Sexuality

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Chapter 10: Sexuality

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10.1 Key messages

What are the inequalities? How persistent and how worrying are they?

LIFE

There are no data on life expectancy collected by sexual orientation. There are differences in lifestyle that might have effects in either direction but the data are not available to show whether this is so.

There are no data relating to cardiovascular mortality and few relating to cancer mortality. There is, for example, a small amount of research suggesting that gay men have a higher risk of prostate and anal cancer. Lesbian women are thought to be at low risk of cervical cancer although the risk is present, particularly as many lesbian women have heterosexual intercourse at times in their lives. As such, it is wrong to deny them access to cervical smears.

Some UK and international research suggests that the suicide rate and risk is higher in the LGB population and that within this there are particularly high risk groups, such as young gay men and disabled gay men. The quality of evidence here is weak, however; more data are required.

HEALTH

The Citizenship Survey 2007 collected some data by sexual orientation. These showed no difference between heterosexual and gays/lesbians in self-report of good health. Bisexual people and those self-classified as other were more likely to report not good health. There seem to be no differences in any of these categories in relation to the proportion reporting LLTI (limiting long-term illness or disability). However, mental health surveys suggest a higher prevalence of mental health problems in the LGB population than in the heterosexual population. As with the suicide statistics, sub-groups within the LGB population, such as bisexual people, report worse mental health. Eating disorders seem to disproportionately affect gay men. HIV and AIDS disproportionately affect gay men.

There are insufficient data to determine whether LGB people are more likely than heterosexuals to report they were not always treated with dignity when using health services; there are some indications that this is so but the numbers fall short of statistical significance. However, numerous surveys suggest that LGB people do have problems in using the health service: reluctance to disclose sexuality and negative effects from disclosing sexuality.

In terms of lifestyle, the national datasets do not collect this information by sexual orientation. However, survey research findings conflict; they point roughly in the direction of a higher smoking rate for gay men but not lesbians. There is some indication from survey data that there is a higher rate of alcohol and recreational drug use.

Comparative data on living with HIV suggest that of those living with HIV in the UK, 43% were Men who have Sex with Men (MSM)[4], 31% heterosexual women, 21% heterosexual men and 4% injecting drug users. As such, MSM are disproportionately overrepresented; 5.4% of MSM aged 15-44 is infected with HIV as opposed to around 1% of heterosexual males.

Are there any emerging trends?

Year on year increases in the diagnoses of HIV and other sexually transmitted infections in gay men is an ongoing health concern.

Mental ill health and suicide risk are also an area of considerable concern in LBG people.

In relation to other areas of health, data sources are largely confined to one-off surveys and qualitative studies and as such provide little meaningful indication of health trends over time. However, individual life style choices such as smoking and alcohol and the provision of health services that are

[4] MSM is the category used to collect clinical data relating to sexually transmitted infections. The emphasis is in activity rather than sexual orientation as this is relevant to transmission of infection.

insufficiently sensitive to the specific needs of this population both have the potential to impact adversely on health.

What are the causes?

- In many studies, homophobia is stated as a possible cause of some health problems. Perhaps the clearest example of this is mental health problems.
- The existence of a club scene in which activities such as smoking, drinking, drug use and unsafe sex sometimes prevail can undermine health and life outcomes.
- HIV infection in gay men is linked to chronic ill-health.

How might change be measured?

- LGB health research should not focus only on sexual health.
- Routine monitoring of sexuality in health care will enable the collection of baseline figures and the monitoring of trends in wider areas of health process and outcomes.

Data quality and quantity

Most official data sets currently provide no information on Life or Health indicators for LGB people. This is set to change in the next Census, which will collect some data on relationship status including civil partnerships and therefore provide some limited data. There are data from other sources although they only provide a small part of the picture. HIV, sex and sexually transmitted infections are prominent as issues covered in research.

10.2 LGB Evidence

The official data sets currently provide no information on life or health indicators for LGB individuals. Data from other sources are available but are usually incomplete or unsatisfactory. In some cases the data are international, in others they are local; there are no attempts to provide comprehensive pictures of the indicators across the three nations of England, Scotland and Wales. It appears that the HIV pandemic spurred health-related research on LGB people in the early 1990s. One problem with this is that the focus of such research is narrow; sex and sexually transmitted infections feature high in the topics chosen. Other health issues for LGB people can be missed and it is possible that, for example, attempts at promoting healthy lifestyles are stymied by insufficient attention to the difference between LGB and the majority population.

Since we do not know the mortality or morbidity rate for LGB people, we cannot know the rate for subgroups by ethnicity, age, disability and so on. It is likely that differences are hidden here. There is some suggestion, for example, of a higher suicide rate in young rather than older LGB people. Without data, serious problems such as these, which appear to call for attention, are missed.

In general, LGBT health research tends to relate to the following areas although the amount of data in some areas is very limited:

- Experiences of services (including homophobia and/or heterosexism)
- Gay men's sexual health
- Mental health
- Young LGB (much relating to mental health, the effects of homophobic bullying, etc.)
- (Poor) LGB health behaviours - smoking / alcohol consumption / drug use
- Breast or cervical cancer (in LGB women)

Noticeable gaps relate to physical health generally, and women's sexual health in particular. There are virtually no data available on 'life' (as opposed to 'health' and related risks relating to 'life'). Much research evidence cited in the UK originates from US research (and to a lesser extent Australia and New Zealand), with less research conducted in the UK. This is slowly changing, however, with more interest recently, including from within the Department of Health (DH) who funded Julie Fish's set of briefings for health and social care staff (Fish 2007). Other notable data sources emerging recently include: Stonewall's lesbian and bisexual women's health check (Hunt and Fish 2008); and the 'Count me in too' surveys carried out in Brighton and Hove (Browne 2007). There still remains a prevalence of small, 'grey' literature in the UK, however. Another source is the annual Gay Men's Sex survey (Hickson et al. 2004) although this covers only sexual health issues. Examples of current work ongoing (and thus not yet reported on) include drug and alcohol research (LGB related) by The Lesbian and Gay Foundation with the University of Central Lancashire.

Three methodological issues restrict/influence LGB health research. First, there is widespread reticence to record sexuality as part of routine monitoring data (health or otherwise) and this restricts the possibility of any baseline/comparative data analysis; the Census is possibly the best example of this. Second, historical beliefs about 'low risk' amongst the medical profession means that some data are unrecorded, thus disallowing any comparison to establish 'low risk' or not. An example of this concerns the recording of data within genitourinary medicine and the Health Protection Agency. Whilst data is routinely reported for men who have sex with men (MSM) there is no comparable recording of sexual health statistics for women who have sex with women. Third, the use of convenience/community samples in LGB research may over-report risk behaviours, for example related to sexual health, alcohol, or drug use, as not all LGB are actively involved in the scene in this way (Dodds, et al. 2004).

Routine recording of sexual orientation in health data could be beneficial however there are problems associated with this. Much research highlights that LGB patients/potential patients already have confidentiality concerns and may therefore be reluctant to disclose their sexuality status (Cant 2002, Mugglestone 1999, Formby 2009, Buston 2004). This would result in inaccurate data recording. One possible solution may be for more research to be conducted through health settings where participants could anonymously record their sexuality and be confident that this would not be reported to their health practitioner. Additionally, research could be conducted within LGB communities to seek further views on the issue of monitoring sexual orientation in health settings.

10.3 Life: main indicators - commentary

10.3.1 Period life expectancy at birth, ages 20, 65 and 80

As sexual orientation is unknown at birth it makes no sense to use life expectancy at birth as a measure for this group. It would be possible to use it as a measure for ages 20, 65 and 80. These data are not collected in the General Register Office for Scotland or the General Register Office Census Longitudinal Study (for England & Wales). We found no data in other sources.

There is speculation that factors in the LGB community could both increase and decrease life expectancy. These are set out in relevant sections below. They include: unhealthy behaviours related to drink, drugs and smoking; low or late childbirth in lesbian women leading to increased risk of breast or ovarian cancer; low uptake of screening; reduced risk of cervical cancer in lesbian women who have had little or no unprotected heterosexual intercourse; and higher rates of depressive illness that are linked to suicide. HIV infection in gay men is higher than the national average; this is likely to be associated with increased mortality and morbidity from AIDS-related illnesses.

However, even where there is some evidence to support the existence of a risk or protective factor, it is not known whether that factor has any effect on lifespan. Furthermore, some concern has been expressed about the attitudes and beliefs underlying the speculation. For example, an assumption that gay men have risky life styles might reflect prejudice or be based on generalisations from the behaviour of gay men on the club scene rather than on firmer evidence.

10.3.2 Cardiovascular disease mortality

No data are available. Cardiovascular disease mortality could be higher in this group due to lifestyle risk factors, including smoking.

10.3.3 Cancer mortality

Few data are available. Cancer mortality rates could be higher in the LGB group due to lifestyle risk factors, including smoking.

Insofar as gay men's behaviour differs from the average in terms of health-related behaviour associated with cancer risk or protection, we should expect differences in morbidity and mortality. Thus there is evidence of increased risk of liver cancer and lung cancer due to higher levels of alcohol consumption and of smoking. These higher levels might be associated with another factor, the tendency not to respond to preventative health messages or campaigns.

There are data relating to sex-specific cancers which affects either gay men or lesbian women. Some is based on UK research alone; other data arises from international research. Gay and bisexual men might be at higher risk of prostate and anal cancer than heterosexual men (Hunt and Minsky 2003) Bower conducted highly specific work which suggested that anal cancer is more common in gay/bisexual men with HIV or AIDS than those without (Bower M. 2004). However, as anal cancer is not an AIDS defining illness, the linkage between these two conditions is not clear.

Turning to lesbians and their risk of cancer, there might be differences in cancer morbidity and mortality between them and the general population of women on the basis of lifestyle factors. Lesbians and bisexual women are thought to be more likely to smoke, have a poor diet, and drink excess alcohol. This puts them at higher risk of various associated cancers, including breast cancer (Hunt and Minsky 2003). The risk of breast cancer might also be increased because women are less likely to go through pregnancy and childbirth, thus losing the protection against breast cancer that pregnancy affords. From UK survey data alone, Hunt and Fish found a much higher rate of breast cancer in lesbian and bisexual women than heterosexual women aged 50-79 (1 in 12 against 1 in 20) (Hunt and Fish 2008).

Lesbians have been thought to be at no or low risk of cervical cancer because the substantial body of evidence which has explored the association between sexual intercourse and cervical cancer has focused exclusively on heterosexual intercourse, exploring factors such as number of sexual partners, age of first intercourse and use of oral contraception (e.g. (Deacon et al. 2000)) with the result that cervical cancer is conceptualised in this way. For this reason, health care professionals have not always recommended cervical smear tests and lesbian women have not sought them. However, exposure to Human Papillomavirus, the primary cause of cervical cancer can occur through all kinds of sexual activity and is therefore not confined to heterosexual women. Smoking is also a recognised risk factor for cervical cancer and rates of smoking are higher among lesbian women. As such, cervical smears are appropriate for lesbians.

10.3.4 Suicide rates/risk

There is evidence from UK and international research indicating higher rates of mental illness, risk of suicide, attempted suicide and self-harm amongst lesbian, gay and bisexual people. A systematic review and Meta-analyses of data extracted on 214,344 heterosexual and 11,971 non heterosexual people revealed a two fold excess in suicide attempts in lesbian, gay and bisexual people [pooled risk ratio for lifetime risk 2.47 (CI 1.87, 3.28)] (King et al. 2008).

UK evidence comes from a number of surveys all of which report high rates of considered and attempted suicide among all LGB groups. Hutchison et al surveyed 98 GB men in Edinburgh and found that 54% of the study sample had at some point seriously considered taking their own life (Hutchison, Porter and Le Voil 2003). The 'Count Me In Too' study which surveyed 819 LGBT people in Brighton and Hove (Browne and Lim 2008) reports that 23% of their sample had had serious thoughts of suicide in the previous five years. A larger national survey conducted by Warner et al. which used a snowball sampling technique to recruit the 1285 LGB men and women who participated in the study similarly reports high rates of considered suicide; 47% for gay men, 56% for lesbian women and 55% and 57% for bisexual men and women respectively (Warner et al. 2004).

These findings are similarly reflected in high rates of attempted suicide in all three studies. In the Hutchison study, 26% of the total sample had attempted suicide whilst Warner et al reports slightly higher rates of 25%, 27%, 31% and 33% for their four groups of gay men, lesbian women, bisexual men and bisexual women (Hutchison, Porter and Le Voil 2003, Warner et al. 2004).

Table 1 Serious thoughts of suicide in LGBT respondents to the 'Count me in too' survey.

	Frequency	Percent	Valid %
Yes	192	23.4	29.8
No	452	55.2	70.2
Total	644	7.6	100.0

Source: Adapted from Count me in too survey

The table above shows that in response to the question ' Have you had any serious thoughts about suicide in the past five years? 30% of respondents reported that they had considered suicide.

In the Hutchison study, a substantial proportion of those attempting suicide had done so on more than one occasion; over one third had made more than three attempts and nearly one quarter had made five or more attempts, indicative of severe and sustained mental health problems within this sub section of the population. The main reasons given for wanting to take their own life were sexual orientation, depression, relationship problems and difficulties with family.

There is some indication that the risk of attempted suicide appears to be higher among specific sub groups of the LGB population although the data are insufficient for statistical significance. Those who are bisexual appear to be more likely to consider and attempt suicide (Browne, K. and Lim, J. 2008) (Warner et al. 2004). There is also indication that young people may be particularly vulnerable because of the problems that they experience in coming to terms with their sexual orientation and coping with social hostility, stigma, bullying and homophobia (Rivers 2001, Mullen 1999, McDermott, Roen and Scourfield 2008, King M, et al. 2007). There is a limited amount of age comparable data which suggests high rates in both gay and bisexual men and women aged under 20 years (Hunt and Fish 2008, Hutchison, Porter and Le Voil 2003) and in younger mid-life; in the Count me in Too survey, those

aged 35 - 45 years were more likely than any other age group to have attempted suicide in the previous five years (Browne and Lim 2008).

Attempted suicide is more common among those with mental health problems and particularly associated with self harm. Browne & Lim report that those who engaged in self harm were five times more likely to have had serious thoughts of suicide and over seven times more likely to have attempted suicide in the past five years (Browne 2007).

10.3.5 Accident mortality rate

These data are not collected in the General Register Office for Scotland or the General Register Office Census Longitudinal Study (for England & Wales).

10.3.6 Deaths from non-natural causes for people resident in health or social care establishments

These data are not collected in the General Register Office for Scotland or the General Register Office Census Longitudinal Study (for England & Wales).

10.3 Health: Main indicators

Outcomes

10.3.7 [2.1] Self-report poor current health

ENGLAND

Table 2 General health by sexual orientation

	Good Health %	Not good health %	N
Heterosexual or straight	76.9	23.1	13337
Gay or lesbian	76.7	23.3	146
Bisexual	61.5	38.5	91
Other or would prefer not to say	62.6	37.8	214

Chi-Square, 36.75; df 4; p<0.001

Source: Citizenship Survey, 2007

The table above suggests no difference between the heterosexual and gay/lesbian population in terms of self-reported health; bisexual and others seem to have poorer health although the sample sizes are small.
'Prescription for change', a large scale opportunistically recruited survey which explored the general health of over 6000 lesbian women and included those from England, Scotland and Wales and reports similar findings; 80% of lesbians who completed the survey reported good or excellent health whilst 2% reported poor health (Hunt and Fish 2008).

WALES & SCOTLAND

No separate data

3.8 [1.1] Longstanding health problem or disability (E W) and longstanding illness (S)

ENGLAND

Table 3 Proportion of reported Limiting Long term illness by sexual orientation

	Has LLTI	No LLTI	N
Heterosexual or straight	19.0	81.0	13337
Gay or lesbian	20.1	79.6	146
Bisexual	24.2	75.9	91
Would prefer not to say	24.2	74.9	214

Chi Square, 6.23: df, 4 p = 0.182

Source: Citizenship survey, 2007

The small numbers for the LGB groups restrict the possibility of making any meaningful interpretation of this data. The lack of any statistical difference in the proportion of those in each category with LLTI tentatively indicates that there is no indication of important differences in the proportion of those with LLTI in relation to sexuality.

A particular long term health concern in relation to this population is HIV. Advances in treatment have contributed to the current conceptualisation of HIV as a chronic health condition rather than a terminal illness. Those living with HIV are subject to physical and mental health problems that may be exacerbated by financial hardship and prejudice (Dodds, et al. 2004, White, L.C. and Cant, B. 2003). 'Count Me In Too' reported that those living with HIV are less likely than other LGB people to report good or very good mental and emotional health over the past twelve months (Browne and Lim 2008). The high prevalence of HIV among gay men make this an area of particular concern for this population.

WALES & SCOTLAND

No separate data

10.3.9 [1.2] Poor mental health or wellbeing

ENGLAND

Data are available from a range of studies and surveys all of which indicate high levels of poor mental health in this population. Warner et al in a survey of 1285 LGB people found that 43% had a mental disorder as defined by the revised Clinical Interview Schedule (CIS-R) (Warner et al. 2004).

The 'Count me in too' study found extremely high levels of reported mental health problems among LGB people. The majority of LGBT people in that survey this research reported experiencing difficulties with their mental health in the past five years. Only one in five respondents stated that they had experienced no mental health difficulties in the past 5 years. 79% (n = 643) of the respondents in that study had experienced a wide range of mental health problems. In many cases, individuals had experienced a number of difficulties; 55% (n = 302) had had three or more mental health problems in the past five years.

Table four below demonstrates the proportions of individuals reporting difficulties with a wide range of mental health problems.

Table 4: Mental health difficulties experienced by LGB people over the last five years

	Frequency	Per cent
Stress	491	60.0
Confidence/self esteem	375	45.8
Depression	361	44.1
Anxiety	361	44.1
Significant emotional distress	274	33.5
Insomnia	274	33.5
Isolation	225	27.5
Suicidal thoughts	174	21.2
Panic attacks	150	18.3
None of the above	140	17.1
Problem eating/eating distress	119	14.5
Fears/phobias	111	13.6
Addictions/dependencies	94	11.5
Anger management	92	11.2
Self harm	73	8.9

Source: *Count me in too, 2008*

There is evidence presented in the 'Dimensions of diversity' report that there are higher levels of mental health problems among LGB people as compared to the general population with higher prevalence rates for depression and anxiety, suicidal thoughts and self-harm, eating disorders and substance misuse (Gordon, et al. 2010). These are supported by a controlled study conducted in London which found that gay men reported higher levels of psychological symptoms than heterosexuals (King and Nazareth 2006). Further evidence is provided from a large systematic review and meta analysis of international data. Meta-analyses of data extracted on 214,344 heterosexual and 11,971 non heterosexual people revealed that the risk for depression and anxiety disorders (over a period of 12 months or a lifetime) on meta-analyses were at least 1.5 times higher in lesbian, gay and bisexual people (RR range 1.54–2.58). Alcohol and other substance dependence over 12 months was also 1.5 times higher (RR range 1.51–4.00). Results were similar in both sexes but meta analyses revealed that lesbian and bisexual women were particularly at risk of substance dependence (alcohol 12 months: RR 4.00, CI 2.85, 5.61; drug dependence: RR 3.50, CI 1.87, 6.53; any substance use disorder RR 3.42, CI 1.97–5.92) (King et al. 2008).

There is some variability in the levels of poor mental health by identity groupings with consensus agreement on the susceptibility of bisexual individuals. 'Dimensions of diversity' reports particularly high rates among young people whilst the 'Count Me In Too' reports some indication that lesbians are more likely to have experienced significant emotional distress than gay men. However both reports are in agreement in identifying that those identifying as queer[5] or bisexual appear to be particularly susceptible to mental ill health. They are significantly less likely to describe their emotional and mental wellbeing as good or very good in the last twelve months compared to lesbians and gay men and more likely to have experienced mental health difficulties than lesbians or gay men. Bisexual and queer respondents are also more likely than lesbians or gay men to have experienced difficulties with: significant emotional distress; depression; anxiety, isolation, confidence/self esteem; anger management, insomnia, fears/phobias, problem eating disorders, panic attacks, self harm, addictions/dependencies and suicidal thoughts. Similar findings were found in the Warner study (2004) and in the systematic review and meta analyses conducted by King et al (2008).

WALES & SCOTLAND

No additional data

[5] "Queer" is given a specialised meaning in this project and elsewhere, referring to non-conventional sexuality outside of the LGBframework, such as sado-masochism.

Process

10.3.10 [3.1] Low perception of treatment with dignity

ENGLAND

From the 2007 'Citizenship Survey' in England & Wales, the findings in response to the question ' in general would you say that you were treated with respect when using the health service?' as analysed by sexual orientation are presented below.

Table 5 Treatment with respect when using health services, by sexual orientation

	All of the time or most of the time	Some of the time or less	N
Heterosexual or straight	91.2	8.8	13260
Gay or lesbian	86.3	13.7	146
Bisexual	92.2	7.8	90
Other or would prefer not to say	87.9	12.1	215

Chi -Square, 7.53: df 4 p = 0.111

Source: Citizenship Survey 2007

The table above shows that whilst gay and lesbian people are more likely than heterosexual people to report that they are not treated with respect all or most of the time, the difference is not statistically significant.

Nevertheless, there is a clear body of work suggesting that experiences, and potentially more importantly, fear of potential prejudice can significantly affect LGB take-up of health advice and services (Cant 2002, Formby 2009, Cook, et al. 2007). Findings from a range of both qualitative and quantitative studies indicate ongoing concerns about the attitudes of health care providers towards sexual orientation and the adverse impact of this on health care provision.

There is a marked reluctance among a proportion of LGB to disclose their sexual orientation to health care providers. Surveys by Dodds et al. and Keogh et al. report that two fifths and one third of their respective samples had no intention of disclosing their sexual orientation to their health care provider and would be unhappy if they were to find out (Dodds, Keogh and Hickson 2005, Dodds, Keogh and Hickson 2005, Keogh, et al. 2004). Similarly the 'Prescription for Change' survey reported that half of lesbian and bisexual women have not told their GP. This can have negative implications for care. When sexual orientation is part of the health issue for which the person seeks help, it can lead to them receiving inappropriate care or advice (Hunt and Fish 2008). It may also impact on mental health. Robertson et al. explored the health needs of gay men and reported that their reluctance to come out to a health professional may not only lead to the under diagnosis of mental health problems, but further exacerbate them through the imposed secrecy (Robertson 1998).

Among those that have shared this information, a substantial proportion have experienced negative effects. King et al. found a third of gay men and up to two-fifths of lesbians recounted negative or mixed reactions from mental health professionals when being open about their sexuality (King et al. 2003). These reactions seemed even more negative for bisexual men and women. It was also common for professionals to link the person's sexual orientation to his or her mental health problem; however, the report points out that it is hard to get the balance right here between underplaying and overplaying the importance of sexual orientation.

A London-based study of gay men showed that, despite all the research participants having previously disclosed their sexual orientation in many areas of their lives, there was considerable anxiety and fear of stigmatisation in relation to doing so in the context of primary care services (Cant 2002). This generated problems for men wishing to discuss health needs and treatments in relation to their sexual orientation. This research illustrates the difficulties experienced by gay and bisexual men in communicating their personal needs

and the social context of their lives to primary care providers which may further impact on their health and wellbeing.

In terms of experience of discrimination, a survey conducted for Stonewall by Hunt & Fish in 2008 suggests that one in fourteen lesbian and gay people expect to be treated worse than heterosexuals when seeking healthcare. Gay women are almost twice as likely to expect discrimination because of their sexual orientation. However, there are some significant regional differences in attitudes to healthcare. For example, Welsh lesbian and gay people are seven times more likely to expect unequal treatment in an emergency and during routine procedures than those in the South West. Additionally lesbian and gay people in Yorkshire and the Humber are five times more likely to expect discrimination during routine procedures than those in the South West. The figures for discrimination from this survey seem relatively low; other evidence puts them higher. For example The Equality Network reports on findings from a small online survey conducted on lesbian and bisexual women's experiences of information and support around sexual health. The majority (81%) of the 43 respondents lived in Scotland. The survey found that that 42% of the respondents had experienced prejudice or discrimination when seeking help or advice about their sexual health (Equality network 2004).

'Inside out' is a survey of the experiences of LGB people accessing health services in North and West Wales produced in 2007 (Cook, et al. 2007). It surveyed the 67 respondents by means of questionnaires (52 participants) and focus groups (15 participants). 62% of questionnaire respondents had either come ‘out’ or been ‘outed’ whilst accessing a health service. One quarter of these people felt that this changed the response or attitude of the health care provider. Experiences of attitudinal changes after disclosure ranged from a less friendly atmosphere, a change in mannerism, staff being embarrassed and respondents feeling uncomfortable, to staff being judgmental. 67% of questionnaire respondents in that same study reported a positive and 15% a negative experience whilst receiving care or treatment. However, the qualitative data indicates that respondents had such low

expectations that they classified as ‘positive’ the absence of overt prejudice. The positive experiences reported are summarised as: a lack of negative reaction from staff to disclosure of sexual orientation, being treated for the illness, and partners being treated with respect and equal footing to heterosexual couples.

WALES and SCOTLAND

No separate data

10.3.11 [5.1] A&E attendance/accidents

The main source of data for A&E attendance is provided by the Department of Health. Information on sexual orientation is not routinely collected and these data have not been aggregated by sexual orientation. The effect of injury or death through homophobic attacks on the recipients' and/or their immediate family/friends' health outcomes remains largely unexplored.

10.3.12 [3.2] Lack of support for individual nutritional needs during hospital stays

These data are not collected in the National Patient Survey Programme.

Autonomy

10.3.13 [4.1] Healthy lifestyle

These data are not collected in the health surveys of Wales, England and Scotland.

SMOKING

Research suggests that LGB people in general are more likely to smoke than heterosexual people although there is a lack of agreement in terms of differential rates between the sub-groups and the smoking patterns. This is due in part to the nature and scale of the evidence base. A controlled study from London reports that women classified as bisexual and lesbian, and men classified as bisexual were more likely to be smokers (King and Nazareth 2006). From Scotland, the Dimensions of diversity report cites a smoking rate of 32.5% among gay men which is substantially higher than that of the general population (26%) (Gordon, et al. 2010).

However, other research, in relation to lesbian women, suggests that smoking rates appear to be broadly similar to those of the general population (25% and 24% respectively in 2007) (Gordon, et al. 2010). These findings are supported by 'Prescription for change' which reports that two thirds of lesbian and bisexual women have smoked compared to half of women in general and that just over a quarter currently smoke. 20% of those who smoke, smoke more than 20 cigarettes per day, as compared to 28% of women in general. Thus their data indicates that lesbians are more likely to have ever smoked than women in general but no more likely to smoke now, and among those who do smoke, the amount of smoking is lower than for the general population (Hunt and Fish 2008).

ALCOHOL

Reported levels of alcohol and drug use are higher within the LGB population as compared with the general population (Mercer et al. 2007). A number of sources, primarily surveys, find high levels of illicit drug use among gay and bisexual men, with up to half having used at least one drug in the last year (Gordon, et al. 2010, Keogh, et al. 2009). A similar pattern is seen among women who are five times as likely to have taken drugs as compared to women in general (Hunt and Fish 2008). Specific identities and conditions predispose to high levels of alcohol and drug use. In relation to alcohol, women classified as bisexual appear more likely to abuse alcohol (King and Nazareth 2006) whilst men living with HIV are much more likely to use almost all drugs (Keogh, et al. 2009). Levels of drug and alcohol use among those with mental health problems are high. In the 'Count me in too' report, 85% of the sample drank alcohol and 50% said that they had taken illegal drugs or used legal drugs without a prescription in the last five years. Focus groups from that study pointed to the use of drugs and alcohol as coping mechanisms for the social and emotional difficulties experienced by LGB people (Browne and Lim 2008).

EXERCISE, DIET AND OBESITY

There is little evidence relating to exercise, diet and obesity. Physical activities levels have been found to be low among young LGB people in Glasgow as compared with other young people (Gordon, et al. 2010). From the 'Prescription for Change' survey, lesbian and bisexual women have the same BMIs as women in general and half of them exercise three times per week (Hunt and Fish 2008).

A matter of greater concern relating to this population may be the patterns of eating disorders which appear to be disproportionately prevalent in gay men as compared to the general population, reflective of different community norms and expectations about size and body image. However the evidence base for this assertion is not great and draws on non UK literature (Gordon, et al. 2010, Scott et al 2004).

SEXUAL HEALTH.

Sexual health is a matter of concern in relation to the incidence of sexually transmitted infections and HIV. The majority of lifestyle research in relation to the LGB population has been conducted in this area and largely focused over recent decades on gay men in response to the emergence of HIV. Data supplied by the Health Protection Agency comes from the collation of statutory returns provided by genitourinary medicine clinics throughout the country. For the purpose of these data, information is gathered on sexual activity rather than sexual orientation. As such it categorises men who have sex with men (MSM) (rather than gay or bisexual men) and does not routinely gather data on women who have sex with women.

It is difficult to obtain any prevalence data in relation to sexually transmitted infections because of high rates of asymptomatic infection and the consequent high proportion of undiagnosed infections. However data are available from the Health Protection Agency in relation to HIV in specific populations from the unlinked anonymous prevalence monitoring programme. This shows that of all new HIV diagnoses in 2007, 41% (3,160) were among men who have sex with men (MSM), and 82% of these infections were probably acquired in the UK. Table 6 below presents the numbers of individuals living with HIV (diagnosed and undiagnosed) by exposure category, excluding those infected by blood, tissue or blood products or by mother to child transmission. This demonstrates that an estimated 30,000 MSM were living with HIV, with between one in three and one in four of them being unaware of their infection (Health Protection Agency 2009).

Comparative data on living with HIV suggest that of those living with HIV in the UK, 43% were MSM, 31% heterosexual women, 21% heterosexual men and 4% injecting drug users. As such, MSM are disproportionately overrepresented; 5.4% of MSM aged 15-44 are infected with HIV as opposed to around 1% of heterosexual males (Health Protection Agency 2007)

Table 6 Estimated number of adults (15-59) living with HIV (diagnosed and undiagnosed) UK 2007.

Exposure category	Number diagnosed	Number undiagnosed	total
MSM	20,900	9,200	30,100
IDU	1,600	1,100	2,700
Heterosexuals	25,300	11,100	36,400
Men	9,100	5,600	14,700
Women	16,200	5,400	21,600
Grand total	47,800	21,600	69,400

Source: Adapted from Health Protection Agency: Testing Times:

The number of HIV diagnoses among MSM has increased steadily over the current decade; from 1,565 in 2000 to 2,828 diagnoses in 2007. This figure appears to have levelled of and then fallen to 2,126 in 2009 although this is considered an underreporting and the HPA have given a corrected figure for new HIV diagnoses in 2007 of 3,160 (Health Protection Agency 2008). Whilst it is encouraging to note that the level of increase in infection is currently falling slightly, it is probably too early to report this as a trend.

First AIDS diagnoses and deaths in this population have decreased year on year over the same time period. For first AIDS diagnoses, the number per year fell from 349 in 2000 to 125 in 2009 whilst deaths fell from 349 in 2000 to 125 in 2009.[6]

[6] Source: Health Protection Agency: http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1203928687610

Table 7 Percentage of MSM who have been tested for HIV, percentage tested positive, and percentage living with diagnosed HIV

Year	% HIV tested	% diagnosed positive among men ever tested	% living with diagnosed HIV
2007	70.6%	15.2%	10.7
2006	65.7%	12.9%	8.5
2005	60.1%	11.9%	7.2
2004	59.8%	11.8%	7.1
2003	59.1%	11.7%	6.0

Source: Adapted from Testing Targets, 2009: http://www.sigmaresearch.org.uk/files/report2009f.pdf

Some indication of testing rates are available from the Gay men's survey conducted in 2007 and presented in the report Testing Targets which involved a self-selected sample of over 6000 men(Hickson, et al. 2009). The table above shows that across the UK, one third of the sample had never been tested for HIV. Whilst a matter of concern, this represents a substantial increase in testing rates when compared to previous similar reports.

The health burden associated with HIV is enormous and falls disproportionately upon the MSM population. The proportion of MSM with HIV in the gay men's survey has increased year on year. As shown in the table above, in the 2007 report, 10% of the sample was living with HIV. In 2007, a total of 23,990 HIV diagnosed MSM were seen for HIV-related care, more than double the number accessing services in 1998, a product of new diagnoses and improved life expectancy of those who are HIV infected.

HIV and sexually transmitted infections are a double health problem. HIV negative men who are exposed to HIV are more vulnerable to infection if they have another STI at the time of their exposure. Also an HIV positive man who has another STI is more infectious than if he did not have another infection. Together, these effects mean that the more sexual exposures that occur in the presence of another STI, the more HIV transmissions will occur.

Incidence rates of some sexually transmitted infections, several of which have seen substantial year on year increases, are extremely high in the MSM population. Two are of particular concern. Rates of gonorrhoea, the second most common STI in MSM, have seen a 23% increase in cases between 2000 and 2007. MSM accounted for 30% (3,868/12,933) of all men diagnosed with gonorrhoea in 2007, the majority of whom were aged 25-34 (39%; 1,499/3,868) (Health Protection Agency 2007).

Syphilis is also a health problem for this group of people. Between 2000 and 2007, diagnoses of infectious syphilis among MSM in genitourinary medicine (GUM) clinics increased over 11-fold, from 130 to 1463. Enhanced surveillance in 2007 reported 1,568 diagnoses of infectious syphilis among MSM. The highest proportion of cases was seen in the 35-44 age group (37%, 518/1,439). Primary syphilis was diagnosed in 40% of cases, with secondary and early latent syphilis being seen in 30% and 24% of cases respectively.

Rates of sexually transmitted infections in MSM are substantially higher for those who have tested positive for HIV as compared to those who have not. The HPA in Testing Times report that 28% (148/523) of those who were infected with Gonorrhoea were HIV positive. For syphilis 34% (444/1,324) of those diagnosed in England & Wales and 22% (30/137) of those diagnosed in Scotland were co-infected. The greatest proportion of HIV co-infection was seen in LGV cases, accounting for 75% (362/484) of cases reported. HIV co-infection was greatest within the 35-44 age group for all three STIs.

Findings from the survey Testing Targets which surveyed over 6000 men support this data. 11.4% (n=707) of respondents said they had picked up an STI in the last year and this proportion was much higher for men who had tested HIV positive (28.4%) than those whose last test was negative (12.8%). The lowest rates were in those who had never tested for HIV (3.9%) (Hickson, et al. 2009). The table below which presents data from that report shows the proportion of those diagnosed with each STI who were living with HIV.

Table 8 New STI in the last year self-reported in the Gay Men's Survey 2007

STI diagnoses	Number diagnosed with this infection in the last year	% of those diagnosed in the last year who were living with diagnosed HIV at the time of survey
Gonorrhoea	166	27.2
Chlamydia	152	27.6
Syphilis	94	46.8
NSU	91	17.6
Crabs/lice/scabies	86	3.5
HPV/warts	68	7.4
HIV	34	-
Herpes	29	24.1
LGV	7	100
Hepatitis C	6	83.3
Other	17	17.6

Source: Testing Targets (2009)

There is less information about rates of sexually transmitted infections among lesbian women and they appear to be a neglected group in this respect. Data is routinely gathered in genito-urinary medicine clinics for women who have sex with women and there is no equivalent of the gay men's sex survey for women. 'Prescription for Change' reports that over half of lesbian and bisexual women in their survey had never been for a sexual health check up. Three quarters of those who have not been tested did not consider themselves to be at risk and 4% had been told by healthcare workers that they do not need a test (Hunt and Fish 2008).

Health screening attendance

Cervical screening uptake rates in lesbian and bisexual women appears to be comparable with that of the rest of the population. Whilst the proportion of lesbian and bisexual women over the age of 25 who had never had a cervical smear test was lower than that of women in general (15% as compared to 7%), 70% of the respondents had had a smear test in the last three years, which is comparable with national data (Hunt and Fish 2008). From the same report, one in five of those who had not had a test had been told that they did not require one. Although the numbers are not large, this is a matter of concern as it appears to indicate that there is an erroneous perception among some health professionals that these women are not at risk and so do not require the offer of screening.

There do not appear to be differences in the uptake rates of breast screening. Four in five lesbians over the age of 50 reported that they had had a breast screening test, which is similar to women in general (Hunt and Fish 2008).

10.4 Health and life: LGB: Discussion

Julie Fish's briefings for health and social care staff are a good starting place for discussion of health and life inequalities as they affect LBG (and Trans) people. She suggests that LGB experience health inequalities that often go unnoticed. In the data collected here using Equality and Human Rights Commission indicators, those inequalities are seen in relation to: experience of health services; some risk-taking behaviour; suicide; and mental health issues. Lack of data in relation to many indicators means we cannot draw conclusions about these; there might be significant issues in relation to life-span, for example. The Equality and Human Rights Commission indicators are appropriate, in the main, although data on sexual health might be informative in relation to this strand and perhaps also to others. The lifestyle indicators are of interest although data are limited. Inequalities here could indicate at least two problems. The first is stress linked to homophobia and indirectly to risk-taking behaviour (and, perhaps, suicide). The second is that approaches to health promotion that are based on the heterosexual population might be of little use for LGB people.

A key aspect of much of the literature concerns the existence of homophobia and/or heterosexism in wider society that informs LGB experiences of health care (and hence health inequalities, and potential human rights breaches). Not only are discriminatory experiences from health services documented, but some research suggests that the ‘stress’ of identifying as LGB in this context can lead to poorer health behaviours, such as higher rates of smoking or drug use, as well as poorer health outcomes, such as mental health problems (Hutchison, Porter and Le Voil 2003, McDermott, Roen and Scourfield 2008, King 2006). Other research studies, however, explain these behaviours as being more linked to LGB ‘cultures’ on the scene (Hunt and Fish 2008, Dodds, et al. 2004, Hunt and Minsky 2003, Keogh, et al. 2004, Keogh, et al. 2009) (which may be linked to homophobia). A body of research suggests that young LGB groups may be particularly vulnerable to mental health problems or ‘self-destructive behaviours’ due to the stresses of coming / being out in adolescence, with related levels of homophobic bullying, etc. (Rivers 2001,

King M, et al. 2007, Mitchell, M., Collins, P., Doheny, S., Randhawa, G., Davis, S. 2001).

Some research studies have also suggested that LGB patients who are not 'out' are put at risk of not receiving applicable/appropriate advice or treatment (Hunt and Fish 2008). Other studies have recorded inappropriate and/or insensitive responses when patients did come out to a health care worker (Hunt and Fish 2008). Research has also documented LGB patients/potential patients feeling invisible and/or ignored in health promotion and/or information materials. Research participants have emphasised the lack of appropriate / in-depth knowledge or information about LGB communities and/or health issues among health practitioners, which is sometimes coupled with a lack of sensitivity and/or understanding (Mugglestone 1999, Farquhar, C., Bailey, J. & Whittaker, D. 2001, Henderson, et al. 2002).

Sexual health remains an important area for LGB communities, though researchers in this area are often at pains to point out that LGB health should not be viewed as referring to only sexual health (just as people's identities should not only be related to their sexuality). Sexual health is important for two main reasons: first, there is growing recognition that lesbian and bisexual women's sexual health has been largely ignored or under-explored which has resulted in widespread misperceptions among both health practitioners and women themselves. Second, HIV rates continue to rise, particularly among men who have sex with men (and young men in particular), suggesting that more is still to be done in terms of health promotion and HIV prevention.

Other issues explored in LGB health research identify potentially increased cancer risks due to health behaviours such as poor diet, smoking or drinking (linked to causing ill-health), as well as lower levels of behaviours designed to help early diagnosis (e.g. self-examination or attending cancer screening

services) and/or different lifestyle patterns, such as lower/later conception rates.

Local and national level studies have also evidenced poorer mental health within some LGB communities, including suicide attempts, self harm, depression, and anxiety, with some evidence to suggest that young people, bisexuals and trans people are particularly vulnerable in this regard. Those using mental health / related services are not always satisfied with the support they receive, with some suggestion that there is a balance to achieve for health care professionals between ignoring sexual orientation and addressing the impact that it may have on mental ill-health.

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