Lesbian, Gay, Bi-sexual and Transgender (LGBT) Joint Strategic Needs Assessment 2018

LGBT JSNA Contents

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Executive Summary

Introduction and Context

Lesbian, Gay, Bisexual and Transgender (LGBT) people in the UK continue to face discrimination, harassment, disadvantage and inequality in all policy areas including, civil society, education, employment, health, housing and public attitudes across all stages of the life course from young to older people (Hudson-Sharp and Metcalf, 2016). This Joint Strategic Needs Assessment (JSNA) explored the health and social care needs of lesbian, gay, bisexual and transgender (LGBT) people in Swindon with the aim to provide demographic information to inform future commissioning intentions to improve services for LGBT people in Swindon. LGBT people are not a singular group but are a diverse group of people with individual differences. Individuals may identify with many different groups of which just two are based on sexual orientation and gender identity. It is recognised that within the LGBT population there will be further minorities within minorities (Varney, 2014).

Key Messages

- Sexual orientation and gender reassignment are protected characteristics under the Equality Act (2010). Section 29 of the Equality Act (2010) prohibits discrimination in the provision of services on the basis of sexual orientation or gender identity.

- There is a lack of routine monitoring of sexual orientation and gender identity across a wide range of health and social care services in Swindon.

- The evidence base for health and social care inequalities by sexual orientation and gender identity is deficient with major gaps. This is due to the lack of routine monitoring across health and social care services and a lack of data relating to the health of LGBT communities derived from population-based studies and statistical datasets. Available evidence does not disaggregate disadvantage into single LGBT groups.

Summary of Findings

- Heteronormative assumptions as well as experiences of, or fears of discrimination, prevent LGBT people from accessing mainstream services resulting in the compounding of inequalities across the life course, with this disadvantage compounded further for young and older LGBT people.

- Research shows that LGBT people experience significant health and social inequalities compared to the wider population from high rates of physical and emotional bullying, poor mental health, through significantly higher rates of suicide and self-harm, drug and alcohol use and smoking in adulthood, as well as social isolation and extreme vulnerability in old age (The National LGB&T Partnership, 2014; Williams et al, 2013).

- There is evidence to suggest that many LGBT people face barriers to accessing national screening and immunisation programmes (Stonewall, 2015).

- Evidence also shows that LGBT people experience poorer sexual health across the life course with a greater burden of sexually transmitted infections (PHE, 2014a).

- Research reveals that LGBT people and carers experience discrimination and marginalisation which impacts on their ability to access services and receive the most appropriate support. (Cartwright, Hughes, Lienet, 2012).

Summary of Voices from Swindon's LGBT Community

The following is a summary of the focus groups held involving Swindon's LGBT community.

- Younger LGBT people were concerned around the lack of recognition and respect from health professionals regarding their concerns. Negative attitudes from professionals together with discrimination and bullying regarding sexual orientation and gender identity affected young people's health and wellbeing.

- Younger LGBT people identified and valued the support received from schools and colleges in supporting them by promoting a positive culture of acceptance of diversity.

- Young transgender people were concerned about gender reassignment and transitioning due to inadequate support from professionals which was a contributing factor to poor mental health.

- Older LGBT people reported lived experiences of discrimination and homophobia and transphobia in the wider civil society and in health services.

- Older transgender people also reported negative attitudes from health professionals.

- Older LGBT people were concerned about isolation and a lack of social support which had negatively impacted upon health and wellbeing.

Recommendations

Recognition

1. The needs of Lesbian, gay, bisexual and transgender (LGBT) people as distinct groups to be included in all future Joint Strategic Needs Assessments.

2. To work with the LGBT community to produce a charter of best practice for health and social care services.

3. For each organisation to assess their training needs to ensure their workforce follow the best practice for providing inclusive services for LGBT people.

4. The Adult Social Care Provider Forums to discuss this JSNA to ensure that routine sexual orientation and gender identity monitoring are considered and that the needs of LGBT people are recognised by social care.

Monitoring

5. All health and social care services to record sexual orientation and gender identity data (where appropriate).

Reducing Inequalities in Health and Social Care

6. Health and Wellbeing Board to use its influence across the system to reduce health inequalities for LGBT people in Swindon.
7. For all organisations to challenge heteronormativity by ensuring gender neutral language to promote a positive culture of inclusivity.

1. **Introduction**

1.1 Aims

This Joint Strategic Needs assessment (JSNA) aims to map the needs of lesbian, gay, bisexual and transgender (LGBT) people whilst recognising that sexual orientation and gender identify are distinct characteristics. This JSNA will be a tool to inform future commissioning intentions and improve service planning for LGBT people in Swindon. Whilst it is acknowledged that the quantity and quality of available evidence used is limited, this represents an important step in recognising the diverse needs of LGBT people. This JSNA will enable commissioners and service providers to be aware of the demographics of the populations they service and the need for routine gender identity and sexual orientation monitoring in all health and social care settings, to ensure equitable services to improve the health and wellbeing of Swindon's LGBT community.

1.2 Scope

The scope of this JSNA will include the health and social care needs of LGBT people aged over 16 in Swindon. A Diversity Impact Assessment (DIA) was undertaken which considered equality issues and defined the scope of this JSNA, which whilst recognising the importance of the wider determinants of health and wellbeing, will focus on the key areas of health and social care. We recognise that LGBT people are not a singular group but are a diverse group of individuals with individual differences. Individuals may identify with many different groups of which just two are based on sexual orientation and gender identity. We also recognise that within the LGBT population there will be further minorities within these groups. For, example LGBT people who are also disabled or also from a Black or Minority Ethnic background. These minorities within minorities will also be considered. Within the scope of this JSNA the following key areas will be considered for each group using a life course approach:

Improving Wider Determinants of Health and Wellbeing

- *Overview of wider factors*
- *Workplace health and wellbeing*

Health Improvement

- *Lifestyle behaviours*
- *Mental health and wellbeing*

Health Protection

- *Sexual Health*
- *Screening and immunisations*

Healthcare Public Health

- *Service access and quality*

Social Care

- *Care and support across the life course*

1.3 Objectives

The objectives of this Joint Strategic Needs Assessment are:

- To describe the current health and social care needs of LGBT people in Swindon.

- To assess the provision of access to, and utilisation of health and social care services by LGBT people to identify barriers and opportunities for improvement.

- To ensure the needs of LGBT people are included in future commissioning, service planning and provision.

1.4 Overview of Method

This JSNA is based on the principles of an epidemiological needs assessment approach (Stevens and Raftery,1994). To understand the needs of the LBGT community a three stage approach was used. Firstly, a review of demographic data to understand the LGBT population of Swindon, which also included local data from commissioned providers of health and social care. Secondly, an online literature review of peer reviewed evidence from 2007 onwards on LGBT health and social

care needs using the NICE Evidence Search[1]. This also included grey literature through a snowball approach to widen the review due to the paucity of available research in this area. Thirdly, engagement with the LGBT community through focus groups to gain an understanding of community identified local issues.

1.5 Definition and Terminology

LGBT is the description used by Swindon Borough Council to reflect gender and sexual diversity. It identifies those whose gender and sexual orientation sits outside presumed heterosexuality and binary male-female gender identity. It is intended as an inclusive description and includes others such as "queer", or "non-binary" and others. The following terminology[2] is used throughout this JSNA:

> *Bi-sexual*: refers to an emotional and/or sexual orientation towards more than one gender.
>
> *Lesbian*: refers to a woman who has an emotional, romantic and/or sexual orientation towards women.
>
> *Gay*: refers to a man who has an emotional, romantic and/or sexual orientation towards men. Also a generic term for lesbian and gay sexuality - some women define themselves as gay rather than lesbian.
>
> *Gender Identity*: the internal perception of an individual's gender and where they identify (whether in accordance with the traditional gender binary or somewhere else along in the gender continuum)
>
> *MSM:* men who have sex with men.
>
> *Sexual Orientation:* a person's emotional, romantic and/or sexual attraction to another person.

[1] https://www.evidence.nhs.uk/
[2] http://www.stonewall.org.uk/help-advice/glossary-terms

Trans: an umbrella term to describe people whose gender is not the same as, or does not sit comfortably with, the sex they were assigned at birth. Transgender people may describe themselves using one or more of a wide variety of terms, including (but not limited to) Transgender, Transsexual, Gender-queer (GQ), Gender-fluid, Non-binary, Gender-variant, Crossdresser, Genderless, Agender, Nongender, Third gender, Two-spirit, Bi-gender, Transgender rman, Transgender woman, Transgender rmasculine, Transgender feminine and Neutrois.

Queer: Once a derogatory term for LGBTQ individuals. The term has now been reclaimed by LGBT young people in particular who don't identify with traditional categories around gender identity and sexual orientation but may be viewed by some to be derogatory.

WSW: women who have sex with women

1.6 Caveats and Limitations

This JSNA acknowledges that the evidence base for health and social care inequalities by sexual orientation and gender identity is deficient with major gaps. There is a shortage of robust, representative data, together with a failure of research to disaggregate disadvantage into single LGBT groups. There is also a lack of evidence relating to gender identity. The evidence that is available is largely based on small studies and qualitative research due to a lack of representative quantitative research.

2. Background and Context

2.1 Why do we need to focus on LGBT People?

A recent comprehensive evidence review commissioned by the Government Equalities Office (Hudson-Sharp and Metcalf, 2016) concluded that LGBT people continue to face discrimination, harassment, disadvantage and inequality in the UK in all policy areas including, civil society, education, employment, health, housing and public attitudes and across all stages of the life course from young to older people. Consequently, the needs of LGBT people are frequently unaddressed through a culture of heterosexism and heteronormativity.

The Public Sector Equality Duty (2011)[3] is a key part of the Equalities Act (2010)[4] places an obligation on all public sector organisations to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between those who share a protected characteristic and those who do not. Sexual orientation and gender reassignment are protected characteristics under the Equality Act. Section 29 of the Equality Act (2010) which prohibits the discrimination in the provision of services on the basis of sexual orientation or gender identity. However, sexual orientation and gender identity have been overlooked as a significant factor in health and wellbeing outcomes.

There are significant knowledge gaps in this area, due to the lack of routine monitoring of sexual orientation and gender identity across health and social care services and a lack of data relating to the health of LGBT communities derived from population-based studies and statistical datasets. However, there is a significant evidence base on the health inequalities experienced by LGBT communities from peer-reviewed research, grey literature published by the LGBT community, and indicative evidence.

2.2 Improving Wider Determinants of Health

Wider determinants are a diverse range of social, economic and environmental factors which impact on people's health which determine the extent to which different individuals have the physical, social and personal resources to identify and

[3] https://www.gov.uk/guidance/equality-act-2010-guidance
[4] https://www.legislation.gov.uk/ukpga/2010/15/contents

achieve goals, meet their needs and deal with changes to their circumstances. Individuals from the LGBT community often experience prejudice and marginalisation that affects wider factors such as education, experiences of crime and housing stability. Both the LGBT Public Health Outcomes Framework Document (Williams et al, 2013) and the Adult Social Care Outcomes Framework LGBT Companion Document (The National LGBT Partnership, 2014) comprehensively map outcomes relating to the wider determinants of health and wellbeing relating to LGBT people. Evidence suggests that multiple and compounding disadvantages and inequalities across a range of indicators lead to significant health inequalities and difficulties in accessing a range of services.

2.3 Health Improvement

Health Improvement aims to improve the health and wellbeing of individuals and communities through enabling and encouraging healthy behaviours and lifestyle choices as well as addressing the wider determinants of health. Research shows that LGBT people experience significant health and social inequalities compared to the wider population from high rates of physical and emotional bullying, poor mental health, through significantly higher rates of suicide and self-harm, drug and alcohol use and smoking in adulthood, as well as social isolation and extreme vulnerability in old age (The National LGB&T Partnership, 2014; Williams et al, 2013).

2.4 Health Protection

Health protection focuses on protecting the population's health from communicable diseases and environmental threats, whilst reducing health inequalities. There is currently a lack of evidence on LGBT communities in relation to many of the indicators used by Public Health and Adult Social Care (The National LGB&T Partnership, 2014; Williams et al, 2013). However, the available evidence indicates that this group are likely to be experiencing health inequalities in relation to health protection. There is evidence to suggest that many LGBT people face barriers to accessing national screening and immunisation programmes (Stonewall, 2015). Furthermore, many LGBT people experience poorer sexual health across the life course with a greater burden of sexually transmitted infections (PHE, 2014a).

2.5 Healthcare Public Health

Healthcare public health (HCPH) is concerned with maximising the population benefits of healthcare while meeting the needs of individuals and groups, by prioritising available resources and by preventing diseases by improving health-related outcomes through design, access, utilisation and evaluation of effective and efficient healthcare interventions and pathways of care. There is evidence that LGBT communities are more likely to experience health inequalities in relation to preventable ill health. For instance, the evidence for greater levels of risky behaviour such as smoking and drinking suggests higher mortality rates from causes considered preventable which includes a range of disorders such as cancer, liver disease and respiratory diseases (Hudson-Sharp and Metcalf, 2016). However, sexual orientation and gender identity are not routinely monitored by the National Cancer Data Repository[5] therefore there is not a clear picture of inequalities in cancer rates for LGBT people. The picture is also unclear with regards to access to healthcare. However, given the higher prevalence of mental health conditions amongst LGBT people, as well as limited uptake of public health messages, almost six in ten health and social care staff don't think sexual orientation is relevant to healthcare (Stonewall, 2015). There appears to be a gap as research shows that patients want to talk to healthcare professionals about their sexual orientation and want health and social care professional to initiate these conversations (Rogers, 2014).

2.6 Social Care

Evidence points to the significant impact of discrimination on LGBT people's experiences of care and support and outcomes for their wellbeing (The National LGBT Partnership, 2014). Research has shown that LGBT people and carers often experience discrimination and marginalisation that impacts on their ability to access services and receive the most appropriate support. (Cartwright, Hughes, Lienet, 2012). For example, research into LGBT ageing indicates that these communities have particular needs in relation to care and support. Older LGBT people are at greater risk of social isolation and dependence on services with around 1 in 20 gay and bisexual men living with HIV requiring additional social care and support (The National LGBT Partnership, 2014). The National LGB&T Partnership (2014) found

[5] http://www.ncin.org.uk/collecting_and_using_data/national_cancer_data_repository/

that only 10% of LGBT people requiring social care were in receipt of a personal budget or direct payments (for care) for either themselves or a person they cared for. Of those receiving a personal budget of direct payments 53% described the choices they got were still limited. Only 4% of LGBT carers surveyed felt that they were able to balance caring responsibilities with their own quality of life, with 64% stating that they could not balance the two. Finally, the following needs were found to be relevant for all LGBT groups requiring care and support (The National LGBT Partnership, 2014):

- The need for personal choice in care providers.
- The need for greater training of non-LGBT care agencies.
- The need for discrimination and heteronormativity in care settings to be addressed
- The need for LGBT friendly environments for care delivery.
- The need to create a positive environment to disclose sexual orientation and gender identity to health and social care providers.
- The need to eliminate experiences of and fear of discrimination.

3. Population – what do we know?

3.1 National Population Estimates

The following draws on a number of sources that estimate the prevalence of being Lesbian, Gay, Bisexual, Other or Transgender in the UK. In the absence of local data we will apply these prevalence rates to the population of Swindon Unitary Authority in 2016, as provided by ONS (Office for National Statistics.) The measurement in these surveys is of people who identify themselves as being in one of those categories, rather than of people who feel or behave in a certain way; it is a measurement of how people identify their orientation rather than a description of their actual sexual emotions or activity. Being Transgender is usually treated as being in a wholly distinct category, whereas estimates of being Lesbian, Gay or Bisexual are sometimes combined to give an overall 'LGB' estimate. Some, but not all surveys have included an 'Other' category and this is sometimes combined with the LGB estimate to give a 'LGB plus O' estimate. It is not clear in the literature what 'Other' might mean; it could, for example, include people who regard themselves as 'asexual' or 'fluid' or who regard their identity as not fitting within an existing label. 'Other' probably overlaps with 'Transgender' but it cannot be as being equivalent to it, and it should be interpreted with caution.

Department of Trade and Industry/Treasury Figure 2003[6]

A percentage of 6% for the LGB population in the UK has commonly been used as the standard prevalence figure. This figure originated in a government calculation which was required when the Civil Partnership Act was being developed. The estimate seems to have been based upon research from Europe and the USA, and encompassed 'behaviour' as well as 'self-identification'. For this reason it is often regarded as an over-estimate of people who identify themselves as LGB, and we cannot recommend that it is used in this way without support from other sources.

(Source: Final regulatory impact assessment. Civil Partnership Act 2004, London. Dept of Trade and Industry 2003.)

NATSAL-3 2013

The 3rd National Survey of Sexual Attitudes and Lifestyle (NATSAL-3), published in 2013 was based on 2010 to 2012 fieldwork, although prevalence of self-

[6] Latest available data

identification was not formally published until early 2018. Adults aged 16 to 74 years were included.

1.5% of men and 1.0% of women identified themselves as Lesbian or Gay. 1.0% of men and 1.4% of women identified themselves as Bisexual, while 0.3% of either sex identified themselves as Other. Thus, 2.5% of adult men and 2.4% of adult women identified themselves as LGB. Self-Identification as Gay or Lesbian declined with age in both sexes.

The study also reported on attitudes to partnerships of the same sex. (It is not clear whether this question refers to casual, ongoing or officially recognised partnerships and the questionnaire suggested different degrees of wrongness or not being wrong as potential responses.) This revealed a growth in acceptance since previous surveys, and a difference in attitudes between men and women. Men thought same-sex partnerships to be 'not wrong at all' (*sic*) at levels of 48% between males and 52% between females. Women thought same-sex partnerships to be 'not wrong at all' (*sic*) at a level of 66%, for male partnerships and for female partnerships.

(Source: NATSAL-3. 3rd national survey of sexual attitudes and lifestyle. Nov 2013. Sexual identity, attraction and behaviour in Britain: the implications of using different dimensions of sexual orientation to estimate the size of sexual minority populations and inform public health interventions. Geary, RS, Tanton C, Erens, B. *et al.* published: January 2, 2018. PLOS One. https://doi.org/10.1371/journal.pone.0189607)

Integrated Household Survey 2014

In 2014 in this survey of adults in the UK 1.6% identified themselves as Lesbian, Gay or Bisexual (LGB). A further 0.3% identified themselves as Other. 1.5% of men identified themselves as gay, 0.7% of women as lesbian with figures respectively of 0.3% and 0.7% for identification as bisexual. Self-Identification as LGB decreased with age in the survey, with 2.6% of adults aged 16 to 24 years and 0.6% of adults aged 65+ years reporting this.

(Source: Integrated Household Survey 2014.)

ONS: Annual Population Survey 2013-15

Experimental statistics have been produced by using three year pooled estimates from the Annual Population Survey for the UK. Although ONS recommends that these are not used in practice, they are useful for consideration, in conjunction with other evidence, since they illustrate estimates at local authority level.

In this survey, 1.1% of adults aged 16 years or more identified as Lesbian/Gay, with 0.6% as Bisexual and 0.3% as Other. 4.5% returned a 'Don't Know' response or Refused to Answer. The estimates for Swindon UA were very similar, although the 'Don't Know/Refusal' response was slightly higher at 5.9%.

(Source: ONS. Subnational sexual identity estimates, UK. 2013 to 2015. Published 2017.)

ONS Sexual Identity Estimates for the UK 2016 (APS)

Data from the Annual Population Survey of adults in the UK provided the following estimates: 1.2% of people identified themselves as Lesbian or Gay, and 0.8% as Bisexual, with 0.5% as Other and 4.1% reporting Don't Know or Refusing. If men and women are looked at separately 1.7% of men and 0.9% of women identified themselves as Gay or Lesbian, with 0.6% and 0.9% respectively as Bisexual. This is one of few studies to report on change over time and records an increase in the adult LGB percentage from 1.7% in 2015 to 2.0% in 2016.

(Source: ONS, Statistical bulletin. Sexual identity, UK: 2016. Experimental Official Statistics on sexual identity in the UK in 2016 by region, sex, age, marital status, ethnicity and National Statistics Socio-economic Classification. October 2017.)

PHE Modelled Estimates of the LGB Population of England 2017

In January 2017 Public Health England published a systematic review of surveys of self-reported sexual identity, combining data in a meta-analysis from 15 surveys for adults in England. The authors statistically adjusted the pooled data to allow for possible bias, response rate and missing data in the contributing surveys. The final estimate was a percentage of 2.5% of adults identifying themselves as LGB or Other. 1.3% identified themselves as LG, 0.6% as Bisexual and 0.6% as Other.

The authors assume that these figures are under-estimates, partly due to the sections of people surveyed who reported as Don't know or Refused in various surveys (e.g. 4.1% in the ONS Sexual Identity survey), although it would be unwise to assume that we can validly assign this group to any of our standard categories. This report is probably the most rigorous investigation of this topic to date in the UK. It should be noted that none of the other studies mentioned above were incorporated into this meta-analysis with the exception of the Integrated Household Survey 2014.

(Source: Public Health England. Producing modelled estimates of the size of the Lesbian, Gay and Bisexual (LGB) population of England. Final Report Published January 2017)

Comparing the Estimates

Figure 1: Estimated national prevalence of self-identified LGB status in adults aged 16+ years in five studies (NATSAL-3 study included people aged 16 to 74 years)

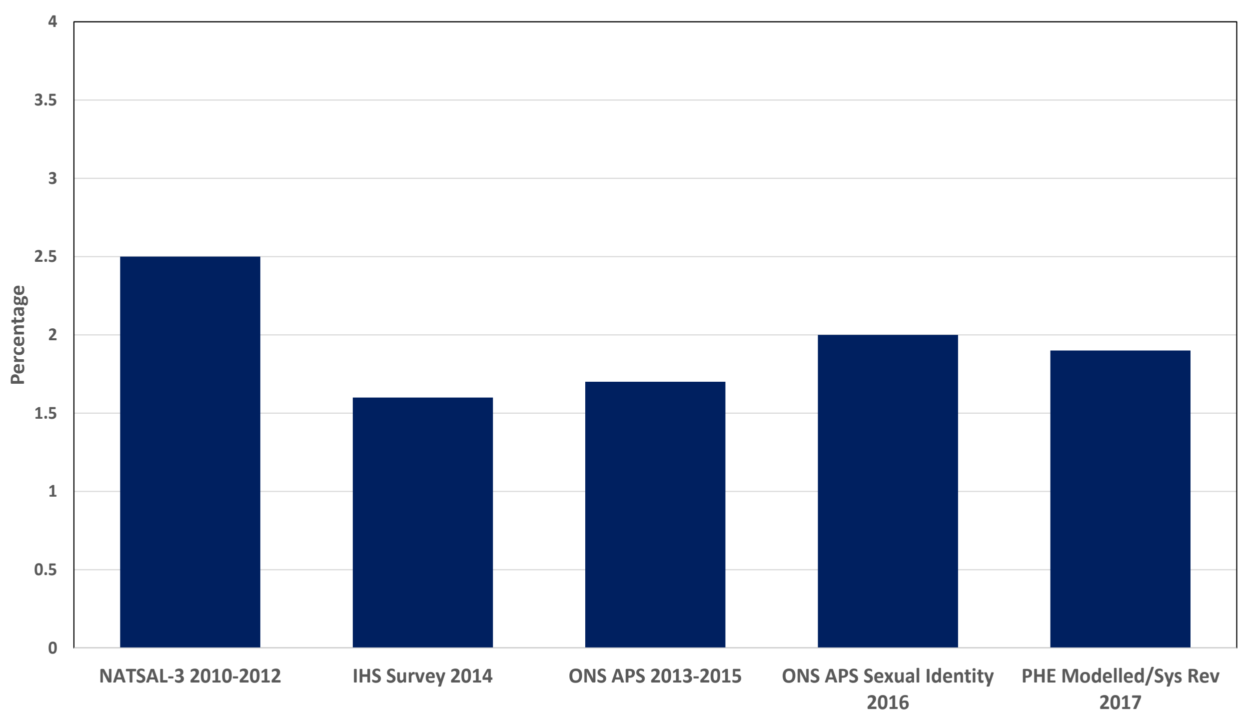


Figure 2: Estimated national prevalence of self-identified LGB plus Other status in adults aged 16+ years in five studies (NATSAL-3 study included people aged 16 to 74 years)

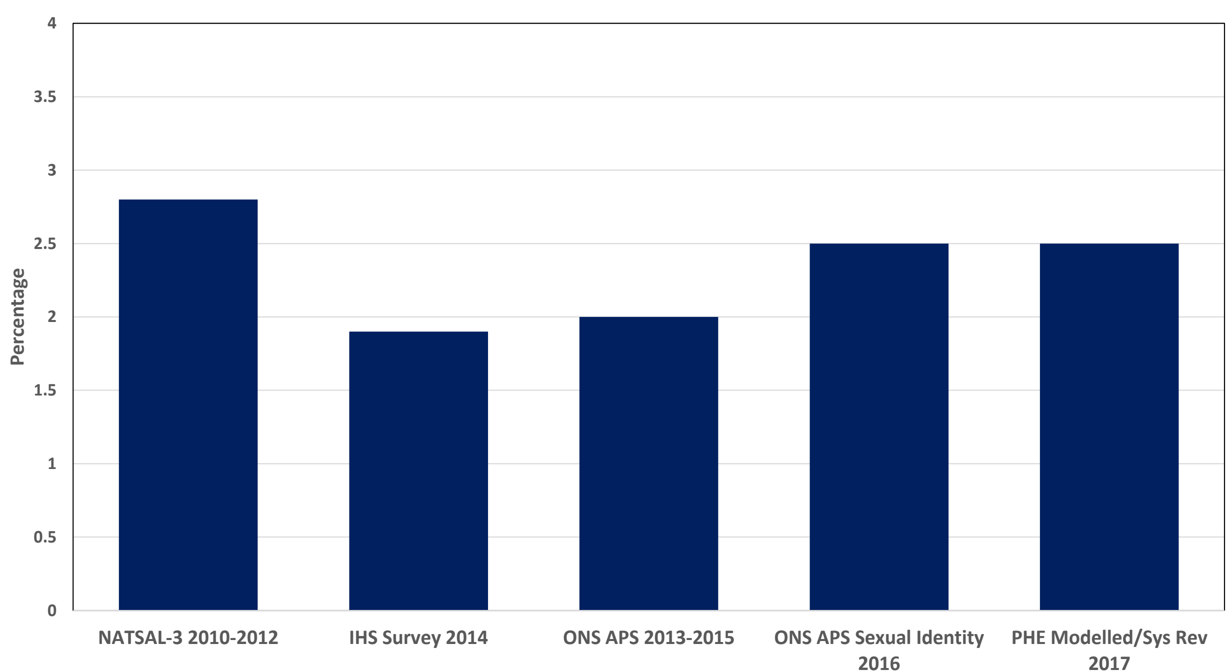


Table 1: Estimated national prevalence of self-identified LGB or Other status in adults aged 16+ years in five studies (NATSAL-3 study included people aged 16 to 74 years)

	NATSAL-3 2010-2012	**IHS Survey 2014**	**ONS APS 2013-2015**	**ONS APS Sexual Identity 2016**	**PHE Modelled/ Sys Review 2017**
Self-identifying as **Lesbian, Gay or Bisexual**	2.5%	1.6%	1.7%	2%	1.9%
Self-identifying as **Lesbian, Gay, Bisexual or Other**	2.8%	1.9%	2%	2.5%	2.5%

Figures 1 and 2, and Table 1, compare the estimates for LGB and LGB plus O across the five studies. The first graph shows a range of values for LGB of 1.6% to 2.5%, although the NATSAL-3 study which reported 2.5% had a slightly younger sample than the others. Likewise, the second graph shows a range of values for LGB plus O from 1.9% to 2.8%, with NATSAL-3 reporting the highest value.

In both graphs it is evident that the ONS Sexual Identity Study had values which were very similar to the systematic review by Public Health England and the latter is arguably the most robust figure we have. The ONS Sexual Identity Study reported data for a number of socio-demographic sub-groups and so these estimates are featured in the following section.

Socio-demographic variations from the ONS Sexual Identity Estimates for the UK 2016 (APS)

Figure 3: Estimated National Prevalence of Self-Identified Lesbian/Gay, Bisexual or Other status in Adults aged 16+ years By Age-Group in ONS "Sexual Identity, UK. 2016"

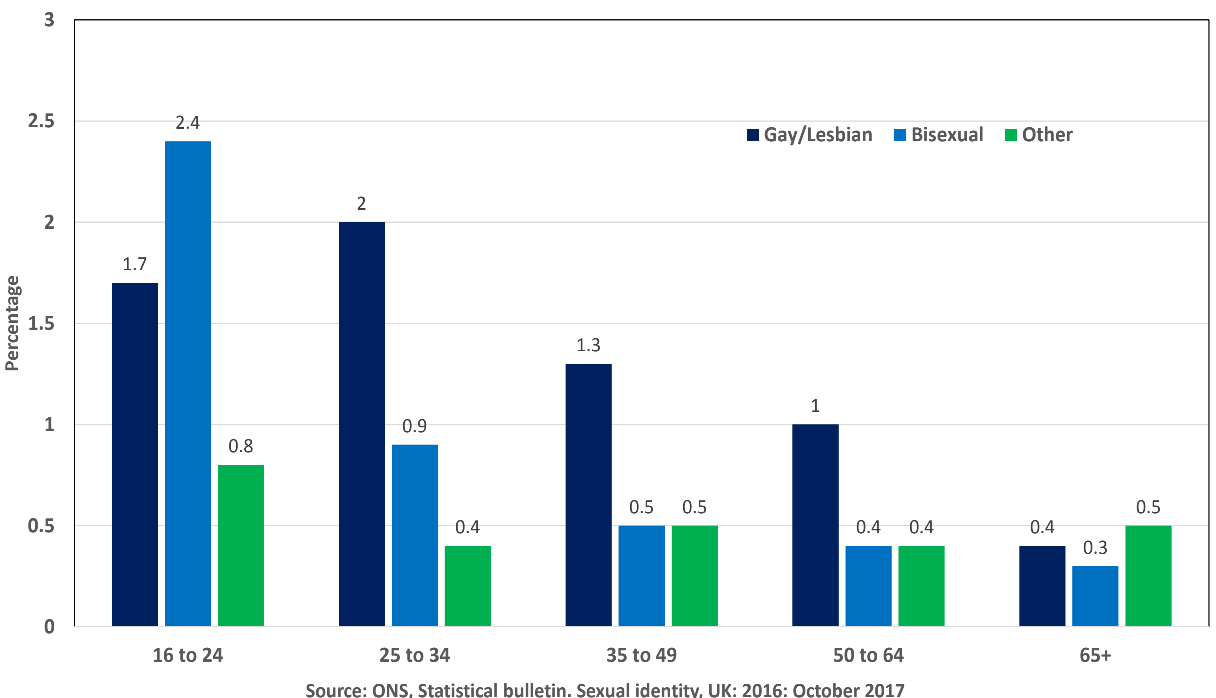
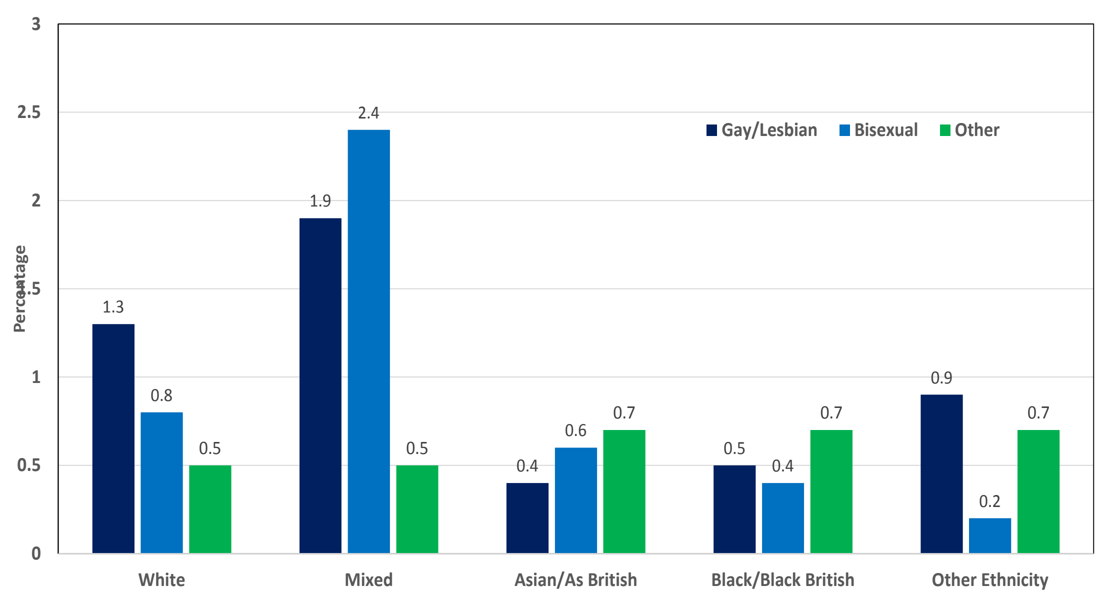


Figure 4: Estimated National Prevalence of Self-Identified Lesbian/Gay, Bisexual or Other status in Adults aged 16+ years By Ethnic Group in "Sexual Identity, UK. 2016"



Due to the relatively small numbers involved, the authors recommend that these figures should be treated with caution.

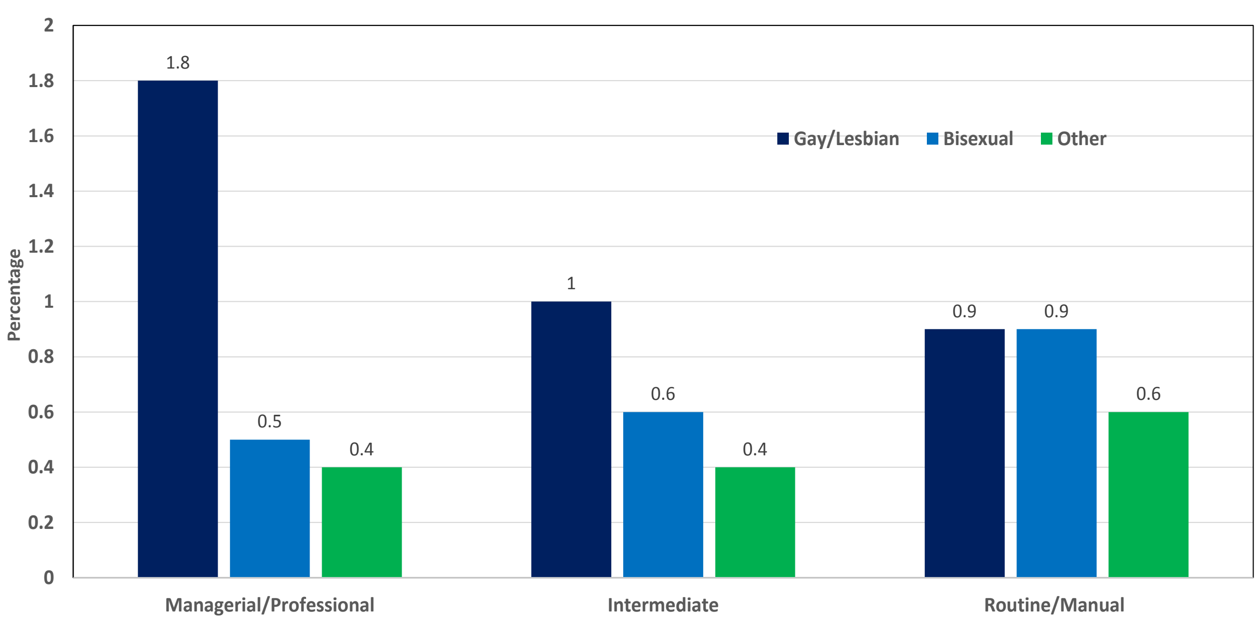
Figure 3 shows the percentages of people self-identifying as Lesbian/Gay, Bisexual or Other in the national ONS Sexual Identity estimates, by age-group. After the 25 to 34 years age-group the percentage identifying as Lesbian/Gay decreases (from 2% to 0.4% in people aged 65+ years.) The percentage of people identifying themselves as Bisexual declines immediately after the 16 to 24 year old age-group is passed, the same pattern as displayed by the Other group.

The overall decrease by age in proportions of people who self-identify within one of these categories may be due to one or more of the following, and perhaps to a combination of all three: people of older generations, because they were adults before the decriminalisation of homosexuality, still believe it is less socially acceptable to declare being in a minority category of sexuality; people's assessment of their sexual identity changes with age, for whatever reasons; people's interest in being specific about their own sexual identity, or reporting on it, declines with age.

Thus, it seems reasonable to regard the overall estimate of people who make up the LGB plus O group as an under-estimate, probably due to older people being less prepared to report a minority status. It must also be re-stated here that this survey was designed to measure self-reported sexual identity and not sexual thoughts, feelings or activities.

Figure 4 shows the percentages of people self-identifying as Lesbian/Gay, Bisexual or Other in the national ONS Sexual Identity estimates, by ethnic group. Due to the small numbers involved, these estimates should be regarded with extreme caution, although the statistics are strong enough to support the possibility that people of mixed ethnicity are less likely to identify themselves as heterosexual as compared with White/White British people.

Figure 5: Estimated National Prevalence of Self-Identified Lesbian/Gay, Bisexual or Other status in Adults aged 16+ years by Broad Economic Group in ONS "Sexual Identity, UK. 2016"



Source: ONS, Statistical bulletin, Sexual identity: 2016. October 2017

With regard to broad socio-economic group as shown in Figure 5, we are on more solid ground statistically. People in the Managerial/Professional group were most likely to self-identify as Lesbian/Gay (1.8%), compared with the other groups whereas people in the Routine/Manual group were most likely to self-identify as Bisexual (0.9%), compared with other groups

3.2 Swindon LGB Population Estimates

(Predicted Numbers of People self-identifying as LGB plus O in Swindon UA in 2016)

Table 2: Predicted Numbers of people (LGB plus O) by Age-Group in Swindon population in 2016, imputed from the percentage rates for the UK in 'ONS Sexual Identity. UK. 2016'

	Swindon Population, 2016	**Predicted Numbers in Swindon population, 2016**				
Age-Group	**Persons**	**Heterosexual**	**Lesbian/Gay**	**Bisexual**	**Other**	**Don't Know/Refusal**
16 to 24 years	20,767	18,815	353	498	166	955
25 to 34 years	29,669	27,384	593	267	119	1,305
35 to 49 years	47,991	44,872	624	240	240	2,016
50 to 64 years	41,357	39,041	414	165	165	1,572
65+ years	33,733	31,979	135	101	169	1,383
16+ years total	173,517	162,091	2,119	1,272	859	7,231

Source: ONS Sexual Identity. UK. 2016. ONS population figures. Columns do not sum exactly to 16+ years total due to rounding.

Table 2 sets out the numbers of people we would expect to find in the Swindon population in 2016, by age-group and the categories of Heterosexual, Lesbian/Gay, Bisexual, Other. To be more precise, these are the numbers of people we would expect to find in our population as identifying themselves in these groups. We have imputed these numbers by applying the percentage rates for the UK in the ONS 'Sexual Identity. UK. 2016' report to the Swindon UA population for 2016. (We have included a predicted 'Don't Know/Refusal' category, as some commentators, though not all, believe this response may have some significance, perhaps in being

another sexual identity category in itself, but we have not attempted an interpretation in the present report.)

Summarising LGB plus O Status in Swindon

- To summarise, in the population of Swindon (aged 16 years or more) of 173,517 people, we would predict that:
- 162,091 (93.4%) would self-identify as Heterosexual or straight
- 2,119 people would self-identify as Lesbian or Gay (1.2%), with the highest rate in the 25 to 34 year old group (593 people)
- 1,272 people would self-identify as Bisexual (0.8%), with the highest rate being in the 16 to 24 year old group (498 people)
- 859 people would self-identify as Other (0.5%), with the highest rate being in the 16 to 24 year old group (166 people)
- 7,231 people would respond in a survey as a Don't Know/Refusal
- Other and Don't Know/Refusal (in particular) are difficult categories to interpret
- These overall predicted LGB plus O figures are likely to be an under-estimate, since older people may be reluctant, due to earlier life experience, to report a minority identity
- Thus the reporting levels in the younger age-groups might be more accurate

Projections of Numbers of People self-identifying as LGB plus O in Swindon UA in 2021 and 2026

Table 3: Projected Numbers of people (LGB plus O) by Age-Group in Swindon population in 2021, imputed from the percentage rates for the UK in 'ONS Sexual Identity. UK. 2016'

	Swindon Projected Population, 2021	Projected Numbers in Swindon Population, 2021				
Age-Group	**Persons**	**Heterosexual**	**Lesbian/Gay**	**Bisexual**	**Other**	**Don't Know/refusal**
16 to 24 years	22,687	20,554	386	544	181	1,044
25 to 34 years	34,481	31,826	690	310	138	1,517
35 to 49 years	49,183	45,986	639	246	246	2,066
50 to 64 years	46,800	44,179	468	187	187	1,778
65+ years	39,504	37,450	158	119	198	1,620
16+ years total	192,655	179,995	2,341	1,406	950	8,025

Source: ONS Sexual Identity. UK. 2016. SBC population projections 2013. Columns do not sum exactly to 16+ years total due to rounding.

Table 4: Projected Numbers of people (LGB plus O) by Age-Group in Swindon population in 2026, imputed from the percentage rates for the UK in 'ONS Sexual Identity. UK. 2016'

	Swindon Projected Population, 2026			**Projected Numbers in Swindon Population, 2026**		
Age-Group	**Persons**	**Heterosexual**	**Lesbian/Gay**	**Bisexual**	**Other**	**Don't Know/Refusal**
16 to 24 years	23,740	21,508	404	570	190	1,092
25 to 34 years	34,548	31,888	691	311	138	1,520
35 to 49 years	50,943	47,632	662	255	255	2,140
50 to 64 years	48,807	46,074	488	195	195	1,855
65+ years	46,458	44,042	186	139	232	1,905
16+ years total	204,496	191,144	2,431	1,470	1,010	8,511

Source: ONS Sexual Identity. UK. 2016. SBC population projections 2013. Columns do not sum exactly to 16+ years total due to rounding.

Projections of numbers of people in Swindon in the LGB plus O categories (that is, numbers of people projected to self-identify in those groups) are set out for 2021 in Table 3 and for 2026 in Table 4. These estimates were imputed by applying the prevalence rates for the UK in the 'ONS Sexual Identity' report to the population projections for Swindon UA, published by Swindon Borough Council in 2013. According to these estimates, the number of people we would expect to self-identify as Lesbian or Gay would rise from 2,119 in 2016 to 2,341 in 2021 and to 2,431 in 2026. In addition, the number of people we would expect to self-identify as Bisexual would rise from 1,272 in 2016 to 1,406 in 2021 and to 1,470 in 2026.

3.3 Transgender/Transsexual people

Measuring the proportion of a population who are transsexual or transgender people is a difficult task. Aside from the issues involved in gaining a response in public surveys, there is not absolute agreement on which terminology is appropriate and how it should be used. Glen and Hurrell have given the following definition, which we will quote here, as we also cite prevalence data from Glen and Hurrell's

landmark Technical Report on measuring gender identity. It must be stressed, however, that other definitions might be employed elsewhere:

> ***'Trans/Transgender people:*** *The terms 'transgender people' and 'transgender people' are both often used as umbrella terms for people whose gender identity and/or gender expression differs from their birth sex, including transsexual people, transvestite/cross-dressing people (those who wear clothing traditionally associated with the other gender either occasionally or more regularly), androgyne/polygender people, and others who define as gender variant / non-conforming.'*

Glen and Hurrell have not stipulated prevalences from their research, but other authors have drawn upon statistical aspects of their work to estimate the prevalence of transgender people in the UK. For example, Winter, Diamond, Green *et al.* interpret the work as indicating a prevalence of 0.6% in men, 0.4% in women, and so a prevalence of 0.5% in all adults. In its professional guidance, the Royal College of Psychiatrists has drawn upon the same research to cite a prevalence of 1%. This has the appearance of an over-interpretation of the research, (perhaps statistical in nature, involving the rounding up of the estimate to a whole number) but it is in the published guidance of an authoritative body, so must be considered seriously. In terms of the Swindon population of 173,517 people aged 16 years or more, this would equate to 868 people (if the prevalence were 0.5%) 1,735 people (if the prevalence were 1%) and 1,301 people (if the prevalence were in between at 0.75%).

(Sources: Glen F. and Hurrell K. Technical Note: Measuring gender identity. Manchester: Equality and Human Rights Commission. 2012.

Winter S, Diamond M, Green J et al. Transgender health 1. Transgender people: health at the margins of society. Lancet 2016; 388: 390–400 Published Online. June 17, 2016. http://dx.doi.org/10.1016/. S0140-6736(16)00683-8.

Royal College of Psychiatrists. CR181. Good practice guidelines for the assessment and treatment of adults with gender dysphoria. October 2013.)

3.4 Civil Partnerships and Same-Sex Marriage

In total 650 civil marriages were performed by the Swindon Borough Council registration service in 2017. In approximate terms, about 5% of civil marriages in Swindon are for same-sex couples, so this would mean that about 30 to 35 marriages were for same-sex couples that year. In addition, two couples converted their civil partnerships to marriage in that year. Only one civil partnership ceremony

took place in 2017, presumably because by 2017 marriage had become the preferred option for same-sex couples.

In the 2011 Census 426 people in Swindon reported being in a civil partnership (therefore there were 213 same-sex couples in a civil partnership), but this was before the implementation of same-sex marriage legislation in the UK in 2014. No data are available relating to the number of people currently in a civil partnership or same-sex marriage in Swindon.

(Source: Head of Registration and Bereavement Services, Swindon Borough Council. ONS, 2011. Census.).

3.5 Sexual Orientation and Gender Identity Monitoring

Sexual orientation is one of the nine protected characteristics defined by the Equality Act 2010[7]. The Act and the corresponding Public Sector Equality Duty (PSED) (section 149 of the Act) contain a legal obligation for all public sector bodies to pay due regard to the needs of LGBT people in the design and delivery of services and ensure (and be able to demonstrate) that people are not discriminated against based upon their sexual orientation. Sexual orientation is already collected in certain data sets but is not consistently collected across the health and social care system. Collecting and analysing data on sexual orientation allows public sector bodies to better understand, respond to and improve LGB patients' service access, outcomes and experience. It is evidence of an organisation's compliance with the PSED. The Fundamental Standard for Sexual Orientation Monitoring Information Standard is recommended to provide a consistent method of monitoring sexual orientation for organisations. Monitoring sexual orientation and gender identity ensures that:

- All health and social care organisations are able to demonstrate the provision of equitable access for LGBT individuals.

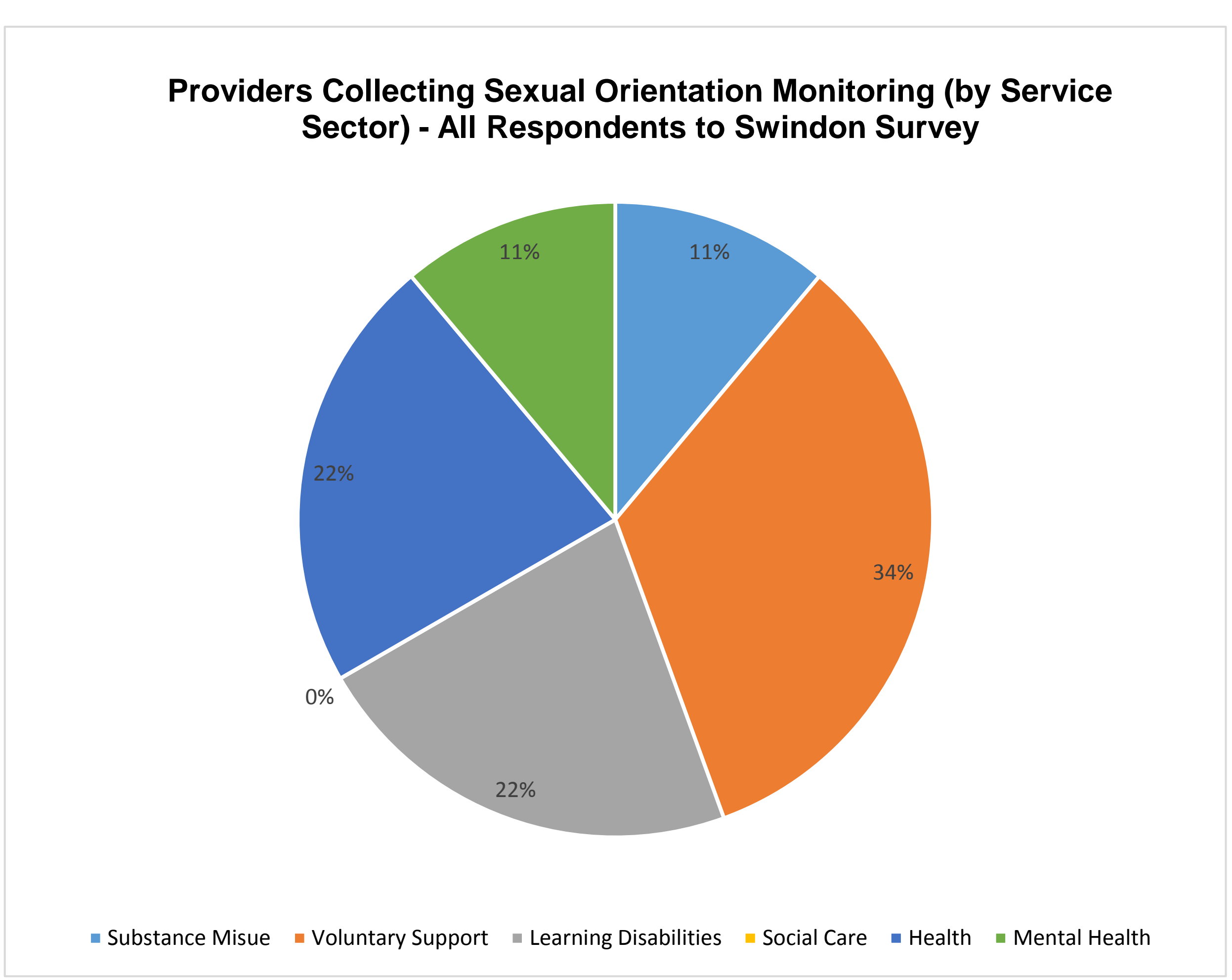
- Health and social care providers have an improved understanding of the impact of inequalities on health and care outcomes for LGBT populations in England.

[7] http://www.legislation.gov.uk/ukpga/2010/15/contents

- Commissioners can better identify health risks at a population level. This would support targeted preventative and early intervention work to address health inequalities for LGBT populations.

3.6 Swindon Service Monitoring Data

In order to gain an understanding of access to services by Swindon's LGBT population local service gender identity and sexual orientation monitoring data was requested from all commissioned health and social care providers. Fourteen responses were received from a range of organisations from the voluntary sector, health and social care. No providers were monitoring Gender Identity. The following is a summary of responses from service providers grouped by service sector that are currently collecting Sexual Orientation data:



3.7 Specific Support Services for LGBT People in Swindon

There are a range of dedicated services that provide specific support for LGBT people to promote health and wellbeing. The following services all provide support for LGBT people in Swindon:

  GOC-GAY OUTDOOR CLUB Covers Wiltshire, Gloucestershire and North Somerset and consists of 40 groups which are geographically based or specialise in a type of activity such as climbing. All events are organised through one of these groups.	 SEXUAL HEALTH CLINIC AT THE GREAT WESTERN HOSPITAL HIV and STI testing, advice and information and contraception, that is non-judgemental.
 GAY SOCIAL GROUP Provides an opportunity for LGBT people to meet away from the 'scene'.	 INTERCOM TRUST Provides professional training and information that support LGBT communities in the South West. They provide consultancy and work in partnership with local government, the police and health.
 OUT OF THE CAN A group for young LGBT people aged 13-19 years. It offers support to those unsure of their sexuality and wanting to meet other young LGBT people.	 WILTS COUNCIL LGBT STAFF FORUM Support LGBT staff at Swindon and Wiltshire Council as well as wider public services such as police and health services.

 SWINDON AND WILTSHIRE PRIDE Organises and runs the yearly Swindon and Wilts Pride and provides information for LGBT people living in the area.	 LGBT CARERS Works with carers to support them in their role, and is part of the Swindon Carers Centre.
 SWINDON COLLEGE PRIDE GROUP Is a group for young LGBT students and is based at Swindon College.	 SWINDON EQUALITY COALITION Is a network of groups and people, who are interested in making equality a reality for the people and communities living in Swindon.
 SWINDON TG GROUP A support group for transgender people in Swindon and also provides support for those who are confused about their gender identity. Provides a safe place where people can be themselves.	 NHS SOUTH, CENTRAL AND WEST COMMISSIONING SUPPORT UNIT Provides information for transgender people considering gender reassignment around funding for surgery and medical procedures.
 HOMETRUTHS Provides support for specialist services to anyone from the age of 16 who is, or has experienced domestic violence and abuse from partners, ex-partners or family members, living in Swindon and North Wiltshire, including stalking & harassment.	 SWINDON BOROUGH COUNCIL Supports LGBT Foster Carers with free membership of New Family Social for all LGBT foster carers.

4. What are the key health issues and inequalities for LGBT people across the life course?

4.1 Lesbian and Bi-sexual Women (WSW)

4.1.1 Wider Factors

Lesbian and bisexual women lack acknowledgement both in mainstream society and within LGBT communities (Barker, 2015) and are invisible in health and social care (Humphreys et al, 2016). Lesbian and bi-sexual women's needs are often doubly hidden, both within the topic of women's health, which often focuses on reproductive health, and in the health needs of the LGBT community in general (Fish and Bewley, 2010). The LGBT Foundation's (2016) evidence review of women's health needs identifies the need for research that moves beyond the narrow focus of reproductive health to address the wider determinants of health and wellbeing. One area that impacts upon health and wellbeing is domestic abuse. Lesbian and bisexual women are a hidden group with regards to domestic abuse. For example, Stonewall's (2013b) research shows that one in four lesbian and bisexual women have experienced domestic abuse in a relationship with two thirds of those reporting that the perpetrator was a woman, with a third reporting a man.

4.1.2 Lifestyle Behaviours

For lesbian and bisexual women research has focused on access and uptake of breast and cervical cancer screening. Studies have shown that compared to heterosexual women, lesbian and bisexual women were more likely to develop breast cancer but less likely to develop cervical cancer (Equality and Human Rights Commission, 2010). This can be in part attributed to studies that show that lesbian and bisexual women are also less likely than heterosexual women to conduct breast self-examinations (Ellison and Gunstone, 2009). This study also showed prejudice and discrimination linked to sexual orientation which also caused physical health problems in 6% of lesbians (Ellison and Gunstone, 2009). Substance misuse is also more prevalent in lesbian and bisexual women with higher levels of alcohol consumption among lesbian and bisexual women (Hudson-Sharp and Metcalf, 2016). This was attributed to poorer mental health and both greater levels of

depression and higher rates of alcohol use which was directly affected by sexual orientation (Pesola et al, 2014).

4.1.3 Mental Health & Wellbeing

The risk for depression and anxiety disorders for LGBT people is estimated to be at least 1.5 times higher than the general population (King et al, 2008). Stonewall's (2012) study found that 40% of LGB people had been diagnosed with depression and 30% with anxiety. Prevalence of mental ill health is greater for lesbian and bisexual women than heterosexual women, with one study finding that 16% of lesbians and 26% of bisexual women suffered from mental ill-health, compared to 8% of heterosexual women (Gusap, 2010). A further study found that 21% of lesbian and bisexual women attributed their own mental health problems to prejudice and discrimination which was directly linked to their sexual orientation (Ellison and Gunstone, 2009)

4.1.4 Sexual Health

Studies have shown that lesbian and bisexual women experience lower rates of sexually transmitted infections (STIs) compared to both gay men and heterosexual groups (Bailey et, al 2004, EHRC, 2010a). However, research shows that there is a general lack of recognition and knowledge amongst healthcare professionals on the transmission of STIs through lesbian sex (EHRC, 2010a). Consequently, lesbian and bisexual women were less likely than heterosexual women to be screened for STIs or to have a cervical smear, leaving them at greater risk of cervical cancer and damage from STIs (EHRC, 2010a). Stonewall Scotland (2014) found that NHS staff often made incorrect assumptions about sexual orientation or gender identity, in 55% of cases studied relating to LGBT people and rising to 75% in the case of lesbian and bisexual women which impacted on access to sexual health services with respondents reporting that they received inappropriate questioning about their sexual health. Fish and Bewley (2010) also found that there was a lack of knowledge regarding lesbian and bisexuals women's sexual practices amongst healthcare staff which sometimes resulted in inadequate treatment.

4.1.5 Workplace Health

There are few studies of workplace health specifically relating to lesbian and bisexual women. However the Lesbian, Gay and bisexual People in Later Life study (Gusap, 2010) found older LGB people are more likely to be in work than older heterosexual people. Consequently older LGBT have reported negative attitudes and discrimination in the workplace reflecting the wider societal prejudice and discrimination experienced by LGBT people in general (Hudson-Sharp and Metcalf, 2016).

4.1.6 Service Access and Quality

Fish and Bewley (2010) found that there were three main barriers to lesbian and bisexual women accessing services; firstly the fear of discrimination, secondly the lived experiences of actual discrimination and a thirdly a culture of heterosexism. The National LGBT Partnership's (2016) study of lesbian and bisexual women's experiences of healthcare revealed that 18% of lesbian and bisexual women experienced an assumption of heterosexuality from healthcare professionals. With 17% of lesbian and bisexual women having experienced discrimination, hostility or poor treatment because of their sexual orientation when using GP services (Stonewall, 2013).

4.1.7 Social Care

Older lesbian and bisexual women are more likely to live alone as they age and are therefore more likely to need to access care services (The National LGBT Partnership, 2014). One in six older lesbian and bisexual women have experienced discrimination, hostility or poor treatment because of their sexual orientation from social care providers (The LGBT Foundation, 2016).

4.2 Gay and Bi-sexual Men (MSM)

4.2.1 Wider Factors

Public Health England (2014a) estimate that 2.6% of the male population of the UK is gay, bisexual or MSM (classified as men who have had sex with at least one male partner in the last 5 years). Evidence suggests that this diverse population continues to experience significant inequalities relating to health, wellbeing and broader social and economic circumstances (PHE, 2014a). Mercer et al (2013) suggests that there are a trio of inequalities across the life course that negatively impact upon gay and bisexual men's health and wellbeing:

- The development and acceptance of a person's gay or bisexual identity
- The person's first same-sex experience or relationship
- Disclosure and coming out to friends family and wider acquaintances.

Research suggests that healthy transition through key life stages for gay and bisexual men is dependent upon men feeling accepted and supported from an early age and into adulthood (Mercer et al, 2013). Gay and bisexual men require a supportive environment to make healthy choices about their lives together with a supportive community to access and receive appropriate health and social care through the life course (PHE, 2014b). In addition Stonewall's (2013b) research found that 49% of all gay and bisexual men have experienced at least one incident of domestic abuse from a family member or partner since the age of 16.

4.2.2 Lifestyle Behaviours

Public Health England (2014b) identifies three main areas in which gay, bisexual and MSM bear a disproportionate burden of ill-health:

- Sexual Health and HIV
- Mental Health
- The use of drugs, alcohol and tobacco

Gay and bisexual men are almost twice as likely to take drugs and drink alcohol compared to heterosexual men and twice as likely to have drunk twice or more in a week than heterosexual men (PHE, 2014b). MSM were twice as likely to be dependent on alcohol compared with the rest of the male population (PHE, 2014b).

Research suggests that substance misuse was most strongly associated with homophobic and bi-phobic bullying, a lack of supportive environments and negative disclosure reactions (PHE, 2014b). Smoking rates are also higher for MSM compared to their heterosexual counterparts (PHE, 2014b). Furthermore, the younger MSM group (18-19 years) were more than 2.4 times more likely to smoke than their heterosexual peers (Varney 2014).

4.2.3 Mental Health & Wellbeing

MSM of all ages (apart from over 55 years) were twice as likely to experience poor mental health compared to heterosexual men, with bisexual men at the highest risk of poor mental health (Meyer, 1995). Public Health England (2014b) also found that:

- 21% of MSM reported feeling unhappy or depressed compared to 12% of heterosexual men.
- 29% of gay and bisexual men had suffered from depression.
- 24% from anxiety.
- 6% had made suicide attempts.
- 14% had self-harmed.

Research (Hudson-Sharp and Metcalf, 2016) shows that there are other contributing factors that either contributed to, or mitigated the effects of homophobia and discrimination amongst gay and bisexual men, which also affected levels of mental health reported by some groups. For example, MSM who were more economically privileged and better educated were more able to resist the impact of homophobia.

4.2.4 Sexual Health

MSM experience a disproportionate burden of poor sexual health (PHE, 2014a,b, 2017c). However, caution should be exercised not to define the needs of gay and bisexual men by their sexuality or sexual activity: whilst HIV infection is a key health concern, gay men experience other health inequalities not explicitly linked to sexual activity. Evidence suggests that some MSM self-report a higher number of sexual partners when compared to heterosexual men (PHE, 2014b). Statistics recorded by PHE in 2016, for the period 2015-2016, suggest that there has been a rise in new diagnosis for some STIs and a reduction in others for MSM. There were 49,445 new STIs diagnosed among MSM in 2016, broken down as follows:

- Gonorrhoea made up 36% of all new STI diagnosis in 2016.
- Chlamydia made up 26% of all cases in 2016.
- New cases of Gonorrhoea decreased by 22% during the period 2015 to 2016.
- Chlamydia cases had increased by 1%
- Syphilis diagnosis in this period had increased by 14%
- New HIV diagnosis amongst MSM had decreased by 23% between 2015 and 2016 (PHE 2017c).

Related to sexual health, PHE (2014b) report that;

- MSM had higher rates of HPV and anal cancer.
- MSM are at higher risk of penile, oral and throat cancer.
- 7.7% of HIV positive MSM in 2013 were co-infected with Hepatitis C (PHE, 2014b)

Chemsex is the use of drugs to increase disinhibition and sexual arousal which includes the injecting use of drugs in a sexual context (slamming). Chemsex is prevalent amongst a small minority of men who have sex with men (MSM) and has been linked to an increased risk of blood-borne infection transmission (European Monitoring Centre for Drugs and Drug Addiction, 2016). Purfall et al (2018) found that three in ten sexually active HIV-positive MSM engaged in chemsex in the past year, which was positively associated with self-reported depression/anxiety, smoking, nonsexual drug use, risky sexual behaviours, STIs, and hepatitis C. Chemsex may therefore play a role in the ongoing HIV and STI epidemics in the UK.

4.2.5 Workplace Health

Gay and bisexual men face discrimination in the workplace (Stonewall, 2013b). A study of working-age gay and bisexual men and found that:

- Bisexual men earn 30% less than gay male colleagues.
- Bisexual men earn 31% less than heterosexual colleagues. (Bryson, 2016)

The study found that gay men earn similar and in some cases slightly more than heterosexual counterparts in equivalent roles. Stonewall (2013b) also found that 11% of bisexual people could find role models in their workplace, compared to 53% of gay men and 42% of lesbians.

4.2.6 Service Access and Delivery

The Gay and Bisexual Men's Survey (Stonewall, 2013a) found that:

- 34% of gay and bisexual men accessing healthcare, in the last year have had a negative experience.
- 16% said that their GP or healthcare professional assumed that they were heterosexual.
- 15% felt that there was no opportunity to discuss their sexual orientation
- 3% only had come to their GP or healthcare professional and felt that they were either ignored or that the professional continued to assume that they were heterosexual.
- 3% were asked inappropriate questions by their GP or healthcare professional having 'come out' to them.

4.2.7 Social Care

There is a lack of evidence related to the specific social needs of the gay and bisexual men.

4.3 Transgender People

4.3.1 Wider Factors

Transgender is an umbrella term that covers numerous variations in gender identity. The Gender Recognition Act 2004[8], gives transgender people the right to be recognised under the law by their chosen gender identity, to have a new birth certificate and some new rights in other areas of life under the law. The Gender Recognition Act 2004 requires transgender people to have a formal diagnosis of gender dysphoria and to live in their acquired gender for two years, which is based on a psychological definition to describe gender incongruence (Stonewall, 2017c). However, the World Health Organisation (2016: 790) has evolved its definition of gender identity to move away from this:

> '*The World Health organisation (WHO), now recognises that gender incongruence is not psychopathological, accordingly it will be moved out of its' present location under Mental and Behaviour Disorders in the International Classification of Diseases, into the non-psychopathological section'.*

Therefore there is a general need to adopt a broader view of gender beyond the stereotypical binary models (McNeil et al, 2015).

Studies of transgender communities show that transgender people face discrimination in many areas of life (Hudson and Sharp, 2016, Morton, 2016). Evidence suggests that transgender people experience and are severely affected by transphobia in a wide range of forms, which includes bullying and discriminatory treatment in school, harassment, physical/sexual assault and rejection from families, work colleagues and friends (Whittle, 2014). Stonewall's (2017a) *LGBT in Britain-Transgender Report* found that:

- 25% of transgender people have experienced homelessness.
- 42% of transgender people who would like to undergo medical intervention, as part of their transition, have not yet done so because they fear the consequences it might have on their family

[8] https://www.legislation.gov.uk/ukpga/2004/7/contents

- 48% of transgender people do not feel comfortable using public toilets through fear of discrimination or harassment
- 34% have been discriminated against because of their gender identity when visiting a café, restaurant, bar or night club in the last year.
- 28% of transgender people in a relationship in the last year have faced domestic abuse from a partner.
- 44% of transgender people avoid certain streets because they do not feel safe there as an LGBT person.
- 25% have been discriminated against for a house or flat to rent or buy in the last year
- 36% of transgender students have experienced negative comments or behaviour from staff in the last year.

There is limited research on how many transgender people experience domestic abuse in the UK. However, a report by the Scottish Transgender Alliance (2010) found that 80% of transgender people had experienced emotional, sexual, or physical abuse from a partner or ex-partner.

4.3.2 Lifestyle Behaviours

There is a paucity of research on lifestyle behaviours of transgender people. A recent study of young transgender people notes that many were vulnerable to self-harm, relationship difficulties, social isolation and educational disadvantage (Gender Identity Research & Education Society, 2014). Furthermore *coming out* as a transgender person is very difficult for many people which negatively impacts on mental health and wellbeing (Gender Identity Research & Education Society, 2014).

4.3.3 Mental Health & Wellbeing

Adams et al (2013) states that cost, a lack of cultural safety (the ability to provide services that appropriately recognise diversity), and a lack of staff competence around LGBT issues were all substantive barriers to LGBT people accessing mental health services. Minority stress is an important factor in the mental health and wellbeing of transgender people (Whittle et al, 2007). However, there is a lack of evidence on prevalence of mental illness within the transgender population. Available research has focused on the experiences of transition and accessing the

services of Gender Identity Clinics (GICs). The UK Transgender Mental Health Study (McNeil et al, 2012) of 1,054 participants found that:

- 74% felt that their mental health had improved as a result of transitioning. The 5% who reported a decline in their mental health since transitioning felt that their issues related to a lack of appropriate support, losing family and loved ones, or for reasons which respondents felt were unrelated or 'not directly related' to the transition, such as employment or cultural/environmental issues.
- 66% of transgender respondents reported having used mental health services (NHS, private, voluntary) for reasons over than accessing gender reassignment medical assistance-many prior to transitioning.
- 34.7% were sometimes open to mental health professionals about being transgender and 29% said they were completely open to professionals.
- 32.6% had worries about accessing mental health services in the future because they are transgender or have a transgender history.

One of the biggest factors contributing to patient satisfaction amongst transgender people has been linked to the importance of knowledge of health professionals on transgender issues (Adams et al, 2013). Furthermore, the Ellis at al. (2014) study found that 29% of transgender people felt that their gender identity was not validated as genuine instead being treated as a mental illness.

4.3.4 Sexual Health

There is a lack of evidence around the sexual health needs of transgender people.

4.3.5 Workplace Health

In relation to transgender people's experiences in the workplace, Stonewall (2017c) found that:

- 12% of transgender employees have been physically attacked by a colleague or customer in the last year.
- 51% of transgender people have hidden their gender identity at work for fear of discrimination.
- 52% never felt comfortable being *out* at work

- 32% avoided workplace opportunities because of a fear of being harassed, being outed, or being read as non-binary.

4.3.6 Service Access and Delivery

Stonewall Scotland (2014) also note that the current provision of transgender healthcare is rooted in the medicalisation of gender diversity and that new models of care moving beyond psychiatric models are required (McNeil et al, 2012). A study by the Scottish Transgender Alliance (Stonewall Scotland, 2014) found in a survey of 895 transgender people, that:

- 60% never felt comfortable being out to general NHS services
- 50% never felt comfortable being out to their GP
- 48% never felt comfortable being out to other public services
- 38% never felt comfortable being out in education
- 37% never felt comfortable being out to Sexual Health Services
- 33% never felt comfortable being out to charities/voluntary organisations
- 29% never felt comfortable being out to mental health services. (Guasp 2015)

McNeil's (2015) study on Gender Identity Clinics (GICs) found that 22.7% had accessed GICs, however, 46% had difficulty obtaining the assistance or treatment they needed. Barriers to access treatment are a common concern for younger transgender people. A recent study of young people accessing gender reassignment services at the Tavistock and Portman Gender Identity Development Service (GIDS) found that 50% of families were dissatisfied with the distances needed to travel to clinic (GIRES 2017).

4.3.7 Social Care

Many carers and parents of transgender children reported that there was little support for them whilst a child or young person was transitioning (Hatton and Waters, 2013). Furthermore, parents and carers of young transgender people found that they were often concerned regarding their own mental and physical wellbeing, and were often unable to maintain employment whilst caring for a child or young person (Hatton and Waters, 2013). With regards to older transgender people Withall (2014) found that some transgender people in this cohort felt that they would *'rather*

end their own life than go in to residential care'. Older transgender people are often concerned that their gender presentation may not be respected in a care environment, especially if they lost mental capacity due to dementia or Alzheimer's disease (The National LGBT Partnership, 2014).

4.4 Younger LBGT People

4.4.1 Wider Factors

The Metro Youth Chances (2014) survey of 6,514 respondents found that 53% of LGB respondents knew that they were LGB by the age of 13 and 58% of transgender respondents knew they were transgender by the same age. Evidence from across all the policy areas covered by the review shows younger LGBT people face a hostile environment, in education, at home and in wider society at a stage in their lives needing appropriate support and approbation (Hudson-Sharp and Metcalf, 2016). Younger LGBT people are subject to extensive homophobia, biphobia, transphobia, greater mental ill health and unwanted and risky sex. Therefore, experiences at this stage of the life course have life-long implications for mental health and wellbeing and levels of resilience.

4.4.2 Lifestyle behaviours

Younger LGBT people are more susceptible than their heterosexual peers to cancers and poor physical health outcomes partly owing to negative health behaviours such as smoking, drug use, inadequate dietary intake and alcohol misuse (Fay, 2016). Younger LGBT people experience higher rates of substance misuse and are more likely to drink alcohol and smoke tobacco compared to their heterosexual peers (Hudson-Sharp and Metcalf, 2016).

4.4.3 Mental Health & Wellbeing

Poor mental health is high among younger LGBT people with higher rates of depression, suicidal thoughts and self-harm than their peers (Hudson-Sharp and Metcalf, 2016). LGBT people under 35 are twice as likely to report a mental health problem (Fay, 2016). This has been confirmed by recent research and a combined meta-analysis of 12 UK population health surveys based on a sample of 94,000 (Semlyen et al. 2016). Experiences of homophobic bullying, as well as not having someone to talk to, can have an impact on young LGBT people's mental health (Department of Health, 2007) in the following ways:

- Young LGBT people are at increased risk of mental health problems.
- Depression was the most common mental health problem.

- Young LGB people are more likely to have attempted suicide than their heterosexual peers.

Increased suicide risk among younger LGBT people is associated with:

- identifying as gay or bisexual at a younger age;
- boys (or girls) who do not conform to gender stereotypes;
- conflict with parents or peers about their sexual orientation;
- not coming out;
- being told by other adults that their feelings are transitory or just a phase; and
- being forced to leave home because of negative attitudes to their sexual orientation.

Stonewall's (2017d) study on young LGBT people in school found that (84 per cent of young transgender people have self-harmed and for lesbian, gay and bi young people 61 per cent have self-harmed. Suicide is a serious concern for young LGBT people (Fay, 2016). With 45% of young transgender people and 22% of LGB young people reporting to have attempted to take their own life. Semlyen et al (2016) found that bisexual identity was slightly more associated with increased risk of poor mental health symptoms when compared to heterosexuals than lesbian or gay identity.

4.4.4 Sexual Health

The impact of STIs remains greatest in young heterosexuals 15 to 24 years and MSM (PHE, 2017c). When compared to other LGB people, young LGB people and particularly young gay and bisexual men are at a higher risk of HIV and STIs (Hudson and Sharpe, 2016). However, available data for young people does not fully differentiate by sexual orientation or gender identity. PHE's latest data (2017c) reports that there were 1,171 diagnoses of first episode genital warts in 15 to 17 year old girls in 2016, a 74% decrease relative to 2009 (PHE, 2017c). Over 1.4 million chlamydia tests were carried out and over 128,000 chlamydia diagnoses were made among young people aged 15 to 24 years (PHE, 2017c).

4.4.5 Educational Settings and Health

Evidence suggests that appropriate LGBT sex and relationship education is of particular importance for LGBT young people, both in order to address issues of their sexuality and also because of the high rates of risky sexual behaviour amongst young gay and bisexual men (Hudson-Sharp and Metcalf, 2016). Guasp's (2012a) survey of younger LGB people found that only one third of the sample of LGB pupils had discussed LGB issues in Personal, Social, Health and Economic (PSHE) lessons, and fewer in sex and relationship education (SRE) or in other classes. Moreover, only 34% who had been taught about LGB issues at school reported that this had been taught in a positive way. Eighty-five per cent said they were never taught about biological or physical aspects of same-sex relationships at school and 8% said they were never given information on where to seek advice and help. This lack of information extended to discussion of civil partnerships and having children. Furthermore, 17% of pupils who had received information about LGB issues said this had been addressed negatively. In such schools, a much higher percentage of LGB students reported bullying. Twelve per cent of LGB young people reported that the information they were given was inaccurate or misleading (Guasp, 2012a).

4.4.6 Service Access and Quality

Access to health care is a major concern of younger LGBT people (Hudson-Sharp and Metcalf, 2016). Non-disclosure of sexual orientation was found to be a barrier to accessing appropriate health care with notable difference in disclosure rates to GPs by younger LGBT people (Stonewall Scotland, 2014).

4.4.7 Social Care

There is little evidence on the inequalities experienced by young transgender people, and no evidence was found on young LGBT young people who were in social care.

4.5 Older LGBT People

4.5.1 Wider Factors

Many older LGBT people have lived through times when society and the law was less tolerant and subsequently they may have faced higher levels of prejudice. For some older LGBT people homosexuality was illegal in the UK, whilst they were growing up and into their adult lives, which may have forced them to be less open about their sexuality, than younger LGBT people. This may have affected their confidence in using services and trusting professionals. Evidence from across all the policy areas covered shows that older LGBT people, compared with older heterosexual people, are more concerned about the implications of ageing in relation to care needs, independence and mobility, health, housing and mental health (Hudson-Sharp and Metcalf, 2016). Research suggests that older LGBT people are more likely than heterosexual people to be concerned about having to move into residential accommodation as they age, because of fears of homophobia and heteronormativity. Evidence is, however absent on the actual experiences of older LGBT people in residential homes. Furthermore, there is little evidence and research relating to older transgender people in the UK.

4.5.2 Lifestyle behaviours

Stonewall (2010) found that older LGB people tended to be financially better off than heterosexuals of the same age and are more likely to have a private pension but more reluctant to access care and health services. Much of the research hinges around the expectations of LGB older people in relation to services which has highlighted gaps in research regarding actual deficiency in services (Hudson-Sharpe & Metcalf, 2016). Relating to specific lifestyle behaviours, Stonewall's study (2010) found that of their sample of older LGB people (over 55 years):

- 9% took recreational drugs
- Consumed more alcohol than heterosexuals of the same age.
- Smoking levels amongst both LGB and heterosexuals was roughly equal.
- Took more exercise than heterosexuals.
- Were more concerned about their personal health.
- Were more likely to rely on social networks/friends than family for support because a lack of family support and were less likely to have children

- Are more likely to live alone in older age than heterosexuals

4.5.3 Mental Health & Wellbeing

Older LGBT people experience double stigmatisation. Firstly, because of their sexual orientation and/or gender identity and secondly because of stigma associated with old age. This experience of double stigma leads to a cumulative health inequalities with poorer mental health (Hudson-Sharpe and Metcalf, 2016). Older LGBT people with dementia form a specific minority that experience disadvantage, discrimination and prejudice that impacts their health and social care experience, leading to health inequalities and unmet needs through triple marginalisation due to age, gender/sexual identity and cognitive impairment. Older LGBT people are more likely to be isolated and lack the family support that heterosexual people with dementia may have greater access to. This increases LGBT people's need for dementia care services (Dementia Action Alliance, 2018)[9].

4.5.4 Sexual Health

Older LGBT people are less likely to test for HIV compared to younger LGBT people. This leads to a higher proportion being diagnosed late, poorer health outcomes after diagnosis and increased risk of onward transmission (PHE, 2017c). Stonewall's (2011a) research suggests that older LGBT people are as likely to have 'unsafe sex' as younger LGBT people. Reasons cited, were fear of discrimination and a fear of being open about their sexuality which ties in with research on other areas of health where older LGBT people were reluctant to access sexual health services (Stonewall, 2011a).

4.5.5 Workplace Health

Stonewall's (2011a) study found that older LGBT people were more likely to be in work with 67% LGBT, 55-59 years olds in work, compared to 52% heterosexual. Reasons cited for continuing to work in to retirement were enjoyment of work and financial need. Furthermore, older LGBT people were more likely to have a private pension which lends support to evidence on higher employment rates between LGBT people and heterosexual people (Stonewall, 2011a).

[9] https://www.dementiaaction.org.uk/news/19643_dementia_and_the_lesbian_gay_bisexual_and_trans_lgbt_population

4.5.6 Service Access and Quality

Stonewall's (2011a) found that LGB were more likely to require support from health and care services due to being more likely to live alone and less likely to have familial support. Older LGBT people that they were more reluctant to access such services and often delayed doing so for longer than heterosexuals after the time that they needed to do so. The study found this was often because they often expected to be discriminated against and be a victim of homophobia. Furthermore, older LGBT respondents from the study were concern about accessing care service due to a lack of ability to be able to be oneself and also the lack of privacy and safety. The study identified a need for services to provide support from existing LGB social networks.

4.5.7 Social Care

Older LGBT people face a number of distinct issues which may facilitate the need for more health and social care services than non-LGBT older people. LGBT people are less likely to have children and less likely to live with children or family members. In addition older LGBT people are less likely to see family regularly with less than 25% seeing their biological family weekly (Stonewall, 2011a). In relation to care providers (The National LGB&T Partnership, 2014) 75% of care providers and commissioners of services, do not collect data for older LGBT people going in to rehabilitation centres. With regard to social care and housing for older LGBT people the EHRC (2010a) Sexual Orientation Research Review found that:

- 50% of older LGB people worried about housing arrangements in old age
- 95% wanted to remain in their own home
- 60% considered sheltered accommodation to be acceptable
- 76% of LGB people worried about maintaining personal dignity in care settings

4.6 LGBT People with Disabilities

4.6.1 Wider Factors

Evidence suggests that LGBT people with disabilities face multiple inequalities through compounding disadvantages compared to nondisabled LGBT people and compared to disabled heterosexual people (Hudson-Sharpe and Metcalf, 2016). However, there is a lack of specific evidence relating to issues faced by Transgender disabled people.

4.6.2 Lifestyle Behaviours

The available evidence relating to disabled LGBT people is limited. Figures produced by Stonewall (Guasp and Taylor, 2012b) show that for disabled lesbian and bisexual women (compared to non-disabled lesbian and bisexual women):

- Lesbian and bisexual women who are disabled are more than twice as likely to have experienced domestic abuse in a relationship 39% (compared to 24%).
- Lesbian and Bisexual women who are disabled are more likely to have attempted to take their own life 10% (compared to 4%).
- Lesbians and bisexual women who are disabled are less likely to drink three or more days a week 30% (compared to 44%) and less likely to have taken illegal drugs in the last year 30% (compared to 36%).

The study identified the following specific issues for disabled gay and bisexual men (Guasp and Taylor, 2012b). :

- Disabled gay and bisexual men are more likely to have experienced domestic abuse from a family member or partner since the age of 16 with 63% compared to 44% of non-disabled gay and bisexual men.
- Gay and bisexual men who are disabled are more likely to have had a problem with their weight or eating in the last year 23% compared to 11%)
- Gay and bisexual men who are disabled are more likely to have attempted to take their own life in the last year 7% (compared to 2%) and are more likely to have deliberately harmed themselves in the last year 15% (compared to 5%) (Stonewall 2011a)

The latest study of transgender people commissioned by the Scottish Government (McNeil 2012) found that of transgender people surveyed 58% identified as a having a disability or chronic health condition.

4.6.3 Mental Health & Wellbeing

In a recent study 36% of disabled LGBT respondents identified as having had a mental health issue (McNeil 2012). Access to mental health services is problematic for many disabled LGBT people. Gusap (2012) found that 23% of disabled LGB respondents did not access mental health services that they needed in the last year compared to 6% of non-disabled LGBT people. The Transgender Mental Health Study (2012) found an ambiguous picture around disability amongst Transgender people as many classed gender dysphoria as a disability.

4.6.4 Sexual Health

There is a current lack of data around the access and treatment of LGBT disabled people and sexual health.

4.6.5 Workplace Health

There is little or no data on LGBT disabled people in the workplace. This has identified a gap in research and monitoring in the workplace.

4.6.6 Service Access and Delivery

Disabled LGBT people who use care support such as personal assistants, may not be able to have all of their support needs met, if they are not able to be open about their sexual orientation, gender identity or transgender status to the people assisting them (Humphreys and Weeks, 2016). The National LGBT Partnership (2016) recommends that to improve services for LGBT disabled people resources need to be invested into actively combatting ongoing stigma and discrimination towards the LGBT community. Furthermore, LGBT people need to be involved at all levels in the commissioning, design, delivery and monitoring of services as active participants in health and social care.

4.7 LGBT People from BME Groups

4.7.1 Wider Factors

There is a current lack of evidence relating to the experiences of Black Minority Ethnic (BME) LGBT communities. Siraj (2014) states that a*s* a largely hidden population an exploration of the lives of BME LGBT people remains a critically underdeveloped area of investigation. However, the limited evidence suggests that LGBT people from Black Minority Ethnic (BME) backgrounds already face discrimination and inequality compared to white British people living in the UK (Hudson-Sharp and Metcalf, 2016). Varney states in *Minorities within Minorities* that '*ethnicity, religion and sexual orientation interact differently in different ethnic contexts'* (Varney 2013). Minority groups are more likely to experience internal and external manifestations of prejudice, victimization and discrimination which can lead to health problems because these experiences are internalised (Semlyen 2016). Furthermore, the LGBT Foundation (2012) reports that LGBT ethnic minority people are subject to discrimination from both BME and LGBT communities, forcing some to express one identity at the expense of the other.

4.7.2 Lifestyle Behaviours

Varney (2013) in Minorities within Minorities found that BME LGB people are more likely to smoke than heterosexual BME people, but less likely to smoke than white LGB people. Furthermore, BME LGB people may be more likely to experience physical abuse and more likely to experience harassment from a stranger than white LGB people (Varney 2013).

4.7.3 Mental Health & Wellbeing

BME LGBT people have poorer mental health (Varney, 2013). The picture on mental health is complex with BME minority gay men living with HIV are more prone to psychological stress related to their lifestyle than white HIV positive men (Varney, 2013). King (2003) found that BME LGB respondents were less likely than white LGB respondents to have considered suicide, possibly because of cultural taboos around suicide. Furthermore migrant gay men are particularly vulnerable because of their socio-economic circumstances, with higher risks of mental ill-health and sexual risk taking (Hudson-Sharp and Metcalfe, 2016).

4.7.4 Sexual Health

There is a lack of evidence relating to sexual health amongst BME LGBT communities.

4.7.5 Workplace Health

The Micro Rainbow Foundation Report (2013) found that LGB refugees felt particularly vulnerable after disclosing their sexual orientation to potential employers when attempting to access the job market or when already within employment. The report identified greater conflict and difficulties for some BME and Muslim LGB people than other ethnic groups.

4.7.6 Service Access and Delivery

Some research has been carried out on the treatment of LGBT BME asylum seekers and refugees by the UK Border Agency (The Micro Rainbow Foundation, 2013) but research on other areas of service delivery is lacking.

4.7.7 Social Care

There is a lack of evidence relating to specific social care needs of BME LGBT people.

5. What do Swindon's LGBT people think?

A series of focus groups were held involving Swindon's LGBT community. The aim of the focus groups were to listen to the views of LGBT community on issues that mattered to the community. The general theme of the focus groups was health and wellbeing in Swindon. This included asking participants to talk about their experiences of accessing health and social care services in Swindon. Participants were encouraged to identify emerging issues that were deemed important to LGBT people. The following is a summary of the key themes for each stage of the life course.

5.1 Younger LGBT people (from 16 to 25 years)

Attitudes of Health and Social Care Professionals

> *"They don't listen", young LGBT person*

Younger LGBT people in the focus groups were concerned regarding the attitudes of health and social care professionals in recognising and addressing their unique needs. Ensuring that professionals use the correct pronouns was deemed as important for younger LGBT people.

> ''*Their facial expressions and tone of voice make me feel judged", young Transgender person*

Participants felt that a lot of GP's had poor knowledge around LGBT issues, avoided conversations around their concerns. Some participants had experience of friends, who had had their sexuality disclosed inappropriately by GPs "*they went to the GP, expressed gender dysphoria….the GP told them all about another patient"* leaving the young person reluctant to visit the GP, in case their details were also disclosed. They also complained that because they had different GP's at each appointment, there was a lack of continuity and they had to "*tell their story over and over again at every appointment"* which caused them stress. Many felt that GP's had dismissed their concerns. It was felt that younger health practitioners were much more comfortable with talking about gender and sexuality than older GPs.

Mental Health and Wellbeing

> *"No one took me seriously about my gender identity because of my age", young Transgender person*

All participants had experienced discrimination and bullying around their sexuality or gender, which had caused them varying degrees of mental health problems. Other causes identified were lack of acceptance by parents, family and peers and by professionals. One young person said '*I didn't want to go to the doctors as I didn't think they would take it seriously*'. When asking for advice from parents and professionals some said their concerns were '*brushed aside'* or they '*might grow out of it'* and were sometimes offered generalist counselling rather than being supported around who they were. Most of the group said they had not known '*where to start'* when looking for help. Younger LGBT people in the focus group talked about their experiences of accessing the services of several providers that came under the mental health umbrella. These included TAMHS, CAMHS, On Trak, school and college counsellors. Participants thought that the services worked well but that waiting times were far too long which caused further distress.

Relationship and Sex Education (RSE) and School

> *"They questioned my sexual orientation and gender identity by saying "Don't be silly you aren't……" one young LGBT person*

Participants valued the support that schools and colleges provided to young LGBT people. One college age participant felt supported because "*They (College staff) use your pronouns and call me by my name".* Participants felt valued when schools and colleges ensured that *"Policies on bullying and hate speech are enforced".* Participants spoke of how a positive culture helped and how it was important that staff supported this. As one participant stressed *"they are allies that stand up for you".* Participants spoke of the negative treatment that often came from other pupils/students. Some said that other students use '*homophobic, transphobic and offensive terms'* and that some other students made jokes about LGBT people.

With reference to a transgender young people they had received comments such as *“Is that male or female?”*

Younger LGBT people all agreed that schools and sixth form colleges should provide the basis for good relationship and sex education (RSE). They felt that it was their experiences in these settings, that formed the basis for how they felt accepted as young LGBT people and how they moved on to be confident adults. The issues they raised were: sex education was mono sexual and did not explore lesbian and gay sex or relationships or transgender issues. One young person said *‘teachers don’t know the terminology’* and *‘don’t take it as seriously as they should’.* Many teachers lacked knowledge around these issues, in particular Transgender issues and this often led to feelings of isolation and bullying from peers *‘it’s like they are pretending that you don’t exist’* said one young Transgender person.

Gender Reassignment

> *“they swept it under the mat…clinging to the hope that I might turn out straight’.* Young, Transgender Person

Younger Transgender people considering gender reassignment all felt that they had usually had to *‘educate’* the professionals around Transgender issues and one participant commented ‘*I knew a lot of people who had been referred, so knew what to do…..I had to tell her’* (the GP). The group participants felt that the process was too long, up to 18 months for a referral and that gender reassignment facilities were too far away in London. One young transgender person said ‘*people are accessing hormone blockers online…. it’s due to the wait’*. This led to increased anxiety and poorer outcomes for them if, and when they transitioned at a later stage. Two participants said their parents were not supportive and had advised them to delay making a decision. Participants all felt that transitioning was more successful if carried out at a younger age. Participants were unhappy about the process, by which you are assessed as a child and then have to restart the whole process again once you had reached 18 years. Participants also felt that the long distances which needed to be travelled for consultations were unaffordable and that they required the young person to have the support of their family, which some felt was an issue and detrimental to positive mental health.

5.2 Older LGBT People

Discrimination

> *"I've experienced discrimination and homophobia all through my life",*
> *Older gay man*

Older participants had all experienced discrimination and homophobia or transphobia at various points in their lives. Other sources of discrimination were from certain religious groups with one person being told that *"being gay is the devil's work"*. They said that there are *"still people who hold these prejudicial views"*. And one lesbian couple had been told by a police officer that they could not kiss in public, although this was later addressed by an LGBT officer. The group felt that all staff in all public bodies and companies should receive LGBT training. The group all knew of incidents where people had attended Pride's for the sole purpose of "*gay bashing".*

Access to Health Services

> *"The GP didn't want to refer me because they had previously referred a person for male to female surgery and the person had regretted it"*,
> Older, transgender women

Participants were on the whole fairly independent financially and reported being in good health so had not needed to access many health and social care services (other than relating to gender reassignment). Transgender participants had experienced problems with GP surgeries and health professionals. One transgender woman said she had been stared at in GP waiting rooms and felt that GP surgeries should have separate and more private areas for transgender people. She also noted that medical professionals insisted on putting down their birth gender rather than their current gender identity and were told by medical professionals that they had *"to say what's on the system"*. Another transgender person said that they visited their GP to discuss gender reassignment but was told by the GP that they would not refer them because they had previously referred a person for male to female surgery and the person had regretted it. Another participant were told by a GP that they could not get gender

reassignment on the NHS. Participants spoke of the importance of GPs getting *"to know"* their patient.

Isolation and Social Support

> *"Being out challenges prejudice, they can't stop you being who you are, there are a lot of people hiding because of fear",* older gay man

One of the primary concerns was around isolation amongst LGBT people. All participants spoke of their experiences of isolation as members of the LGBT community. Participants all agreed on the importance of having social support networks and to feel part of a wider community. A transgender woman said she "*dresses down because of a fear of being judged*" and there was a need to educate the public so *"that people could be themselves".* Participants agreed that there *"needs to be a cultural change but it will take a generation"*.

The group talked about how important it is to have access to public social venues like pubs and clubs as socialisation is an important part of wellbeing. Experiences for some participants were negative, with many participants having been told that they could not enter bars because the other customers did not *"like*" LGBT people. One participant said '*they (the bar staff) would rather exclude the minority than deal with the problem'.* Some of the group had received verbal harassment and one person had been physically attacked because they were LGBT. A gay man commented that there is *"still prejudice, it is about training people and respect for different lifestyles"* and clarified by saying that "*its people not seeing it through other people's eyes".*

6. Conclusions and Recommendations

This JSNA brings together a large amount of data and information about the needs of LGBT people in Swindon, including both quantitative demographic data and qualitative research. This final chapter draws together a summary of the findings, some key messages and then makes some recommendations for the way forward.

Summary of Key Findings

- Heteronormative assumptions as well as experiences of, or fears of discrimination prevent LGBT people from accessing mainstream services resulting in the compounding of inequalities across the life course, with disadvantage compounding for young and older LGBT people.

- Research shows that LGBT people experience significant health and social inequalities compared to the wider population from high rates of physical and emotional bullying, poor mental health, through significantly higher rates of suicide and self-harm, drug and alcohol use and smoking in adulthood, as well as social isolation and extreme vulnerability in old age (The National LGB&T Partnership, 2014; Williams et al, 2013).

- There is evidence to suggest that many LGBT people face barriers to accessing national screening and immunisation programmes (Stonewall, 2015).

- Evidence also shows that LGBT people experience poorer sexual health across the life course with a greater burden of sexually transmitted infections (PHE, 2014a).

- Research reveals that LGBT people and carers experience discrimination and marginalisation which impacts on their ability to access services and receive the most appropriate support. (Cartwright, Hughes, Lienet, 2012).

Key Messages

- Sexual orientation and gender reassignment are protected characteristics under the Equality Act (2010). Section 29 of the Equality Act (2010) prohibits

the discrimination in the provision of services on the basis of sexual orientation or gender identity.

- There is a lack of routine monitoring of sexual orientation and gender identity across a wide range of health and social care services in Swindon.

- The evidence base for health and social care inequalities by sexual orientation and gender identity is deficient with major gaps. This is due to the lack of routine monitoring across health and social care services and a lack of data relating to the health of LGBT communities derived from population-based studies and statistical datasets. Available evidence does not disaggregate disadvantage into single LGBT groups.

Recommendations

Recognition

1. The needs of Lesbian, gay, bisexual and transgender (LGBT) people as distinct groups to be included in all future Joint Strategic Needs Assessments.

2. To work with the LGBT community to produce a charter of best practice for health and social care services.

3. For each organisation to assess their training needs to ensure their workforce follow the best practice for providing inclusive services for LGBT people.

Monitoring

4. All health and social care services to record sexual orientation and gender identity data (where appropriate).

Reducing Inequalities in Health and Social Care

5. Health and Wellbeing Board to use its influence across the system to reduce health inequalities for LGBT people in Swindon.

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6. For all organisations to challenge heteronormativity by ensuring gender neutral language to promote a positive culture of inclusivity.

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Dr Ayo Oyinloye, Consultant in Public Health Medicine, Swindon Borough Council

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