important in supporting LGBT people to develop and remain healthy and resilient and reduce the impact or incidence of other health problems.

4.5. The adoption of the Marmot Framework means a life course approach to LGBT people might look like this:

Marmot Outcome	Qualities for LGBT People	An LGBT Person who experiences this will:
Start well	Same as for all communities	Start life like anyone else, but free of discriminatory attitudes and bullying in early life
Develop well	Ensure effective support of young people experiencing or questioning orientation or gender identity Ensure development free of homophobia/transphobia Accepting of identity Otherwise same as for all children and young people	Grow up understanding their sexual orientation, and health. Accepting this identity and able to enter adulthood ready for study, work, relationships and maximum quality of life
Live well	Ensure LGBT people can access public services, live, work and socialise in a city which is anti-discriminatory Ensure public services are LGBT affirming	Able to live, work, socialise and relate to others in their wider communities free of discrimination, with services which affirm and understand them
Work well	Ensure workplace free of discrimination and LGBT people have equity of access to employment opportunities (good economic development)	Work in an environment which affirms their contribution to the workplace and respects their dignity
Age well	Ensure LGBT people are able to experience the same outcomes as general ageing population Ensure public services and care services are LGBT affirming	Age with dignity and with services which affirms their LGBT identity and their important close relationships
Die well	Ensure LGBT people can die in an LGBT affirming service environment	Die in an environment which affirms their LGBT identity.

5. The Strategic Actions

5.1. *Unequal Access; Worse Outcomes* (Appendix A) identified the areas of excess ill-health which LGBT people experience. This strategy identifies actions which ought to be taken within the City's Public Services to improve the health of LGBT populations.

5.2. It is important to reduce the gap in avoidable disability, illness and life expectancy between LGBT people and the general population. This section focuses on direct action.

5.3. The LGBT citizens of Birmingham want to be active and included citizens, confident in their LGBT identity, able to make a full contribution to their City, neighbourhoods and communities; in control of their health and the services they access.

5.4. To this end, this strategy has five priority areas with aspirational outcomes. Success indicators under the outcomes are identified in the table at 5.5 but no measures are proposed. It is possible to link these to the NHS Equality and Diversity Scheme requirements which would help NHS and Social Care agencies identify their responsibilities.

5.5.

Be You, Make a Contribution	
Building confident secure individuals and confident secure communities	Increasing identity confidence and decreasing internalised self-hate
	Building confidence, resilience and identity comfort across the lifespan
Be Happy	
Improving mental health outcomes among LGBT communities to the Birmingham average	Reducing suicide, suicide ideation and attempts
	Reducing self-harm
	Early intervention for common mental disorders
	Improving access to mental health services
	Improving confidence, resilience and purpose
	Improving access to services for eating disorders
Be Healthy	
Reducing heightened lifestyle risk of non-communicable disease to the Birmingham average	Improving diet and physical activity
	Increasing rates of cancer screening
Improving early detection of cancers and cardiovascular disease to the Birmingham best	Reducing smoking prevalence
	Reducing problematic drug and alcohol use
Improving sexual and relationship health for all LGBT communities	Improving attendance for STI screening and treatment, including HIV
Be Connected	
Improving relationships with families, friends and partners.	Improvement in close and social relationships
Building a strong and resilient LGBT community.	Increasing activities at LGBT Centre
Be Safe	
Tackling homophobic and transphobic hate crime	Increased reporting of crimes and incidents for investigation
Tackling and transphobic and homophobic bullying in schools, college and the workplace	Reduction in experience reported in qualitative research
Reducing LGBT domestic violence	Increased reporting of LGBT domestic violence and support for victims

6. Making It Happen

6.1. Ideally, all public services ought to be 'LGBT-affirmative', since this is an important part of delivering the Public Sector Equality Duty enshrined in the Equality Act 2012. It is important to direct effort and resources towards achieving this.

6.2. However, because many services are not currently fully inclusive or sensitive to the needs of LGBT people, dedicated services are an important service for LGBT people whose needs are not being met by the system currently.

6.3. Dedicated services can also provide an environment in which research and evaluation can be conducted and where best practice can develop. This can then be shared with the wider public service community for implementation in mainstream services.

6.4. There are, therefore, two complementary components to the actions proposed:

6.4.1. providing **dedicated services** where necessary; and

6.4.2. **mainstreaming** LGBT issues in health and social care so that they are fully inclusive of the specific health and wellbeing needs of LGBT people.

6.5. **Providing dedicated services (within next 12 months).**

6.5.1. The Birmingham LGBT Centre (pilot funding from the BIG Lottery) will operate using the Community Asset Model to address health & wellbeing inequities in the LGBT community. The centre will act as a one-stop shop connecting to mainstream services and developing services to meet gaps in current provision. It will also facilitate self-help groups.

6.5.2. Sexual Health Commissioners for Birmingham should explicitly address the needs of LGBT populations, including Sexual Health Services that meet the needs of the communities of transgendered and gay women/lesbians as well as gay men.

6.5.3. Joint commissioners for mental health services should also explicitly address specific mental health needs in a service response.

6.6. **Mainstreaming (with aims to achieve changes over 3-5 years).**

6.6.1. Ensuring mainstream services are LGBT inclusive will be important. There are several strands to this including:

6.6.2. **Monitoring:** This is probably the most important building block for mainstreaming the issues of LGBT inequality in health systems. If it is not possible to identify where and when LGBT people are using health services then it is difficult to improve their experience or outcomes. Robust data collection will give a clearer indication of the specific health needs of the LGBT community in Birmingham and ensure services are designed and delivered to meet that need. All NHS organisations in the UK are required to do this to comply with the Equality Delivery System (EDS). All health agencies should gather monitoring information regarding sexual orientation and trans status. While the NHS Equality Delivery System (EDS) applies to NHS organisations, there is no specific guidance for social care. However, the Public Sector Equality Duty and the directive on publication of equality data means that Social Care agencies should collect and publish this data.

6.6.3. **Workforce Education and Culture Change** to deliver the spirit of the Public Sector Equality Duty is a longer-term goal which includes providing equality education and

training, working with related services (NHS Trusts, Clinical Commissioning Groups, City Council, social services and the police – hate crime and domestic violence services), and promoting flagship NHS Trusts. Using case studies, to frame LGBT health issues, having a 'human face' alongside 'hard' data, on the scale of the problem will create a demand among organisations for training and support. Staff will begin to feel that LGBT issues are their business not 'somebody else's'.

6.6.4. **Leadership and role modelling** within services to create an LGBT affirmative culture within organisations. Identification of LGBT Champions within Trusts and other organisations, ideally at Exec level, and support (troubleshooting, sharing success stories) for as many 'role models' as possible (clinical leadership within NHS clinical services, professional leadership in social care services, and third and independent sector providers), but each with direct access to member of the Exec team with responsibility for the issues, will start the process of change.

6.6.5. **The provision of training** to tackle discrimination, homophobia, and to identify systems that may be indirectly discriminatory to LGBT groups.

6.6.6. Working with the Birmingham Care Development Agency to ensure **social care services are accessible and appropriate**

6.6.7. **Working with Schools** to enable a changed culture and environment for Young People

6.6.8. **Working with Commissioners** to develop quality standards for mainstream services

6.7. The LGBT Centre will afford an opportunity to explore and respond to the challenge of primary and secondary prevention of ill health and the promotion of wellbeing for this community, including screening services, smoking cessation, alcohol support, healthy eating and lifestyle support.

7. Indicators of Success

7.1. The Birmingham Health and Wellbeing Board is asked to endorse this strategy and empower the Operations Group to monitor progress. Evidence of the strategy's successful implementation will include improvements in the two complementary streams of activity outlined above:

7.1.1. Dedicated services - Commissioning systems demonstrate explicit consideration of health inequalities related to the LGBT population of Birmingham, including funding dedicated services where there is demonstrated need.

7.1.2. Mainstreaming - All NHS and Social Care organisations are taking explicit steps (outlined above) to ensure that they are LGBT inclusive, with immediate attention given to improving rates of monitoring of sexual orientation, in line with the Equality Act 2010.

Advisory Group

The Advisory group (listed below alphabetically) convened a range of people chosen for their expertise and experience in LGBT health issues. The group oversaw the production and sense-checking of this strategy, and delegated a small task group to do the writing and production on their behalf.

Nigel Burbidge
Manager of Healthy Gay Life, a Birmingham-based service that works with gay men, bisexual men and men who have sex with men to promote their sexual, mental and social health and wellbeing

Antony Cobley
Senior HR Manager Governance and Equality and Diversity Lead at University Hospitals Birmingham NHS Foundation Trust

Karen Creavin
Head of Sport and Physical Activity, Birmingham City Council

Dr Nicola Gale
Lecturer in the Sociology of Health Care at the University of Birmingham

Mark Hillier
Head of Patient and Public Involvement, Birmingham and Solihull Mental Health NHD Foundation Trust

Steph Keeble
Director of Birmingham LGBT, a third sector organisation that amongst other activities, secured pilot funding for and set up the Birmingham LGBT Health and Wellbeing Centre. Steph has worked in health and wellbeing issues for twenty years including drug and alcohol issues, women's mental health, rape and sexual violence, domestic violence and youth work.

Jim McManus
Joint Director of Public Health for Hertfordshire, Chartered Psychologist and Chartered Scientist. He co-authored the Nacro/Home Office toolkit on homophobic violence with Professor Ian Rivers, and has twenty six years experience of health improvement work. He was Joint Director of Public Health for Birmingham up to August 2012.

Vic Millard
Freelance Consultant

Lesley Pattenson
Lesley Pattenson is a freelance consultant researcher and trainer with particular expertise in diversity and equality in service provision. She has over twenty years management experience within the NHS. She has been active in the LGBT communities for over 35 years with particular focus on health and wellbeing.

Dr Gary Wood
Gary Wood is a Chartered Psychologist

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Appendix A:

Unequal Access Worse Outcomes

A summary of health needs of the Lesbian, Gay, Bisexual and Transgendered communities in Birmingham to support the development of the Lesbian Gay Bisexual Transgendered Health and Wellbeing Strategy

June 2012

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1. Introduction

1.1. There have been several recent research exercises on the health and wellbeing of the Lesbian Gay Bisexual Transgendered (LGBT) populations of Birmingham. This work has highlighted significant inequities in health status and health outcomes experienced by LGBT people in Birmingham and the West Midlands. These inequities are compounded by the impact of high levels of homophobic bullying in schools, hate crimes and other forms of discrimination such as workplace bullying.

1.2. Action to improve the health and wellbeing of LGBT people is important. This is consistent with the findings of Birmingham's Joint Strategic Needs Assessment (JSNA).

1.3. The LGBT community report that there are a wide variety of important physical and mental health issues but very little published on the general health needs of the LGBT community, especially concerning services dedicated to LGBT people or mainstream services which are suitably inclusive and sensitive.

1.4. The only statutorily funded services addressing the health needs of the LGB community focus on HIV prevention, with a smaller amount of funding addressing the support needs of HIV positive gay men. HIV positive gay men make up 1.7% of the gay male population in the UK. While the support needs of HIV positive gay men are important to ensure effective living with HIV, there are other issues which also need appropriate provision.

1.5. A recent survey, *Out & About: Mapping Lesbian Gay Bisexual Transgendered Lives in Birmingham* (Woods et al. 2011), highlighted that a third of LGBT people have experienced a mental health disorder with no specific interventions and limited specialised service provision. Boehmer (2002) notes that research on these issues in LGBT populations is still sparse.

1.6. Research and engagement with LGBT communities suggests there is little recognition amongst health commissioners and providers of health & social care of the links between discrimination and health inequalities for LGBT people. There is little or no appropriate targeted intervention, services or preventative work for the LGBT community to address these issues.

1.7. We summarise here the issues found in the literature and research done to date and highlight the significant inequities in health outcomes among LGBT people compared to the entire population.

2. Mental Health

2.1. **Mental Health Needs**

2.2. LGBT people have significantly higher than average rates of depression, anxiety, self-harm, suicidal ideation and suicidal behaviour. This trend is possibly linked to personal experience with discrimination.

2.2.1. Rates of depression amongst LGBT (28-40%) are high compared to an estimated annual rate of depression of 6% and lifetime rate of more than 15% in the general population (Meads et al. 2009).

2.2.2. 31% of *Out and About* respondents indicated that they had received some form of help for Mood (Affective) Disorders (including mania, depression and bipolar disorder) (Woods et al. 2011).

2.2.3. 19.5% of *Out and About* respondents indicated that they had received some form of help with Anxiety Disorders (including post-traumatic stress, obsessive compulsive disorder, social anxiety and phobias) (Woods et al. 2011).

2.3. Estimates suggest most young men with eating disorders are gay or bisexual. A fifth of all women with eating disorders are lesbian or bisexual (Meads et al. 2009), with just over one in 20 respondents to *Out and About* indicating that they had received some form of help with eating disorders (including anorexia nervosa, bulimia nervosa and binge eating) (Woods et al. 2011).

2.4. As many as half of men and women who self-harm are potentially from the LGBT community (Meads et al 2009). More than one in five respondents to *Out and About* indicate that they had self-harmed. *Out and About* respondents who had been the victim of a homophobic hate crime were slightly more likely to report that they had self-harmed than those who had not been victims (Woods et al. 2011).

2.5. Gay and Bisexual men are three times more likely and lesbian and bisexual women 2-4 times more likely to have attempted suicide (Meads et al. 2009). Just under one half of LGBT people responding to the *Out and About* survey reported that they had contemplated suicide (47.6%%; 272/571) (Woods et al. 2011).

2.6. **Mental Health Service Use**

2.7. LGBT people face significant barriers when accessing mainstream mental health services. There is little or no specialist provision available in Birmingham.

2.8. The National Suicide Prevention Strategy 2011 included LGBT people as a specific group with specific needs.

2.9. Only 20% of the *Out and About* respondents indicated a preference for non specific mental health services in Birmingham (Wood et al. 2011), meaning that LGBT specific services were seen to be preferable in 80% of respondents.

2.10. 60% of the *Out and About* respondents reported using counselling services but a high proportion of those found these unhelpful as therapists were inexperienced in their issues of gender, sexuality, and discrimination (Wood et al. 2011).

2.11. There is no robust research evidence to determine whether specialist counselling is effective in this group of people.

3. Physical Health

3.1. Evidence points to LGBT people experiencing poorer physical health due to poorer diet, lack of exercise, smoking and excessive drink and drug use. Some of these physical health inequalities may be linked to poorer mental health and lower self esteem as highlighted above.

3.2. 83% of Gay and Bisexual men eat fewer than five portions of fruit and vegetables per day, compared to 70% of the general population (Meads et al. 2009).

3.3. LGBT people are much more likely to smoke than the general population (Meads et al. 2009):

3.3.1. 32-45% of Gay and Bisexual men smoke;

3.3.2. 29-48% of lesbian and bisexual women smoke; and

3.3.3. This compares to 22% of the general population.

3.4. LGBT people have higher rates of problem drug and alcohol use than the general population (Meads et al. 2009):

3.4.1. 35% of Gay and Bisexual men used recreational drugs in the year 2007 compared to 13% in the general population;

3.4.2. 26% of lesbian and bisexual women compared to 8% in the general population.

3.5. Lesbian and bisexual women were up to 10 times less likely to have had a cervical screening test in the past three years, suggesting poor re-attendance. 12% - 17% of lesbian and bisexual women have never had a cervical screening test (Fish 2009).

3.6. Mead et al.'s (2009) review also reviewed data on lesbian and bisexual women's screening for cervical smears, breast self-examination, and mammography screening.

3.6.1. 54% of women attended for cervical smears compared to the 80% coverage in the eligible female population.

3.6.2. 70-80% of lesbian and bisexual women checked their breasts regularly.

3.6.3. 93% of eligible women attended for mammography screening examinations which compares very well with eligible women in general (76%).

3.7. *Out and About* respondents (Woods et al. 2011) indicated:

3.7.1. 89% performed self-check for unusual lumps (e.g. breasts and testicles). This study suggested the older population was slightly more likely to self check than the younger population.

3.7.2. In relation to mammogram screening for the over 50s (which included the responses of transgendered–women) almost three-quarters had been screened (74%).

3.7.3. The cervical smear screening question (which included the responses of transgendered–men with a womb) indicated that 76% had been for a check up in the past three to five years compared to the 80% coverage in the eligible female population.

4. Sexual Health

4.1. Sexually transmitted infections (STI) diagnosed in gay and bisexual men during 2010 included:

4.1.1. **Syphilis**, 15 out of 48 diagnosed cases in Birmingham were reported in gay and bisexual men however in 24 cases sexual orientation was not recorded.

4.1.2. **Gonorrhoea**, 54 out of 355 diagnosed cases reported were in gay and bisexual men, 119 were heterosexuals and 182 did not specify any sexual orientation.

4.2. Locally there is insufficient detailed information on the sexual health of lesbians or bisexual women, and this needs to be urgently addressed by better data collection and in-depth research.

4.3. Meads et al's (2009) review did not include studies that focused on gay and bisexual men's sexual health as there is already a large body of evidence in this area.

4.4. Woods et al (2011) found that lesbian (78.1%; 132/169) and transgendered people were less likely to attend a sexual health clinic. This study did not include questions on diagnosed STIs.

4.5. Hunt & Fish (2008) found that less than half of a sample of 6178 lesbian and bisexual women had ever been tested for STIs but over half of those had an infection. Three quarters of the women who had never had an STI check up gave as the reason for not doing so: *"don't think I'm at risk"* and one in ten said that they were *"too scared"* to get tested.

4.6. The women who had been screened and diagnosed reported the following infections; genital warts, Chlamydia, genital herpes, pelvic inflammatory disease and Hepatitis B & C. There is no local data for Birmingham on which to judge recent trends in STI diagnosis. This should be addressed.

4.7. There is no data on the sexual health needs of transgendered people in Birmingham which needs to be urgently addressed.

5. HIV

5.1. Over the last thirty years gay and bisexual men have been one of the two priority risk groups affected by HIV and this will continue in the near future. In 2010 there were an estimated 40,000 gay and bisexual men living with HIV of which 26% were unaware of their infection.

5.2. There were 2704 new HIV infections diagnosed in 2010 (HPA 2011). During 2011**,** 556 gay and bisexual men were living with HIV in Birmingham and 58 new HIV infections were diagnosed in Birmingham residents (HPA 2011).

5.3. The analysis of new HIV diagnoses by age reveals that the majority of new infections were in the 25-34 age group followed by 35-44's and the 45-54's.

5.4. Gay and bisexual men with HIV have continued sexual health needs after a positive diagnosis since secondary STIs increase the viral load of the individual and can make the person more infectious.

5.5. Lymphogranuloma Venereum, a form of Chlamydia that disproportionately affects HIV positive gay and bisexual men, saw a large increase from 190 cases in 2009 to 530 in 2010 nationally. Birmingham reported 16 cases in 2010 with 6 where sexual orientation was not specified and there were no reported cases with heterosexuals (HPA 2011).

5.6. Hepatitis C is also increasing in HIV positive men with the method of transmission being identified as through sexual contact rather than the sharing of injecting apparatus.

5.7. Late diagnosis of HIV is an important issue to address. Out of those diagnosed in 2010, 39% were diagnosed late (CD4 count <350 cells/mm3) and 18% very late (<200). A late diagnosis increases the risk of dying within a year by 10-fold compared to those diagnosed earlier. The HIV prevention sector are delivering work that will encourage men to test for HIV and STIs more frequently to address this issue, however the impact of such campaigns can take time before the outcomes of more frequent testing are identified at the GUM clinics.

5.8. Antiretroviral Therapy (ART) has been in use for a number of years for treating people with HIV. Post Exposure Prophylaxis (PEP) is also available for those HIV negative men who may have been exposed to the virus though sex, as long as this treatment is taken within 72 hours to reduce the chances of infection. The advent of ART that can suppress HIV viral loads to an undetectable level means that an individual is a great deal less likely to transmit HIV than an untreated person. Treatment, including Pre Exposure Prophylaxis (PreP) as a means of prevention of infection, is an emerging area that will influence prevention activities in the future.

6. Effects of Discrimination & Internalised Homophobia

6.1. **Direct discrimination** can have profound impacts on coping, mental health, relationships and physical health. Discrimination can be in the form of one off or repeated mistreatment, verbal abuse, threats, humiliation, or intimidating behaviour or conduct. Direct discrimination includes a range of behaviours ranging from avoidance, to hatred, to physical attack. Verbal hate crimes are common, are often unreported and normalised within the LGBT community (Woods et al. 2011).

6.2. **Perceived discrimination** has a significant negative effect on both mental and physical health. Heightened stress responses are just one of the ways in which this happens.

6.3. In common with research into other forms of prejudice, many individuals within LGBT communities may internalise significant aspects of the prejudice and discrimination experienced within a heterosexist society. This process is consistent with Allport's (1954) theory of `traits due to victimization'. Stigmatised individuals engage in defensive reactions as a result of the prejudice they experience. These mechanisms may be extroverted, including exaggerated and obsessive concern with the stigmatizing characteristic, and/or introverted, which include self-denigration and identification with the aggressor.

6.4. Stigmas has a profound effect on an evolving identity:

> *`The awareness of stigma that surrounds homosexuality leads the experience to become an extremely negative one; shame and secrecy, silence and self-awareness, a strong sense of differentness—and of peculiarity—pervades the consciousness'* (Plummer 1996, pp89).

6.5. **Homophobic bullying** is endemic in schools and has devastating effects on young LGBT people and young people perceived to be LGBT. A study in Lancashire (Preventing Homophobic Bullying in Calderdale Schools) found that the effects of homophobic abuse, isolation and invisibility mean that LGB young people have high levels of truancy, drop-out and low exams results, as well as high levels of mental health problems, including panic attacks.

6.6. 82% of LGB people experience name calling at school (Rivers 2001). Over 70% of (female to male) transgendered men and 55% of (male to female) transgendered women report having been bullied by other children whilst they were at school (Whittle et al. 2007).

6.7. *The School Report*, by Stonewall (2007) studied 1,145 young people and identified that:

- 6.7.1. 98% of gay pupils hear “you’re so gay” or “that’s so gay” used in a derogatory way in school
- 6.7.2. 65% of gay pupils experience bullying in schools – 75% in faith schools
- 6.7.3. 30% report that adults have been perpetrators of homophobic incidents in schools
- 6.7.4. Seven out of ten pupils who experience homophobic bullying state that this impacts on their school work

6.8. In Birmingham 79% of the *Out and About* respondents answered that their school did not/had not taken an active approach in tackling homophobia and transphobia (Woods et al. 2011).

6.9. One third of those surveyed in Birmingham indicated that they had been discriminated against in the workplace (Woods et al. 2011).

7. Violence and Abuse

7.1. Hate crime has devastating effects on the health of LGBT individuals.

7.2. Stonewall's study on homophobic hate crime, which had 1,721 participants, identified that 1 in 5 gay men and lesbians have experienced a hate crime or homophobic incident in the last three years. Three in four did not report it to the police.

7.3. 8% of all lesbian and gay people from Black & Minority (BME) groups have experienced a physical assault as a homophobic hate crime, compared with 4% of all lesbian and gay people.

7.4. In the Birmingham study, 41% of LGBT people declared that they had been victims of a hate (homophobic) crime and 60% of the respondents reported experiencing verbal abuse (Woods et al. 2011).

7.5. One quarter of LGBT respondents to the *Out and About* survey indicated that they had been victims of domestic abuse (Woods et al. 2011).

8. Transgender health

8.1. As with the LGB community, transgendered people experience poorer mental health and low self-esteem than the general population, and have higher levels of problem alcohol and/or drug use and smoking.

8.2. Higher risk of unwanted and/or unsafe sex, lack of knowledge of STI and contraception with poor sexual health education generally. There is no transgendered specific sexual health advice available in Birmingham.

8.3. Negative issues with family and other social networks are common with little or no support and high instances of transphobic abuse/violence.

8.4. Attitudes to, and awareness of transgendered identities and related issues amongst clinical and other professionals, including fear and anxiety of:

8.4.1. transphobia (and homo/bisexual phobia) from healthcare staff,

8.4.2. being exposed to staff curiosity and of being a 'freak show';

8.4.3. inappropriate/irrelevant questions from staff.

8.5. Gender Identity Dysphoria remains a psychiatric diagnosis, with all the stigma attached to mental health issues. At the same time many transgendered people fear not being 'mentally well' because it may affect referrals for gender reassignment. This leads to transgendered people hiding mental health issues.

8.6. There is also a feeling among transgendered people that "LGBT" service provision frequently means "men who have sex with men and women who have sex with women". The 'T' is often just tagged on the end and services are assumed to be transgendered-sensitive. This is often the same for bisexual people, where services afford no scope to allow data to record that transgendered and bisexual people may have had both male and female partners, for example.

8.7. There are issues around data management - using gender-appropriate names, changing names on medical records resulting in, for example, being called in as "Miss Fred Smith" or "Mr Jenny Jones".

8.8. Transgendered men who have changed their name/gender may not be called up for screenings. Transgendered people may therefore be 'under the radar' for some screening services. Conversely, they may be called up for inappropriate services (prostrate checks etc.). The same can happen with transgendered women.

8.9. There are currently no sexual health interventions targeting the transgendered community in Birmingham. Avoidance of sexual health services is common in the transgendered community. This stems from body dysphoria and fear of inappropriate/prejudicial treatment from health professionals.

8.10. Often assumptions are made that transgendered people are all heterosexual (or conversely all being “gay really”). In reality transgendered peoples sexual orientations (as with everyone else), may be binary (gay, lesbian, straight etc.) or not (pansexual, queer etc.).

8.11. Practitioners may make assumptions about how transgendered people have sex (and who with) leading to underestimates of risk, e.g. a trans-man ticking 'gay' on forms may still be at risk of unplanned pregnancy; or a trans-woman may still need access to condoms etc. Gender labels can be confusing when applied to the spectrum of transgendered bodies due to identity/body differences, and to transgendered peoples’ relationships with other transgendered or non-transgendered people. Lack of awareness of transgendered people and these issues by staff, both clinical and administrative, can lead to difficulties, e.g. if a trans-man shows up for a smear test.

8.12. As a result of these difficulties the transgendered community often has a lack of skills/experience concerning issues of sexual health, especially after ‘transition’ e.g. trans-men not having experience of using condom, or skills around how to discuss their use.

8.13. Gendered wards in hospitals can be very difficult environments for transgendered people undergoing clinical procedures. They may cause stress and embarrassment to transgendered people and to others.

9. Cultural and geographical influence on Lesbian Gay Bisexual and Transgendered health

9.1. LGBT people’s circumstances are not homogenous. They can be older, younger, disabled, gay, lesbian, bisexual, transgendered and from BME backgrounds. They cut across class and socio-economic divisions.

9.2. Religion, culture and ethnicity have a massive effect on the experiences of LGBT people in terms of things like ‘coming out’, acceptance by family and community, and integration into the LGBT community.

9.3. Similarly the rural/urban divide may have effects on access to emotional and practical support and the chances of meeting like-minded people.

10. Conclusion

10.1. LGBT people in Birmingham experience significant health inequalities. These issues are often unrecognised in health and social care settings; with an assumption that LGBT health needs are only or mainly related to sexual health and HIV.

10.2. Discrimination has a negative impact on the mental and physical health of LGBT people.

10.3. There is an erroneous assumption that LGBT people form an homogeneous group when in reality LGBT people come from diverse backgrounds and may experience multiple discrimination and complex health needs.

10.4. Many LGBT people are reluctant to disclose their sexual orientation in health and social care settings because they fear discrimination or poor treatment. Healthcare and other professionals commonly make heterosexist assumptions about the health and social care needs of LGBT people.

10.5. This set of circumstances means we have an avoidable burden of illness and poor well-being that we need a clear strategic approach for Birmingham to be able to reduce this.

Principal Research Sources Used

A number of sources of evidence include Birmingham and West Midlands-specific pieces of research and various pieces of national and international research have informed this strategy. While we do not list them exhaustively, some of the key work we have relied on is listed below.

Birmingham/West Midlands specific:

Meads et al (2009) ***A systematic review of LGBT Health.*** **University of Birmingham.**
Available from: http://www.birmingham.ac.uk/Documents/college-mds/haps/projects/WMHTAC/REPreports/2009/LGBThealth030409finalversion.pdf

A systematic review was undertaken of research on lesbian, gay, bisexual and transgender health in the West Midlands region of the UK compared to published UK research 2009. Catherine Meads, Mary Pennant, Jim McManus & Sue Bayliss conducted this. This population based evidence presented all available research conducted in the West Midlands on LGBT health since 2000. It is the first comprehensive LGBT health systematic review in the UK.

Woods et al (2011) ***Out & About, Mapping LGBT Lives in Birmingham.*** **LGBT Trust.**

This internet based survey of over 600 respondents provides a thorough and detailed insight into a wide range of areas in LGBT people who live, work or socialise in Birmingham. Gary Woods, Steph Keeble & David Viney undertook this work. It covered general health and wellbeing through to educational engagement, the support services that are accessed, and the issues of homophobia, suicide bullying in schools and hate crime. While the work was a convenience sample, a comparison of the survey results with the other work found good comparisons with Birmingham's population giving confidence that this work was not only valid but consistent with what is known about the population.

Birmingham Public Health Intelligence Team (2012) ***Mental Health Needs of the Lesbian, Gay, Bisexual and Transgendered Community in Birmingham***

This was a report to the Birmingham Integrated Commissioning board for Learning Disabilities and Mental Health, supplementing the Joint Strategic Needs Assessment, Mental Health: Adults aged 18-64. It is a systematic appraisal of local research and data to support commissioning intentions of the Board.

Other references:

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Rivers, I (2001) 'Retrospective reports of school bullying: Recall stability and its implications for research'*, British Journal of Developmental Psychology, 19*, 129-142.

Stonewall (2007) *The School Report, The experiences of young gay people in Britain's schools.* Available from: http://www.stonewall.org.uk/at_school/education_for_all/quick_links/education_resources/4004.asp

Stonewall (2008) *Homophobic Hate Crime: The Gay British Crime Survey.* Available from: http://www.stonewall.org.uk/documents/homophobic_hate_crime__final_report.pdf

Warner et al. (2004) *Rates and predictors of mental illness in gay men, lesbians and bisexual men and women.* Imperial College London.

Whittle, S, Turner, L and Al-Alami, M (2007) *Engendered Penalties, Transgender and Transsexual People's Experiences of Inequality and Discrimination.* Press for Change.

Advisory Group

The Advisory group (listed below alphabetically) convened a range of people chosen for their expertise and experience in LGBT health issues. The group oversaw the production and sense-checking of this strategy, and delegated a small task group to do the writing and production on their behalf.

Nigel Burbidge
Manager of Healthy Gay Life, a Birmingham-based service that works with gay men, bisexual men and men who have sex with men to promote their sexual, mental and social health and wellbeing

Antony Cobley
Senior HR Manager Governance and Equality and Diversity Lead at University Hospitals Birmingham NHS Foundation Trust

Karen Creavin
Head of Sport and Physical Activity, Birmingham City Council

Dr Nicola Gale
Lecturer in the Sociology of Health Care at the University of Birmingham

Mark Hillier
Head of Patient and Public Involvement, Birmingham and Solihull Mental Health NHD Foundation Trust

Steph Keeble
Director of Birmingham LGBT, a third sector organisation that amongst other activities, secured pilot funding for and set up the Birmingham LGBT Health and Wellbeing Centre. Steph has worked in health and wellbeing issues for twenty years including drug and alcohol issues, women's mental health, rape and sexual violence, domestic violence and youth work.

Jim McManus
Joint Director of Public Health for Hertfordshire, Chartered Psychologist and Chartered Scientist. He co-authored the Nacro/Home Office toolkit on homophobic violence with Professor Ian Rivers, and has twenty six years experience of health improvement work. He was Joint Director of Public Health for Birmingham up to August 2012.

Vic Millard
Freelance Consultant

Lesley Pattenson
Lesley Pattenson is a freelance consultant researcher and trainer with particular expertise in diversity and equality in service provision. She has over twenty years management experience within the NHS. She has been active in the LGBT communities for over 35 years with particular focus on health and wellbeing.

Dr Gary Wood
Gary Wood is a Chartered Psychologist