healthwatch Blackburn with Darwen

lancashire lglbt

Lesbian, Gay, Bisexual and Transgender people accessing Health and Social Care services

Acknowledgements
This research was commissioned to Lancashire LGBT by Healthwatch Blackburn with Darwen, and we would like to thank them for their work. The research was conducted by Dr Lewis Turner & John Miller from Lancashire LGBT. For more information about the Lancashire LGBT please email lewist@lancslgbt.org.uk

Healthwatch BwD and Lancashire LGBT would like to thank the following for assisting with distributing surveys, as well as raising awareness about this research:

- Age UK Blackburn with Darwen
- Blackburn with Darwen CVS
- Drew Dewing-Drake Age Concern 'Older and Out' project
- Jal Iqbal Darwen Resource Centre
- Lancashire Women's Centres
- Project BME
- Rabiya Gangreker Blackburn with Darwen Council
- The Lesbian and Gay Foundation
- Youth Action Blackburn with Darwen

With thanks also to the people who took the time to participate in this research, and Child Action North West for allowing us to use their premises for interviews.

If you would like this report in another format please contact Healthwatch BwD- 01254 504985 or Info@healthwatchblackburnwithdarwen.co.uk

Contents

1. Executive Summary

There is an estimated population of 10,324 Lesbian Gay Bisexual and Transgender (LGBT) people in Blackburn with Darwen. LGB&T people tend to lead less healthy lifestyles and experience additional health inequalities including a higher risk of poor mental health, alcohol or drug misuse, eating disorders and attempted suicide than non-LGB&T people. Many of these are national priorities in the UK's public health strategy yet service providers who tackle these issues do not target LGB&T people or identify them as service users through monitoring. This indirectly leads to LGB&T people's specific health needs being overlooked in health and social care policy and commissioning.

LGB&T people also experience barriers to accessing healthcare. Research has shown that LGB&T people have a perception or experience of negative attitudes from health and social care providers towards LGB&T people, which can lead to many LGB&T people not being 'out' about their sexual orientation or gender identity for fear of poorer treatment or discrimination. This also can deter people accessing routine or preventative treatment.

There is a lack of a coherent network of LGB&T people in Blackburn with Darwen with which organisations can engage and also which can engage with organisations. This is particularly significant in terms of the current Asset Based approach in health strategies and commissioning, where community 'assets' such as 'social capital' are recognised as a significant factor in terms of maintaining health and well-being. In the context of Blackburn with Darwen, the LGB&T community has no tangible 'assets' based on this model and therefore an asset based approach would not be appropriate in tackling LGB&T health inequalities.

Although the sample for this research is small, there are some significant issues raised which correspond with research conducted nationally on the barriers which LGB&T people experience accessing health and social care.

The main finding is that not all LGB&T people are 'out' about their sexual orientation or gender identity to health and social care professionals. This is significant for the following reasons:

-a GP may know a patient throughout their life-time but not be aware of the potential health inequalities that a person faces.

-people who are caring for LGB&T people in their own home as well as those who provide support to LGB&T carers will have a significant aspect of that person's identity and life history hidden from them and thus not know the whole person and understand how to fully support them.

-health and social care agencies will not have an accurate profile of their service users and thus be unable to target services or deliver preventative messages to the most at-risk groups.

These barriers are particularly acute for Black and Minority Ethnic (BME) LGBT people. They are less likely to be open about their sexual orientation or gender identity to service providers due to a lack of trust regarding confidentiality with health care professionals from their own religious or cultural community, as well as a perceived intolerance of being LGB or T.

There are some barriers for LGB&T residents of Blackburn with Darwen accessing mental health services. These barriers are based on perceived cultural or religious differences between White British LGB&T people and BME people delivering services, or a perceived lack of understanding of LGB&T issues and lack of empathy by service providers.

2. Introduction

This research, conducted between February 17th and April 22nd 2014, was commissioned by Healthwatch Blackburn with Darwen to gain an understanding of what issues and barriers LGB&T (Lesbian Gay Bisexual and Transgender) people in Blackburn with Darwen experience when accessing health and social care services. The services covered for the purposes of this research are any publicly funded (free) services available to residents (for example, hospitals, GPs, Dentists, Social Care, Mental Health, substance misuse).

2.1. LGBT Population Statistics

It is widely accepted that 5 – 7% of the population are lesbian, gay or bisexual (LGB) - with Treasury actuaries using this statistic when analysing the impact of the Civil Partnerships Act 2004 and the North West Regional Development Agency using the figure in their 2009 analysis of LGB populations in the North West[1]. The NWDA used the Treasury figure on the basis that the key UK data source[2] for it was a reliable estimate and used a representative sample in terms of age, sex, ethnicity and region. It is estimated that 3% of the population in the North West are bisexual[3]. There are 201 people living in Blackburn with Darwen who are in registered same-sex civil partnerships[4].

Trans or transgender is an umbrella term covering a range of gender identities which are different from one's birth gender and gender role. These include people who cross-dress part of the time (some of whom may seek to undergo gender reassignment at some point) to people who seek to undergo gender reassignment at the earliest opportunity. The statistic for the number of trans people is harder to estimate but existing research suggests that 0.5 - 1% of the population are transgender and that the trans population is dynamic and increasing.[5] Indeed it is estimated that the number of trans people who are seeking to undergo gender reassignment in the UK is "doubling in size every five years".

The population of Blackburn with Darwen is 147,489 [7] and accepting the statistics above which estimate the LGB&T population at around 7% means that approximately 10,324 of the population of Blackburn with Darwen are LGB or T.

1. Hall & Panton, 2009. Improving the Region's Knowledge Base on the LGB&T Population in the North West: Final Report to NWDA & Partners.
2. Johnson et al, 2001. National Survey of Sexual Attitudes & Lifestyles.
3.Lesbian & Gay Foundation, 2009. Breaking the Cycle: Supporting the Delivery of a Sustainable Lesbian, Gay, Bisexual and Trans Sector in the North West Region, p.23.
4. Office for National Statistics 2011
5. GIRES, 2009. Gender Variance in the UK: Prevalence, Incidence, Growth & Geographic Distribution, p.18.
6 GIRES, 2008. Gender Dysphoria, Transsexualism & Transgenderism: Incidence, Prevalence & Growth in the UK and the Implications for the Commissioners and Providers of Health Care, p.1

2. Introduction

2.2. Health Inequalities

It is well documented that LGB&T people tend to lead less healthy lifestyles and experience additional health inequalities compared to their heterosexual counterparts: they are more likely to smoke; more likely to use drugs; more likely to be at risk from alcohol related behaviours; have poorer mental health; have a higher risk of attempted suicide, are less likely to participate in sports and are more likely to experience eating disorders. *8 9 10 11*

Many of the health issues experienced by LGB&T people are national priorities in the UK's public health strategy yet services which tackle these issues are not targeted at LGB&T people. Indeed, there is a lack of monitoring data on sexual orientation or gender identity from health and social care agencies. This indirectly leads to LGB&T people's specific health needs being overlooked in health and social care policy and commissioning.

The health inequalities experienced by LGB&T people are compounded by the fact that LGB&T people experience additional barriers to accessing healthcare. Research has consistently found that the barriers include negative attitudes of health and social care providers towards LGB&T people, which can lead to lack of communication - for example, not being 'out' about being LGB or T for fear of poorer treatment or discrimination. In addition, research has shown that there is a lack of knowledge and awareness of LGB&T needs by service providers. All of these barriers can lead to delays in LGB&T people seeking routine healthcare treatment as well as barriers to accessing screening programmes. *12 13 14*

The ageing LGB&T population also face challenges due to the specificity of their living situations. They are more likely to be single than heterosexual people and less likely to have the support of other family members and children – thus making them more likely to need social care services. However, many may experience barriers to seeking help from services because of an expectation of poorer treatment or discrimination and thus avoid accessing services. *15 16*

7 Office of National Statistics 2011 Census
8 Lesbian and Gay Foundation 2012 Findings from the I exist survey
9 Stonewall and Sigma Research 2011 Gay and Bisexual Men's Health Survey
10 Stonewall 2008 Prescription for Change: Lesbian and Bisexual Women's Healthcheck
11 Mcneil, J et al 2012 Trans Mental Health Study
12 Department of Health 2007 Working with lesbian, gay, bisexual people; Department of Health 2007 Working with Transgender people
13 Whittle, S; Turner, L; Al-Alami, M 2007 Engendered Penalties: Trans people's experiences of inequality and discrimination
14 Stonewall 2012 Stonewall Health Briefing: Experiences of Healthcare
15 Alzheimer's Society 2013 Supporting Lesbian, Gay and Bisexual People with Dementia
16 Age Concern 2002 Issues Facing Older Lesbians, Gay Men and Bisexuals

2. Introduction

2.3 The Context of Blackburn with Darwen

Previous research on the health needs of the LGB&T community in Blackburn with Darwen conducted in 2008 found that the health inequalities experienced locally matched those experienced nationally. Although the report found evidence of positive experiences when accessing health and social care services, there was a lack of awareness and skills in providing good quality accessible services for LGB&T people. *17*

Respondents' experiences with General Practices were the most negative, with the majority of respondents not being 'out' as LGB or T to their GP. The research also found that respondents reported the barriers in accessing services as discussed in the previous section: lack of services targeted at LGB&T people and fears about being treated unfairly, leading to LGB&T people not accessing the services they need. This included lesbians not accessing routine cervical cancer screening services and a low uptake of sexual health services by younger people.

Another local needs assessment study of older LGB people in Blackburn with Darwen consulted with professionals in health, social care and housing found that they had specific needs which were not being addressed by providers and commissioners of services. Many service providers were not aware of the needs of older LGB people in terms of health inequalities, social care services and housing. *18*

Both reports reached similar conclusions, stating that there were several key components to improvements in health and social care services for LGB&T people. One would be in commissioning, which needs to be informed by an LGB&T inclusive approach and that immediate action was required to address the absence of LGB&T communities in public health strategies. *19* Training for staff was also essential to develop skills and confidence in working with LGB&T communities and health and social care services needed to adopt monitoring of sexual orientation and gender identity across services to better understand the profile of service users. Finally, the report recommended better engagement with LGB&T stakeholder groups for consultation as well as other pro-active measures. Targeted health promotion campaigns aimed at LGB&T people for example would improve take-up of access to health and social care services and thus help to reduce health inequalities.

18 Age Concern 2007 Hidden Away: A needs assessment of older gay, lesbian and bi-sexual people in the Blackburn with Darwen Area.
19 Ibid: page 15.

3. Research Methods

We used a mixed methods approach to gather data. We launched an online survey on our website which we advertised through social media as well as flyers which were distributed throughout Blackburn with Darwen (for example local community and voluntary agencies as well as local 'gay friendly' bars).

Paper copies of the survey were also available for people with no internet access. Partner agencies working in Blackburn with Darwen who had contact with individual LGB&T people asked them to fill out paper surveys and returned them to us. We also planned to conduct a focus group but only two people expressed an interest in attending so we conducted a joint interview with them.

In order to ascertain what the barriers were to accessing health and social care, we asked questions in the survey around the level of openness of respondents about their sexual orientation and gender identity with health and social care practitioners (see Appendix for full list of questions). Previous research has found that one of the barriers to accessing health and social care for LGB&T people is the expectation of prejudice or discrimination from practitioners based on their sexual orientation or gender identity (see Introduction). We asked participants if they were 'out' about their sexual orientation or gender identity to their GPs and how that may have affected their relationship with their GP.

For those living in supported accommodation or who received care at home, we asked if they were 'out' about their sexual orientation or gender identity and how 'LGB&T friendly' they rated their accommodation. Those who received care at home were asked how open they were about their sexual orientation or gender identity to carers, and for those who were carers, we asked them if they were open about their sexual orientation or gender identity with the agencies who supported them.

We also asked participants if they had disclosed their sexual orientation or gender identity to a health or social care professional in the past, and what the response had been. We then listed services which participants may access in the future and asked how open they would be about their sexual orientation or gender identity.

3. Research Methods

In other parts of the survey we looked at services accessed by participants in the last two years. One section of the survey focused on the main mental health issues experienced by LGB&T people: eating disorder, body image, anxiety, depression, gender dysphoria and self-harm. We asked participants if they had received treatment locally for any of the conditions in the last two years. We then asked them to rate the service in terms of being 'LGB&T friendly'.

We then focused on other health issues experienced by LGB&T people: stopping smoking, alcohol or substance abuse, sexual health, cancer treatment and fertility treatment, asking participants if they had received treatment locally for any of the conditions in the last two years. We also looked at other general services that participants had accessed or may access in the future (ranging from A&E to community clinics) and asked how open they would be about their sexual orientation or gender identity.

Finally we focused questions in the survey asking participants about negative experiences while accessing health and social care services which they perceived was because of their sexual orientation or gender identity. We then asked them what impact, if any, that experience had on accessing services in the future. At the end of the survey we invited participants to state what improvements could be made in health and social care services for LGB&T people in Blackburn with Darwen.

Although parts of the survey invited participants to say more in a comments box, we also sought to gain more qualitative material by holding a focus group.

4. Research Findings

4.1 Response to the Survey

The response to the survey was disappointing and highlights the lack of a coherent network of LGB&T people in the area with which organisations can engage and also which can engage with organisations. This difficulty was also experienced by a previous longer term study conducted in 2008 assessing the needs for LGB&T people in Blackburn with Darwen.[20] This finding is particularly significant with the currently popular model of an Asset Based Approach in health strategies and commissioning, where community 'assets' such as 'social capital'- for example networks and connections in a community as well as the effectiveness of community organisations, are recognised as a significant factor in terms of maintaining health and well-being.[21]

In the context of Blackburn with Darwen, we suggest that the LGB&T community has no tangible 'assets' based on this model.

The size of our sample of respondents (23n) cannot be understood as representative of the LGB&T community in Blackburn with Darwen but we would suggest that it is a 'good' sample in terms of the diversity of respondents in terms of age, gender, ethnicity, gender identity which is comparable to the percentage proportions in the larger previous study conducted in 2008.[22]

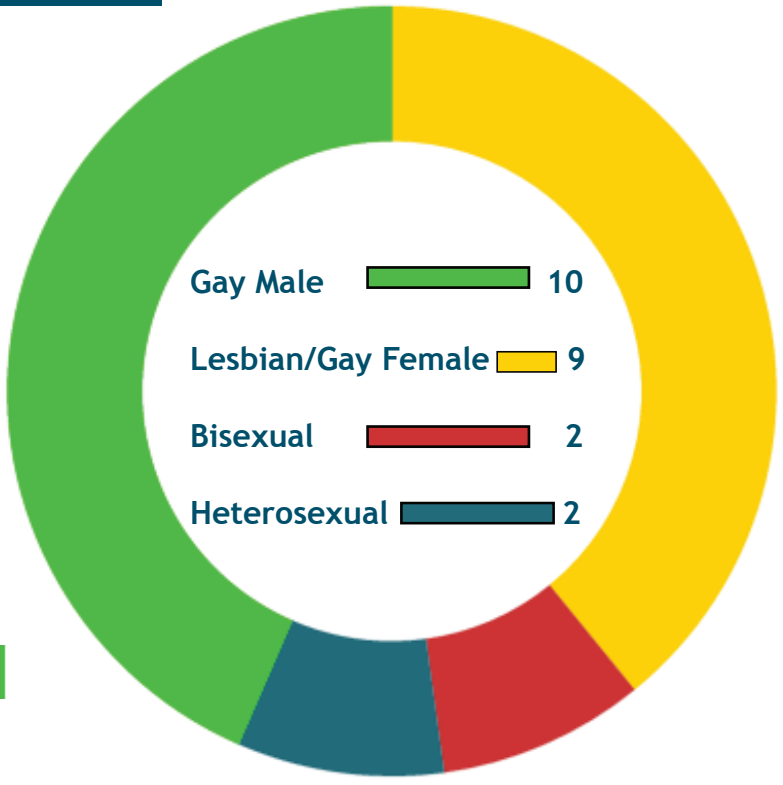
4.2 Profile of Survey Respondents

Gender

Male -10
Female - 10*
Self-identified as 'Other' - 3

Gender the same as the one on original birth certificate

Sexual Orientation

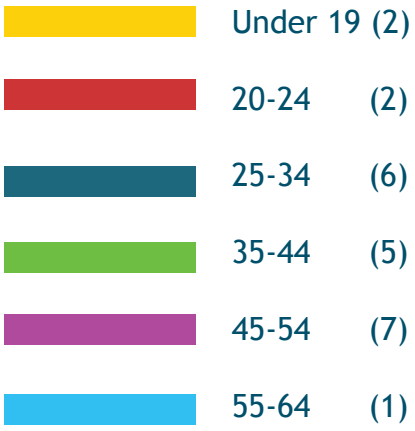


** Of whom one identified their gender as different from the one on their original birth certificate*

20 See NHS Blackburn with Darwen 2008 Lesbian, Gay, Bisexual and Trans Needs Assessment
21 See Foot and Hopkins 2010 A Glass Half Full: How an asset approach can improve community health and well-being
22 See Footnote 19 - this study had a sample of 105 respondents

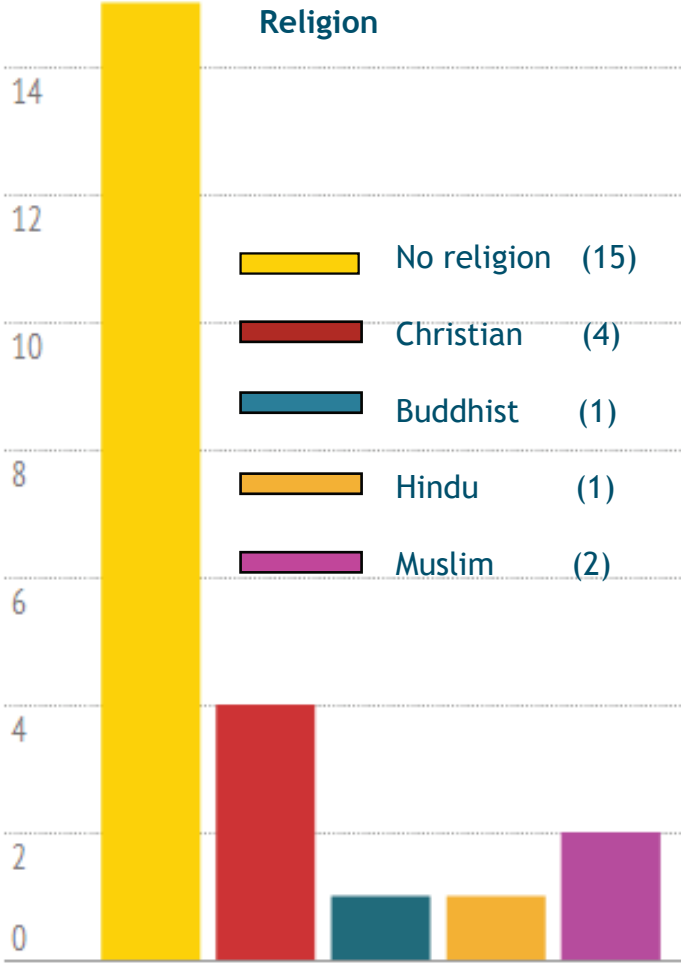
4. Research Findings

Age



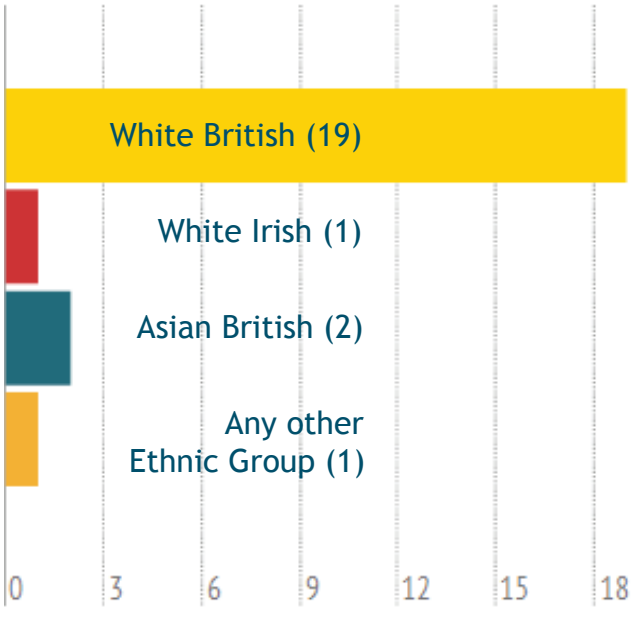
Caring Responsibility for a dependant or another adult

Religion



Disability

Ethnicity



4. Research Findings

4.3 Analysis

Given that the sample size was so small we focused our analysis on the consistent themes that emerged as well as findings which resonated with the well-documented significant health and well-being issues for the LGB&T community.

4.4 Being 'out' as LGB or T

As discussed in the Introduction, one of the main barriers to accessing health or social care for LGB&T people is the real or perceived attitudes of service providers towards LGB&T people, which can lead to LGB&T people not being open about their sexual orientation or gender identity.

4.4 .1 Being 'out' to a GP

One of the questions often asked in health questionnaires is whether or not people are 'out' as LGB or T to their GP. We found that 69.5% of the respondents in our sample were 'out' to their GP. This differs markedly with the previous research conducted in Blackburn with Darwen, where the majority of respondents (69.8%) were not 'out' to their GP, but does correspond with recent research in Greater Manchester where the majority of respondents were 'out' as gay to their GP (70%). [23] Of those who were 'out' to their GP, half stated that it had made no difference at all or they were not sure if it had made any difference. However, nearly half reported a negative effect since being 'out' to their GP – with responses ranging from the fact that they were not sure if their GP understood, to being 'out' having a detrimental impact on their relationship with their GP.

One White British trans female aged 25-34 highlighted the dilemma of being 'out' to one doctor who is part of a larger GP practice and how they perceived that their gender identity may not be so well received by another doctor because of their faith.

"I feel anxious if I see another doctor, because I'm aware my usual doctor understands but others might not, or possibly disapprove if they for example, have a faith that may go against my gender identity"

Another White British gay male respondent aged 45-54 found that coming out to their GP had little impact and that they were still assumed to be heterosexual:

"My GP fails to acknowledge that I am gay."

Significantly, those who were not 'out' to their GP stated that it had not been mentioned when seeing their GP or that they had reservations because they were not confident that their GP would be LGB or T friendly.

One Asian British gay male respondent aged 45-54 explained that he could not be 'out' to his GP as he could not trust that the information would stay within the surgery:

"GP is well known in the community, and also known to my family & friends. Confidentiality will not be kept."

Being 'out' to one's GP is important as having a relationship of trust and being open and honest means that their GP will understand their individual needs and circumstances. A White British trans woman aged 55-64 whom we interviewed explained the value of this:

"... the simple fact that I go in and I don't have to explain things to him means that I'm immediately at ease, I can talk to him, because he understands I can describe to him certain esoteric problems that wouldn't occur in anyone else, or anyone cis, [anyone not transgender] so it's very very useful"

In summary, our research indicates that whilst a good proportion of LGB&T respondents were 'out' to their GP, around 30% were not 'out', partly due to concerns about receiving a potential negative response from the GP. These concerns are borne out by the actual negative experiences reported by nearly half of those who actually are 'out'.

23 Lesbian and Gay Foundation 2012 Lesbian Gay and Bisexual Patients' experiences of their GP: Greater Manchester -Findings

4. Research Findings

4.4.2 Being 'out' in supported accommodation, receiving care at home or receiving carers' support from agencies

As stated earlier, previous research has highlighted the fears that LGB&T people have in losing their independent living situation as a result of growing older or having to receive care at home (or support from agencies as a carer) and perceiving that social care providers may be discriminatory. [24]

Three of the survey respondents lived in supported living accommodation (their ages ranged between 35 and 54). In the survey we asked if their living situation was 'LGB&T friendly'. The responses ranged from 'it could be more LGB&T friendly' to 'not very LGB&T friendly' and no respondent stated that 'it is LGB&T friendly'. Of the two respondents who received care at home, one respondent a White British lesbian/gay woman aged 45-54 was open to 'some of the people' caring for her and the other respondent, a White British bisexual woman aged under 19yrs stated that no-one knew about her sexual orientation.

Three of the survey respondents were carers who received support from agencies. One White British gay male aged 45-54 was open about his sexual orientation, but another carer who was an Asian British gay man aged 45-54 was not open about his sexual orientation. Also an Asian British Lesbian/gay woman aged 25-34 was 'not always' open about her sexual orientation with agencies which supported her.

In the interviews we asked participants if they had any concerns about accessing residential support within a social care setting – for example in later life. Both participants agreed that they could 'see it being an issue'. They went further to discuss how they would know who was LGB&T friendly or not, when making decisions about who would deliver care at home: A White British person of non-binary gender who we interviewed stated:

"…you don't know who's going to be friendly, who's going to come in and be savage. . . I think there'd be people who would either try and exploit or who would just generally, you know . . . If you've fragile mental health anyway, any bad negative things that happen can really really impact your health"

A White British trans woman aged 55-64 also highlighted the difficulties LGB&T people face making decisions about residential care:

"You can't really choose the nursing home, because they don't say "Trans-friendly"

These narratives suggest that some LGB&T residents of Blackburn with Darwen approach the actual or prospective use of supported accommodation, social care at home and carers' support agencies with a degree of caution. The majority were not completely open about their sexual orientation and others were concerned about the way they may be treated in a residential care setting or receiving care at home in the future.

24 Age Concern 2002 Issues Facing Older Lesbians, Gay Men and Bisexuals

4. Research Findings

4.4.3 Being 'out' to health or social care practitioners in general

We listed a range of services which participants may access ranging from mental health services, accident and emergency, to community clinics (see Appendix for full list of questions), asking participants if they had to access or had previously accessed any of the services, how open they would be about their sexual orientation or gender identity. The majority of responses were 'very open' in these situations, or 'not open unless I have to be'. This is important because there are some medical situations where not being 'out' may have a direct effect on the medical treatment given. It would be important to know for example if someone is a transgender woman as she will not have a womb and will still have a prostate gland.

Less than a half of respondents (41%) stated that in accident and emergency for example, they would be 'very open' and just over one third (36.4%) stated that they would be 'not open unless I have to be'. Two of the four trans respondents answered that they would not be open unless they had to be, which means that even in an emergency situation, they may have reservations about being 'out'. Another White British trans female respondent aged 55-64 pointed out that being 'in' or 'out' was not an option for her:

"As a transsexual I could hardly hide my gender identity. After all, it's a bit obvious…"

Some respondents commented on the barriers they faced to being 'out' about their sexual orientation:
One respondent, a South East Asian gay man aged 25-34 stated that he would not be open because of perceived sexual and racial stereotyping:

"As a Thai gay male, it's very difficult for me to open up. I have in the past with my G.P. But he fails to understand my religion and language. Most agencies see me as sexual (deviant). I am afraid at times I had a more open life in Thailand."

One White British lesbian/gay woman aged 20-24 stated that due to negative responses in the past, she was reluctant to disclose her sexual orientation:

"Not sure if I have to be open, As at times I can experience negative responses/attitudes. I have had negative responses from services. So I am reluctant to divulge information."

One Asian British gay male respondent aged 45-54 stated that his perception of the potential fallout from coming out to his GP or any health or social care services made it impossible for him to contemplate doing so and that he did not feel that confidentiality would be kept:

"In the Muslim culture I reside in, it's taboo and dangerous to disclose my sexuality. The damage and fallout from sexuality will be devastating. Services are the same here in B & D, Nothing is confidential."

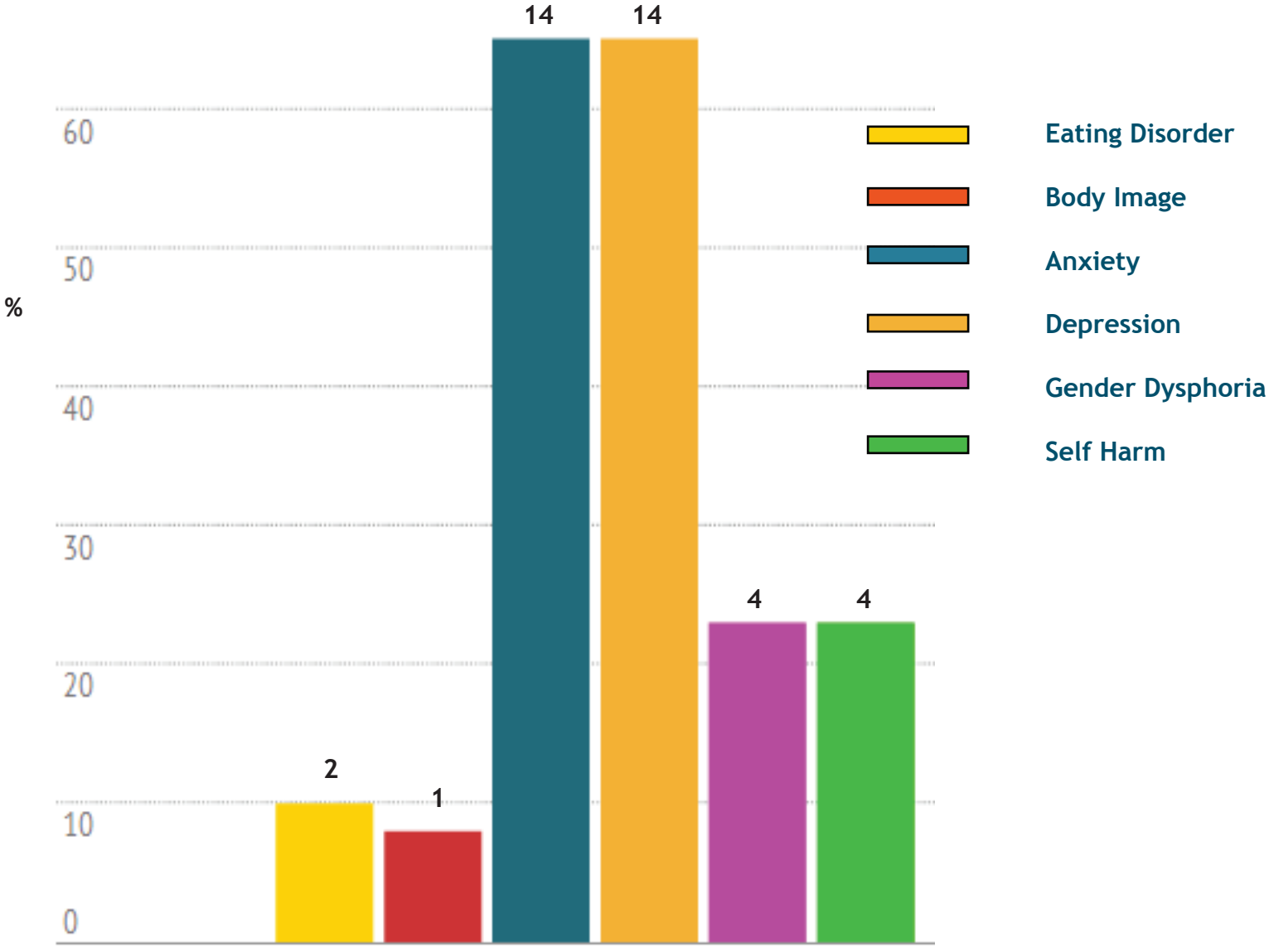
Overall there was a wide range of opinion in relation to the idea of being 'out' to health and social care practitioners in general and the narratives above highlight some of the barriers which some LGB&T people face when accessing health and social care.

4. Research Findings

4.5 Experiences accessing services in Blackburn with Darwen in the last two years

As stated in the introduction, there are specific health inequalities experienced by LGB&T people, for example medical conditions most commonly experienced by the population (eating disorder, body image issues, anxiety, depression, gender dysphoria and self-harm - see Appendix). We listed these conditions in the survey asking if any of the respondents had received treatment for any of them locally in the last two years.

Have you received treatment locally for any of the following in the last 2 years?

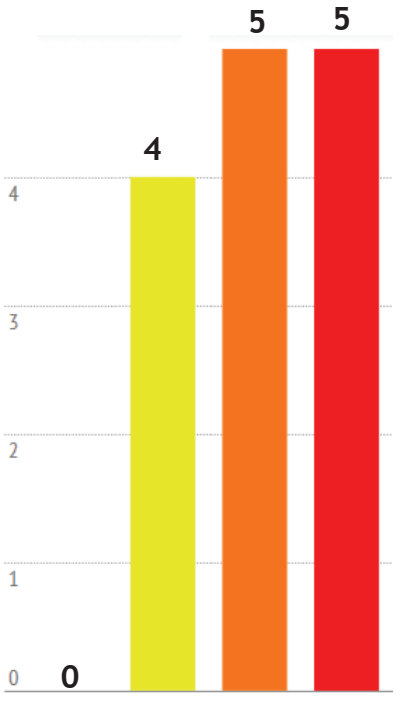


The chart demonstrates that anxiety and depression were the most common conditions that respondents had been treated for in the last two years. Indeed, 11 out of 14 respondents had been treated for both anxiety and depression.

4. Research Findings

How would you rate the service in terms of being LGB or T friendly?

Anxiety



Very Good

Could be improved

Good

Not good at all

The responses were that the majority suggested that the service for anxiety could be improved or that the service was not LGB&T friendly at all. We then asked respondents how they would rate the service for depression in terms of being LGB or T friendly:

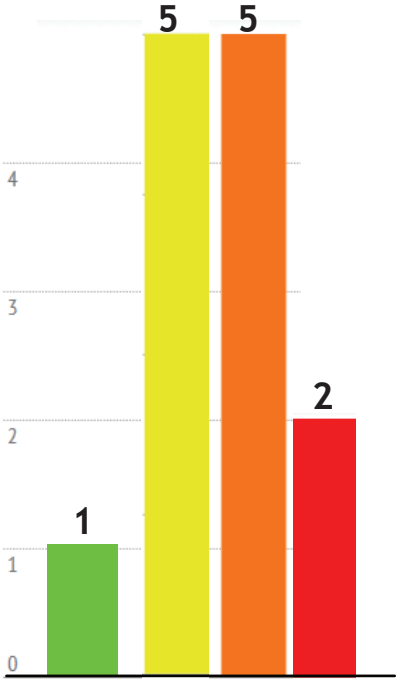
Depression

Very Good

Could be improved

Good

Not good at all



The response for services treating depression was a little more mixed, with varying experiences reported by respondents.

When we asked people in the survey if they had a negative experience in the last two years when accessing health or social care services, over 65% stated that they had not. Of the 35% who stated they did have a negative experience, some commented on their experience of using mental health services.

4. Research Findings

One White British gay male aged 45-54 stated that he did not continue treatment as they did not understand his issues:

"Mental health services, lack of knowledge, counselling offered due to depression, was not appropriate, as they couldn't understand my core issues. I dropped out. As it was negative."

A White British lesbian/gay woman aged 20-34 highlighted the barrier between herself and her GP because of a perceived religious or cultural difference, as well as a barrier when accessing mental health services:

"G.P. was Asian and Muslim, couldn't open up to her, and neither was she receptive of my health needs. It was a barrier. mental health same - appalling. Didn't understand my eating disorder and partner's issues."

Other respondents commented on negative experiences accessing non-specific health services.

A White Irish gay male respondent aged 35-44 also recalled a negative experience while in hospital:

"In 2013 I ended up in hospital and when the doctor done her rounds, she asked who my then partner was, when I told her she gave me a disgusted look and then totally dismissed us."

A White British gay male aged 45-54 simply stated:

"Was told they did not want to treat people like me"

The findings from this limited sample suggest that there are significant barriers for LGB&T residents of Blackburn with Darwen accessing mental health services and that these barriers are sometimes related to perceived cultural or religious differences or a lack of understanding and a lack of empathy.

4.6 What improvements could be made in health and social care services for LGB&T people in Blackburn with Darwen

In the final section of the survey we asked participants what improvements they thought could be made in health and social care services. The majority of responses stated that education or training was needed: Two trans women for example felt that education was needed regarding transgender people.

A White British trans woman aged 25-34 felt that respect and dignity for trans people in service provision was not as highly developed as it was for other equality strands:

"Education to service providers in the area, making it equally important that people understand it's not right to judge or mistreat trans people as much as it is for ethnic minorities."

Other respondents focused on the need for education and training around LGB&T issues.

A White British trans woman aged 45-54 stated:

"Better education on the provision of transgender health matters and what they should be providing."

A South East Asian gay male aged 25-34 stated:

"... more understanding of LGBT issues, more sensitive treatment for gay people"

One Asian British gay male aged 45-54 stated:

"Awareness. Training. Services need to be more accommodating to LGBT"

More education and training for health and social care professionals on LGB&T people and their issues appears to be at the root of respondents' hopes for an improvement in the way LGB&T people are treated.

5. Conclusion

Although the sample of participants is small, many of the findings from this research correspond with other national studies of the barriers which LGB&T people experience when accessing health and social care.

Being 'out' as LGB or T

The majority of respondents (69.5%) were open with their GPs about their sexual orientation or gender identity. Nearly half reported a negative effect since being 'out' to their GP – with responses ranging from the fact that they were not sure if their GP understood, to being 'out' having a detrimental impact on their relationship with their GP.

The 30% who were not 'out' to their GP, raised concerns about receiving a potentially negative response from the GP. This means that their GP may know a patient throughout their lifetime but not be aware of the potential health inequalities that a person faces.

Being 'out' in supported accommodation, receiving care at home or receiving carers' support from agencies

Of the survey respondents who lived in supported living accommodation no respondent stated that 'it is LGB&T friendly'. This means that those respondents will not feel able to be completely themselves at home. The respondents who received care at home, were not open to all the people caring for them and the majority of survey respondents who were carers receiving support from agencies were not open about their sexual orientation. This means that there are LGB&T people who have people supporting them and/or caring for them in their own home with whom they are hiding a significant aspect of their identity and life history.

These findings resonate with the concerns respondents raised about accessing 'LGB&T friendly' residential support within a social care setting – for example in later life. These concerns are important given that LGB&T people are more likely to need social care services later in life (see Introduction).

Being 'out' to health or social care practitioners in general

Overall there was a wide range of opinion in relation to the idea of being 'out' to health and social care practitioners in general and the comments made by participants highlighted some of the barriers which some LGB&T people face when accessing health and social care. Some perceived a negative response if they were open about their sexual orientation or gender identity and some had experienced negative responses in the past.

Not all respondents were completely open about their sexual orientation or gender identity even in an emergency situation due to previous bad experiences – for example perceived sexual or racial stereotyping, negative responses or lack of trust. This means that health and social care agencies will not have an accurate profile of all their service users and thus be unable to target services or deliver preventative messages to the most at-risk groups.

5. Conclusion

Experiences accessing services in Blackburn with Darwen in the last two years

Respondents to the survey had accessed treatment for the most common health inequalities that LGB&T people experience. The most common conditions that participants had been treated for in the last two years were anxiety and depression. The majority of responses were that the service could be improved or that the service was not LGB&T friendly at all.

Over 65% stated that they had not had a negative experience in the last two years when accessing a wide range of health or social care services which is reassuring. However, of the 35% who stated they did have a negative experience, some commented on their experiences using mental health services. These related to perceived cultural or religious differences between White British LGB&T people and BME people delivering services, or a perceived lack of understanding of LGB&T issues and lack of empathy by service providers. This is significant given that LGB&T people are statistically more likely to need to access mental health services than non-LGB&T people.

What improvements could be made in health and social care services for LGB&T people in Blackburn with Darwen

Responses were overwhelmingly that more awareness training about working with LGB&T people was needed as well as a better education about LGB&T issues for health and social care professionals. These findings correspond with the conclusions made in the previous studies on the health needs of LGB&T people Blackburn with Darwen. [25] [26]

25 Age Concern 2002 Issues Facing Older Lesbians, Gay Men and Bisexuals
26 NHS Blackburn with Darwen 2008 Lesbian, Gay, Bisexual and Trans Needs Assessment

6.Recommendations

Creating a welcoming atmosphere in services should be explored, helping to reduce any barriers members of the LGB&T community may have about being 'out'. This could increase the number of residents being 'out' to services, which will enable them to highlight potential health inequalities. This can be achieved by displaying LGB&T literature and posters in a service, and ensuring that staff use inclusive language. Is is also important for staff to not make assumptions that patients are all heterosexual or non- transgender unless they are actually told otherwise.

An audit tool, similar to NHS Lothian [27] should be developed to assist health and social care services in assessing how well they are responding to the needs of LGBT service users, and this should be incorporated into the commissioning process.

Recognised training and signing up to the Lancashire LGBT 'Charter Mark' or the Lesbian and Gay Foundation's 'Pride in Practice' scheme should be explored. These will help to train staff, improve communication, and help the service to be perceived as welcoming and supportive of the LGB & T community. It will also ensure the service develops a core understanding of the key issues faced by the LGB & T community. Sexual orientation and gender identity monitoring, if not already undertaken, should be introduced so that service providers have a profile on their service users.

Strategies, such as the 'Suicide and Self-Harm' and 'Alcohol' should be reviewed to ensure they meet the needs of the LGB & T community, as these have been highlighted as issues within the community.

It has been found that there is a distinct lack of community assets in the Borough. There should be a focus on working in partnership to create community assets within the LGB&T communities - for example a thriving and sustainable community group .

There should be a dedicated officer working in partnership with agencies across the Borough and within Lancashire to engage in early intervention work with at-risk LGB&T people. Such work would be cost-effective in preventing the development of ill health and long-term conditions as well as reducing health inequalities.

27 NHS Lothian Website www.nhslothian.scot.nhs.uk

7. Bibliography

Age Concern 2002. Issues Facing Older Lesbians, Gay Men and Bisexuals.

Alzheimer's Society 2013. Supporting Lesbian, Gay and Bisexual People with Dementia.

Colman, S, 2007. Hidden Away: A needs assessment of older gay, lesbian and bi-sexual people in the Blackburn with Darwen area. Age Concern Blackburn with Darwen.

Department of Health 2007. Working with lesbian, gay, and bisexual (LGB) people: information for health and social care staff.

Department of Health 2007. Working with transgender people: information for health and social care staff.

Foot and Hopkins, 2010. A Glass Half Full: How an asset approach can improve community health and well-being. IDeA http://www.idea.gov.uk/idk/core/page.do?pageId=18364393

Gender Identity Research and Education Society (GIRES), 2008. Gender Dysphoria, Transsexualism & Transgenderism: Incidence, Prevalence & Growth in the UK and the Implications for the Commissioners and Providers of Health Care.

Hall, N and Panton, D, 2009. Improving the Region's Knowledge Base on the LGB&T Population in the North West: Final Report to NWDA & Partners. North West Regional Development Agency.

Johnson et al, 2001. National Survey of Sexual Attitudes & Lifestyles II, 2000-2001.
National Centre for Social Research: London.

Lesbian & Gay Foundation, 2009. Breaking the Cycle: Supporting the Delivery of a Sustainable Lesbian, Gay, Bisexual and Trans Sector in the North West Region.

Lesbian and Gay Foundation, 2012. Findings from the "I Exist" Survey of Lesbian, Gay and Bisexual People in the UK.

Lesbian and Gay Foundation, 2012. Lesbian Gay and Bisexual Patients' experiences of their GP: Greater Manchester Findings.

Mcneil, J et al, 2012. Trans Mental Health Study. Scottish Transgender Alliance.

NHS Blackburn with Darwen, 2008. Lesbian, Gay, Bisexual and Trans Health Needs Assessment. Blackburn with Darwen Primary Care Trust

Office of National Statistics, 2011 Census.

Reed, B, Rhodes, S, Schofield, . and Wylie, K, 2009. Gender Variance in the UK: Prevalence, Incidence, Growth and Geographic Distribution. Gender Identity Research and Education Society (GIRES).

NHS Blackburn with Darwen Lesbian, Gay, Bisexual and Trans Needs Assessment, 2008.

Stonewall 2008. Prescription for Change: Lesbian and Bisexual Women's Healthcheck.

Stonewall and Sigma Research, 2011. Gay and Bisexual Men's Health Survey.

Stonewall, 2012: Stonewall Health briefing: Experiences of Healthcare

Whittle, S; Turner, L; Al-Alami, M, 2007 Engendered Penalties: Trans people's experiences of inequality and discrimination. The Equalities Review.

http://www.nhslothian.scot.nhs.uk/Services/A-Z/HealthPromotionService/TrainingSeminarEvents/

8. Appendix

Appendix 1 – Stakeholder Feedback

BwD Clinical Commissioning Group comments and responses:

Only 23 people responded to the survey – this is a very small number… and while clearly the narrative and comments are valid, the low number of respondents does limit the extent to which meaningful BwD specific conclusions drawn…. And only 3 respondents with experience of supported accommodation.

Response: Yes, the difficulties lying behind the low response in this very time-limited research are discussed in section 4.3.

The estimate of 10,324 LGBT residents in Blackburn is based on a simple 7% or resident population calculation. Earlier in the paper it states that it is accepted that 5-7% of the population are LGB and 0.5-1% are transgendered. These figures are massively different to the integrated household survey 2011 [he Integrated Household Survey (IHS) is the largest social survey produced by the Office for National Statistics (ONS) see here : http://www.ons.gov.uk/ons/dcp171778_280451.pdf] which suggested that this figure is more like 1.5%. If 1.5% was applied to the BwD resident population then the estimate of LGB population would only be 2212 – clearly this is a fraction of the number referenced in the paper… Wehave no feel for which is most accurate… but I do think there needs to be further evidence to back up these figures (clearly a 10k population would require more resource than a 2k population) … as with any paper readers need to be aware of potential bias.

Response: Estimating the size of the LGB&T population is not an exact science, as discussed in a detailed examination of this issue. Aspinall (2009) notes that caution must be exercised with the Integrated Household Survey figure as it only measures people willing to identify their sexual orientation within the context of a household, not outside it and "it is clearly problematic to claim that such an estimate will be representative of the overall LGB population" . We have not found any literature where the IHS statistic is used.

All surveys will underestimate the true size of the LGB population until survey data accumulates and statistical modelling approaches can provide more accurate measures. From 2009, the ONS have introduced a self-perceived sexual identity question to all ONS social surveys but this data will take several years to accumulate and become available at local authority level.

1. Aspinall, P.J., 2009. Estimating the Size and Composition of the Lesbian, Gay, and Bisexual Population in Britain. Equality & Human Rights Commission Research Report 37. Equality and Human Rights Commission: Manchester

2. Aspinall, P.J., 2009. Estimating the Size and Composition of the Lesbian, Gay, and Bisexual Population in Britain. Equality & Human Rights Commission Research Report 37. Equality and Human Rights Commission: Manchester

The only official estimate of 5 – 7% for the LGB population comes from Treasury actuaries who produced the estimate when analysing the impact of the Civil Partnerships Act 2004. The UK Government introduced the Employment Equality (Sexual Orientation) Regulations (2003) which quoted this estimate and the Equality Act (2007) guidance suggested the figure was 6%. This figure has been widely quoted and was used by the North West Regional Development Agency in their 2009 analysis of LGB&T populations in the North West . The NWDA used the Treasury figure on the basis that the key UK data source for it was a more reliable estimate and used a representative sample in terms of age, sex, ethnicity and region.

In the North West region, the Lesbian & Gay Foundation have estimated the LGB population as being 612,000. This was again based on the indicative data from the Treasury actuaries that 6% of the population are lesbian and gay and their own estimation that 3% of the population in the North West are bisexual .

A further issue linked to the population demographics…BwD has a high ethnic minority population - we think that this is likely to play a part in the LGBT prevalence (both actual and reported) – yet there is no specific reference to how this may manifest itself….it is worth noting that the survey of 23 report 87% 'White' yet in the 2011 census the population across Blackburn is 69% white… http://www.blackburn.gov.uk/Lists/DownloadableDocuments/EthnicityAndReligionProfile2011.pdf

Response: We know of no evidence to support the view that areas with a high ethnic minority population in the UK may have a lower prevalence of LGBT people. Reported prevalence however, may well be lower, due to factors including community taboos and to concerns about confidentiality, which are referred to in the report and are also reflected in the difficulty experienced in making contact with potential respondents from this population group. The difficulty of capturing accurate data in this field from members of ethnic sub-groups is discussed in Aspinall (2009) .

A recent Public Health Outcomes Framework companion document also discusses these difficulties stating: "The experience of growing up different within ethnic communities can create additional pressures and challenges as the two cultural norms may conflict. This may be compounded in migrant ethnic communities due to size and social isolation." This document provides evidence showing significant health inequalities amongst LGB&T minorities (including black and minority ethnic groups) and supports a need for further work to understand and address these inequalities.

The NHS Briefing "Lesbian, gay and bisexual (LGB) people from Black and minority ethnic communities" (2007) also states: "BME LGB people are faced with the challenge of integrating two aspects of their identity, both of which are disparaged; many BME LGB people experience dissonance between their cultural/religious and sexual identity." Thus, people who are BME may be less likely to report a LGB identity.

3. Hall & Panton, 2009. Improving the Region's Knowledge Base on the LGB&T Population in the North West: Final Report to NWDA & Partners.
4. Johnson et al, 2001. National Survey of Sexual Attitudes & Lifestyles.
5. Lesbian & Gay Foundation, 2009. Breaking the Cycle: Supporting the Delivery of a Sustainable Lesbian, Gay, Bisexual and Trans Sector in the North West Region, p.23.
6. Aspinall, 2009. Estimating the Size and Composition of the Lesbian, Gay, and Bisexual Population in Britain, p.68.
7. Varney, 2013. Minorities within Minorities – the evidence base relating to minority groups within the LGB&T community, p.1.
8.Department of Health's Sexual Orientation and Gender Identity Advisory Group, 2007. Briefing 12: Lesbian, gay and bisexual (LGB) people from Black and minority ethnic communities, p.6

Some of the quotes are based on reflections on actual experience – others are perceptions of possible experience…see the first green box on page 9 for an example…

Response: We asked respondents about their perceptions because they are the hidden 'barriers' which LGB&T people face while accessing health and social care services which we discuss in the report. These barriers are well documented in previous research which is referenced in the report – and detailed succinctly in the Department of Health report Working with lesbian, gay, bisexual people; Department of Health 2007. Unless services are proactive in showing that they are welcoming of LGB&T people, those barriers will remain, and those LGB&T people will not feel comfortable about being 'out' when accessing health and social care services.

In section 4.4.3 (page 11) we don't think there is much reference to the context e.g. ' …respondents stated that in A&E for example…..just over 1/3rd stated they would not be open'…we suspect this surely would be dependent on what the presenting condition was – i.e. if someone has broken their arm and is getting patched up we not sure to what extent someone being LGBT is applicable / has any bearing on that treatment…

Response: It would be difficult in an online survey to outline dozens of different contexts and presenting conditions. For some services such as mental health, sexual health and substance use the issue is particularly relevant, and we tried to focus on those services. We included A & E because it is a situation where a sudden decision about being "out" or not may have to be made at a time of immediate personal crisis. For many conditions such as a broken arm the sexuality or gender identity of a patient may not be immediately relevant, on the surface, but even being asked to give an emergency contact name and being asked what their relationship is to you, can be very stressful when you are not expecting it or if you are not routinely "out". The impact of this seemingly innocuous experience can be significant for the patient and his or her relationship with healthcare services. The sexuality or gender identity of a patient can also be an indicator of an increased likelihood of certain health conditions such as self-harm, drug or alcohol addiction and attempted suicide - the staff's knowledge and understanding of LGB&T issues could be fundamental in preventing further injury and the healthy management of the patient's current condition. Sexual orientation or gender identity is not always relevant to the medical staff in that situation, but they are to the patient who may be experiencing this hidden stress. In other circumstances – for example a transgender person with internal abdominal injuries, it is critical that the patient is open about their transgender status in A&E.

If in future you need assistance in accessing this section of the community we could assist by using our connections with the E&D service we commission who have built up access to this community.

Response: We would be very grateful if you could link us with the E&D Service you commission and we look forward to engaging with them as well as members of Blackburn with Darwen CCG in the future.

BwD Borough Council Response:

Methodology & finding:

A very helpful presentation of the issue. There are significant limitations on the statistical significance of the findings but as the report says …most local findings confirm and triangulate analysis undertaken at national level on these issues – but provide Bwd relevant insight (e.g. with specific insights on BME community issues).
The sample size is very small if the report is claiming that there are around 10, 000 LGB&T residents, but only 23 responses received. It's good that the report notes that the sample is not representative of the borough.
We can't really offer comments on use of GP services. This is something the CCG should respond to, including use of hospital services. Something Public Health (PH) needs to bear in mind when commissioning services.

Comments on the recommendations, and how the organisation will take them on-board:

Has the Carers' Strategy made any reference to the LGB&T community?

There needs to be two way communication. Residents who experience problems accessing services need to let us know otherwise changes are slow. Were the respondents asked if they had complained regarding the service they received and if they did, what response did they receive?
PH has little control of what display material is in GP surgeries and hospitals. However, any key PH messages are already designed to target at-risk groups.
Training is being delivered to commissioners and PH staff. The CCG has been offered the opportunity to attend Pride in Practice training session in June 2014.
As co-commissioners of preventative mental health services in the Borough, the Public Health Directorate of BwD Borough Council will need to ensure with the CCG that comments on LGBT, ethnicity and mental health services (contained in this report) are addressed by our service providers.
There is clearly a need for further LGBT awareness training amongst local NHS and Adult Social care providers.
A service that is sensitive and relevant to LGBT communities and individuals is one that is sensitive, relevant and personalised for everyone. We need to think of ways to make the issues identified here universal in all local service provision.

Appendix 2 – survey questions

1) Are you resident in Blackburn with Darwen local authority area?
Yes No - please do not continue completing this survey

2) What is your gender?
Male Female Please specify:

3) What is your sexual orientation?
Gay male Lesbian / Gay female Bisexual Heterosexual Rather Not Say
Other (please specify):

4) Is your gender the same as the one on your original birth certificate?
Yes No Rather Not Say

5) What is your ethnicity?
White British White Irish Gypsy or Irish Traveller Any other White background
Asian British Indian Pakistani Bangladeshi
Black British African Caribbean Any Other Black / African / Caribbean
Chinese Arab Dual or Mixed Ethnicity Any Other Ethnic Group
Rather Not Say

6) Do you have a physical disability / impairment?
Yes No Rather Not Say

7) Do you have a learning disability / impairment?
Yes No Rather Not Say

8) What age group are you in?
Under 19 20-24 25-34 35-44 45-54 55-64 65-74
75-84 85+ Rather Not Say

9) Do you have a religion or faith?
No religion Christian Buddhist Hindu Jewish Muslim Sikh
Pagan Other religion Rather Not Say

10) Do you have a caring responsibility for a dependant or for another adult?
Yes No Rather Not Say

11) Are you 'out' to your GP about your sexual orientation or gender identity?
Yes - I am 'out' to my GP - please go to question 12
No - I am not 'out' to my GP - please go to question 13

12) If you are 'out' to your GP about your sexual orientation or gender identity, how has that affect ed your relationship with them?

It has improved my relationship with my GP
It has made no difference at all
I am not sure if it has made any difference
I don't think they understood - my GP continues to assume I am heterosexual/not trans
I feel like I am treated differently now that I have come out to my GP
It has made things difficult between us
Other (please specify):

13) If you are not 'out' to your GP, what is the reason?

I don't think It is relevant to my health
My sexual orientation or gender identity hasn't come up in consultation with my GP
I am not sure if they are OK about LGB&T people
I know that they are not OK about LGB&T people
Not applicable
Other (please specify):

14) Do you live in supported living accommodation?
Yes - please go to question 15 No - please go to question 16

15) Would you say that your living situation is LGB &T friendly? (You can tick more than one box if you wish.)
It is LGB&T friendly It could be more LGB&T friendly Not very LGB&T friendly
I am not open about my sexual orientation or gender identity Other (please specify):

16) Do you receive care at home?
Yes - please go to question 17 No - please go to question 18

17) Are you open about your sexual orientation or gender identity to the people who give you care at home?
Yes - everybody Some of the people Nobody knows about my sexual orientation or gender identity
Other (please specify):

18) If you are a carer, do you receive any kind of carers support from agencies?
Yes - please go to question 19 No - please go to question 20
Not applicable - please go to question 20

19) Are you open about your sexual orientation or gender identity with the agencies who sup port you?
Yes No Other (please specify):

20) Have you received treatment locally for any of the following in the last 2 years?
Yes No

Eating disorder Body image Anxiety Depression Gender Dysphoria Self-harm

22) In the last 2 years have you accessed any of the services below? Please tick as many as are relevant to you.
Yes No

Stopping smoking Alcohol or substance use Sexual Health Cancer treatment

Fertility treatment

23) If you had to access or have accessed any of the services below, how open would you be about your sexual orientation or gender identity? (Answer as many as you feel could be applicable to you.)

Not open at all/Not open unless I have to be/Fairly open/Very open

Sexual Health services Mental Health services Accident and Emergency Hospital treatment - outpatient

Hospital treatment - inpatient Healthcare or social care at home Consultant

Community Clinics (e.g. Podiatry, Weight Management, Dermatology) School Nurse

Maternity Alcohol or Substance Use services Cancer treatment
Fertility treatment Comments:

24) If you have disclosed your sexual orientation or gender identity to a health or social care professional in the past, what response have you had from them? You may tick more than one box

Professionalism and respect Lack of knowledge but respect
Lack of knowledge and little respect Some form of prejudice
Discrimination Not Applicable Other (please specify):

25) How confident are you that health and social care professionals in the future will treat you with respect because of your sexual orientation or gender identity?
Very confident Fairly confident Not very confident Not confident at all
Comments:

26) In the last two years, have you had a negative experience when accessing local health or social care services which you perceive was because of your sexual orientation or gender identity?
No I have not had a negative experience in the last 2 years. Please go to question 28
Yes - please tell us what happened.
Comments:

27) What impact has that negative experience made on you accessing health and social care services in the future?

None at all - I don't care
A little - I tend to be a bit less open when I access health and social care services
I now tend to expect a negative experience when accessing health and social care services
It has put me off accessing health and social care services unless it is an emergency
Other (please specify):

28) What, if any, improvements could be made in health or social care services tor LGB & T people in Blackburn with Darwen?