



FORMERLY LGBT
YOUTH NORTH WEST



Lesbian, Gay, Bisexual and Trans
(LGBT) Young People's Health in the
UK: A literature review with a focus
on needs, barriers and practice.



Executive Summary

Dr. Vanessa Fay, Chartered Clinical Psychologist,
Manchester, on behalf of The Proud Trust.
1/1/2016

*Research funded by South, NHS North, Central and South Manchester Clinical Commissioning Groups, the Big Lottery, and in association with Schools OUT UK



Schools  OUT UK
The LGBT Education Charity

FORWARD



Homophobia, biphobia and transphobia are still prevalent across the UK. Within this climate, young people who are lesbian, gay, bisexual and trans face additional needs to that of the general youth population, including:

- A greater need for mental health support
- Access to accurate, unbiased sexual health information
- Specific youth services to develop a positive self-identity
- Proactive steps to make all health care settings look and feel inclusive to LGBT young people

The following pages summarise a literature review of the UK research into LGBT young people's health. This evidence highlights the importance of:

- A recognition of institutional homophobia, biphobia and transphobia across health care settings and how this affects health services
- LGBT awareness and upskilling for all health care professionals
- Specific health and youth services targeted at LGB young people, LB girls, GB boys and services for trans young people (co-created/ delivered / commissioned by the NHS and the voluntary sector)
- Increased patient voice/ involvement to hear and respond to the diverse needs of LGBT young people in all services, but especially in mental health and sexual health services
- Adequate and accurate information, advice and guidance including resources for patients
- Timely, effective and unbiased support for young people seeking gender reassignment

by Amelia Lee
Strategic Director
THE PROUD TRUST

CONTENTS



What are the barriers to young LGBT people accessing healthcare?	4
Are there key health needs that have specific implications for young LGBT people, and for other LGBT groupings?	6
What works?	12
What can we learn to apply in Manchester (in health settings and in the voluntary sector)?	14
Practitioner points	17

LGBT is an acronym for lesbian, gay, bisexual, and trans. Lesbian, gay and bisexual identities are all related to same-sex attraction. Trans identities are related to gender (being male or female or something else). LGBT is an umbrella term to include these gender and sexuality variations.

Trans or sometimes written as Trans* is an umbrella term for any number of identities and behaviours that cross society's gender boundaries. A person may feel that the sex they were assigned at birth does not match with their gender identity - e.g. someone who is assigned female who feels like, and identifies, as a man. This person may describe themselves as being transgender.

1 What are the barriers to young LGBT people accessing healthcare?

- It appears that commissioners and service providers are not always aware of the demographics of the populations they serve. Thus, there is a need for routine gender identity and sexual orientation monitoring in all health settings (LGF, 2014; Meads et al. 2009).
- There is a lack of relevant needs assessments specific to LGBT young people (Kelleher, 2009; Youth Chances, 2014).
- Compared with their heterosexual counterparts, lesbian and gay people are proportionately more likely to access mental health services. However, LGBT young people describe experiences of poor staff attitudes towards them and/or a lack of LGBT-tailored knowledge/ support.
- There was a theme of services not providing adequate supplies of tailored materials and resources, such as safer sex items for young lesbian and bisexual women (Formby, 2011a), or inclusive advertising and counselling materials (LGF, 2014; Meads et al. 2009).
- There are a lack of available services for LGBT people experiencing suicidal distress (Johnson et al. 2007). Regarding the latter, Johnson et al. (2007) elaborate: ‘Problems included homophobic, transphobic or heterosexist discrimination within educational and health services; lack of a prompt referral system for expressions of suicidal distress; inconsistent and fragmented system of care for suicidal individuals; a focus on diagnosis of mental health issues rather than treatment; lack of mentoring or foster care for young homeless LGBT people; limited access to crisis support when existing services are unavailable’. The lack of, (and barriers to accessing), services tailored to young LGBT people are particularly concerning given that ‘it is a major task for LGBT young people to find the spaces for constructing genuinely unashamed sexual identities’ (Scourfield et al. 2008).

‘homophobic, transphobic or heterosexist discrimination within educational and health services’

- Barriers to accessing services included the far reaching ramifications of discrimination, such as homelessness and disengagement with education, with possible implications for registering with a GP, i.e. owing to the lack of a fixed abode. Thus, Nodin et al. (2015) reported that LGBT young people were ‘twice as likely not to feel accepted where they live, compared to heterosexual or cis (not-trans) young people’, owing to feeling discriminated against as a LGBT person. Moreover, they reported that ‘nearly 1 in 10 LGBTQ young people (8%) had to leave home relating to sexuality or gender...with about 3/4 of LGBTQ young people (74%) having experienced name-calling, nearly half having experienced harassment/ threats/ intimidation and a quarter having experienced physical assault. Nearly half of LGBTQ young people reported school was affected by discrimination/ fear of it, meaning that they were unable to enjoy and learn, achieving lower grades...’
- In addition, discrimination was in the form of violence and active hate crime, whilst also manifested in more implicit and nuanced forms, which were sometimes difficult to name and challenge. Chakroborty et al. (2011) reported: ‘In the non-heterosexual group, discrimination on the grounds of sexual orientation predicted certain neurotic disorder outcomes, even after adjustment for potentially confounding demographic variables...for most of the participants suicidal thoughts and feelings were bound up in a range of experiences of the negative construction of LGBT lives, rather than linked to isolated events. These included homophobic abuse from parents, failure to recognise the significance of same-sex relationships by friends and family (particularly after a relationship breakdown), perceived parental disappointment at LGBT identification, and rejection from religious friends. Problems included homophobic, transphobic or heterosexist discrimination within educational and health services’. Formby (2011) framed this as ‘invisibility and marginalisation’, and ‘workers assuming heterosexuality in health encounters...a lack of visibility of LGBT patients in materials’.

Conclusion...

The key barriers were: inadequate monitoring of gender and sexuality demographics or tailored needs assessments, despite evidence of high rates of service-use in young LGBT people; poor staff attitudes; a lack of tailored resources; poor provision for young LGBT people who are suicidal; a lack of holistic services to meet the multifaceted needs of LGBT young people given the wide reaching effects of discrimination, including homelessness, educational needs, and the detrimental effects of navigating everyday marginalisation.

2 Are there key health needs that have specific implications for young LGBT people, and for other LGBT groupings?

▶▶▶ Young LGBT people

- Formby (2011a) focused on the sexual and relationships element of health in particular, suggesting that there is a need for same-sex sexual education in the relevant curriculum in schools. One consequence of the current dearth of such education, she argues, is a tendency in the young LGB people she interviewed, to make risk assessment decisions on their choice of sexual partners and practices, based on assumptions regarding the partner's appearance, rather than on the type of sexual acts in which they were to engage. This had negative consequences for their individual health outcomes, in terms of potentially not engaging in healthy relationships or gaining full sexual pleasure, along with possible physical health implications of sexually transmitted diseases.
- LGBT young people were more susceptible than their heterosexual peers to cancers and poor physical health outcomes partly owing to negative health behaviours such as smoking, drug use, inadequate dietary intake (Meads et al. 2009) and alcohol misuse (Chakroborty et al. 2011; King et al. 2003; LGF, 2014; Meads et al. 2009; Nodin et al. 2015).
- It was noted that there were elevated levels of suicidal thoughts and self-harming behaviours in young LGBT people (Chakroborty et al. 2011; Johnson, Faulkner, Jones & Welsh, 2007; LGF, 2014; McDermott, Roen, & Scourfield, 2008; Meads, Pennant McManus, & Bayliss, 2009; Nodin, Peel, Tyler & Rivers, 2015; Scourfield, Roen, & McDermott, 2008; Youth Chances, 2014). According to Nodin et al. (2015) 'rates of young trans people in our sample are particularly high when compared with cisgenders [non-trans people], with about half reporting lifetime suicide attempts and over 80% indicating lifetime suicide ideation and self-harm experience...sexual and gender minority young people still experience significantly more self-harm and suicidal distress than non-minority counterparts.'

'half of trans people report lifetime suicide attempts'

- Connected to the suicidal ideation and self-harm, were indications of anxiety (Chakroborty et al. 2011; Meads et al. 2009), low self-esteem (Nodin et al. 2015), shame (Scourfield, Roen, & McDermott, 2008), body image and eating concerns – the latter particularly in young gay men (Nodin et al. 2015), and there was also evidence of elevated levels of social isolation (LGF, 2014).

- Many of the studies emphasised the importance of viewing mental health difficulties in their social context of homophobia, biphobia and transphobia. Thus, many referred to abuses endured by young LGBT people, (at home, in public and at school) (Youth Chances, 2014), and that ‘discrimination may act as a social stressor in the genesis of mental health problems in this population’ (Chakroborty et al. 2011). Furthermore, according to Johnson et al. (2007): ‘suicidal distress is not simply the result of individualised problems but the response by some LGBT people to institutionalised discriminatory practices perpetuated through education, health, religion, media, family’. Moreover, for McDermott et al. (2008) ‘mental health consequences, for LGBT young people, [are a result] of negotiating everyday settings framed by normative discourses, institutions and structures of heterosexuality’.

‘suicidal distress is not simply the result of individualised problems but the response by some LGBT people to institutionalised discriminatory practices perpetuated through education, health, religion, media, family’

Conclusion...



The relevant health needs of young LGBT people appear to be: harmful ways of judging risk regarding sexual health and relationships; poor physical health owing to negative health behaviours; suicidal ideation and self-harm; levels of shame and resulting mental health difficulties such as anxiety, eating disorders, low self-esteem; and difficulties related to the effects of abuse and discrimination.

Lesbian and Bisexual (LB) women

- Across the studies, there was discussion of high rates of self-harm in L&B women, whether in terms of harmful levels of alcohol and drug misuse, and eating disorders, through to intentionally harming oneself through cutting or banging skin, (Alexander & Clare, 2004; Hunt & Fish, 2008). For the women interviewed by Alexander and Clare (2004), self-harm then, resulted as an attempt to try and cope with ‘unpleasant feelings of detachment and numbness, or intense emotions that eventually could no longer be tolerated’ and specifically in some young L&B women in ‘early stages of developing a lesbian identity, a wish to punish oneself could arise in the context of feeling overwhelmed by, and ashamed of, feelings for a female friend’. In terms of individual markers of mental health, Scherzer (2000, emphasised the need for young L&B women to feel safe, and for McNair et al. (2012), safety was particularly important within the doctor-patient relationship so that L&B women felt able to disclose their sexuality without fear of negative judgement. For Alexander and Clare (2004) then, ‘self-injury can be understood as a coping response that arises within a social context characterized by abuse, invalidation, and the experience of being regarded as different or in some way unacceptable.

‘early stages of developing a lesbian identity, a wish to punish oneself could arise in the context of feeling overwhelmed by, and ashamed of, feelings for a female friend’

- Particular concerns were raised about how a lesbian identity had been explained by mental health professionals as a response to sexual abuse. This shows how heterosexism still underpins some mental health practice and how LGBT identities are often still seen as abnormal developmental responses.

Bisexual people

- Much of the content in the studies concerned health behaviours, such as high levels of alcohol and drug consumption, such as a statistic that 41% of bisexual women and 50% of bisexual men had taken drugs in the previous year. This is six times more likely than women in general, and compares with 12% of men in general, respectively (Stonewall, 2012).

- There was also discussion of high rates of mental health difficulties (Jorm, Korten, Rodgers, Jacomb & Christensen, 2002), eating disorders, self-harm, and suicidal ideation. Furthermore, bisexual people tended to have higher rates of mental health difficulties compared proportionately with gay or lesbian people. This is in no small part due to the invisibility/discrimination faced by bisexual people in both the heterosexual community, and in the lesbian and gay community.

▶▶▶▶ Gay men

- There was scant qualitative research into gay men and health, with much focus on sexually transmitted disease and reduction of disease. This may lead to the over-sexualisation of gay men's identities, which may mean other areas of gay men's health receive less attention/ service provision.
- A theme emerged of self-destructive behaviours, including self-harm and drug misuse, driven potentially by self-loathing (McAndrew & Warne, 2010; Stonewall, 2013). Depression and suicide attempts were also described (Stonewall, 2013). Half of the gay men interviewed by Stonewall (2013) had experienced domestic abuse compared with 17% of men generally.

'Self-harm appears to be a health concern for many lesbian and bisexual women, bisexual people in general, and for gay men.'

▶▶▶▶ Trans people

- Themes of depression and psychological distress were evident in this population (Bailey, Ellis, & McNeil, 2014; McNeil, Bailey, Ellis, Morton & Regan, 2012; Van Eden, Deakin, & Usdin, 2013).
- Linked with this were high rates of suicidality, with suicidal ideation (84% lifetime prevalence), and attempted suicide (48% lifetime prevalence) as reported in the paper by Bailey, Ellis, & McNeil (2014).

- Many trans people reported improvements in their mental health post-transition. 5% stated that their mental health declined, which was attributed to losing significant others and support, because of feeling that people socially ostracised them. Following on from this, 19% of those interviewed by McNeil, Bailey, Ellis, Morton and Regan (2012) reported that they saw their children less frequently after coming out as trans. There were also high levels of homelessness, with 19% having been homeless at one point (McNeil, Bailey, Ellis, Morton & Regan, 2012).
- In addition, ‘20% felt their sex life had worsened following transition, due to decreased sex drive in those on feminising hormones and complications from genital surgery resulting in loss of sensation/pleasure’, with complications for intimate relationships (McNeil, Bailey, Ellis, Morton and Regan, 2012). 70% felt they had lost or missed out on something by being trans, transitioning or expressing their gender identity, including missing out on relationships, work opportunities, and a social life (McNeil, Bailey, Ellis, Morton and Regan, 2012).
- There were high rates of service-use from mental health services, albeit for some this was a mandatory clinical part of their gender identity clinic pathway (Van Eden, Deakin, & Usdin, 2013). With 15% of respondents having used drugs and alcohol services in the study by Van Eden, Deakin, and Usdin (2013), and 62% having reported they had ‘alcohol issues’ in the study by McNeil, Bailey, Ellis, Morton and Regan (2012).
- Broader forms of self-harm were also indicated in this population, such as transmen binding their chests so tightly that ‘the majority reported pain, discomfort, cracked ribs, difficulties breathing...’ (Van Eden, Deakin, & Usdin, 2013). Furthermore, there were parts of the trans population being driven to use medications, such as testosterone in uncontrolled or non-vetted scenarios, such as purchasing them over the Internet. Van Eden, Deakin and Usdin (2013) reported that ‘66% of people knew of the risks of self-medicating, although people reported self-medicating’. Some have cited very long waiting lists for gender identity clinics as the reason to ‘self-prescribe’.

‘66% of people knew of the risks of self-medicating, although people reported self-medicating’

- Trans young people often need fast and timely health care interventions. The onset of puberty creates mental distress for many trans people and can result in irreversible gendered body changes, if no hormone treatment is received. Reed et al. (2005, 2014, 2015), recommend more willingness to prescribe ‘hormone blockers’ (e.g. GnRH) and cross-sex hormones. They suggest the Dutch model for this, which includes a focus on body stage (Tanner Stages) instead of age. They also highlight the need to recognise that more young trans people define as non-binary gendered rather than male-to-female or female-to-male, so health care pathways need to reflect this.
- Reed et al (2015) also note the psychological importance of using a person’s chosen name and pronoun during healthcare interactions, and conversely, the distress caused when health professionals forget or refuse to use the young person’s chosen name/pronoun.
- A further point that was discussed across the papers based on McNeil, Bailey, Ellis, Morton and Regan (2012) was that of avoidance and/or ‘doing nothing’. For example, when respondents had felt they were in an acute period of their mental health, 18% ‘did nothing,’ i.e. did not access urgent help or disclose the level of their distress, owing to fears they had of being stigmatised for being trans (Bailey, Ellis, & McNeil, 2014). Those who did seek support reported mixed responses from health care practitioners, including transphobia (Youth Chances, 2014). This avoidance through fear transgressed the realm of clinical services, to public services more generally: According to McNeil, Bailey, Ellis, Morton and Regan (2012): ‘81% avoided situations due to fear. 50% of these avoided public toilets and gyms, 25% avoided clothing shops, leisure facilities, clubs, social groups. 51% avoided social situations and places because of fearing harassment, being read as trans or outed.’

Conclusion...



The health needs for trans people appear to include: depression and suicidal ideation; detrimental changes in their sex life and relationships more generally as a result of transitioning or coming out as trans; lack of access to timely interventions regarding hormone treatment; alcohol misuse and other forms of self-harm; avoiding seeking help because of the fear of discrimination.

3 What works?

- Services need to see the whole person, and positively reinforce LGBT young people's identities and recognise the resilience already employed by young people. For instance, Scourfield et al. (2008) stated 'LGBT young people employ strategies in the face of distress.' They emphasised the importance of health workers being able to hold in mind the reality of an increased risk of self-harm and suicidality in LGBT young people, whilst also avoiding a deficit model by not making assumptions that all LGBT young people will be distressed i.e. owing to homophobia and other discriminations. Moreover, for Scourfield et al. (2008), given the level of continuing discrimination towards LGBT young people, there is a 'need for ecological approaches and for sexual cultural competence in practitioners'.

'hold in mind the reality of an increased risk of self-harm and suicidality in LGBT young people, whilst also avoiding a deficit model by not making assumptions that all LGBT young people will be distressed'

- It was noted that many young LGBT people search for LGBT young people's support groups (Meads et al. 2009; Nodin et al. 2008; Scourfield et al. 2008). Such support groups could be in the form of LGBT young people's youth provisions, specific health support groups, and targeted addiction support groups. Nodin et al. (2015) described some of the benefits of such tailored spaces as facilitating: 'forgiveness of the self, contributing to enhanced self-esteem amongst LGB&T [people]...means of self-expression and regaining control... support from close allies, sensible professionals or other formal resources (e.g. support groups/specialised units)'. Moreover, Meads et al. (2013) described the benefits of such provisions in 'reducing isolation and alienation through the formation of interpersonal connections'.
- For Formby (2011a), the World Health Organisation's conceptualisation of sexual health needs to be operationalised to underpin sexual health services, in order to move away from a focus on 'penetrative heterosexual sex and/or protecting young people's "innocence" at the expense of lesbian, gay, and bisexual young people's health education, and understandings of safer sex'. One way to facilitate such a change would be through the training of staff in health and education, about the specific needs and experiences of LGBT young people, and of young women in particular, given that they appeared particularly neglected in current LGBT resources. Formby (2011a) stated that 'LGB awareness courses are available - often a simple change in pronoun helps inclusivity ("they"/partner' rather than 'he'/she'). For sexual relationships education to be inclusive, an equalities, human rights foundation to all learning and advice about sex and relationships must be adopted that foregrounds the right to sexual health/pleasure for all.

- A further theme to improving access and inclusion for all was that of ‘increasing genuine and authentic patient and public involvement and voice’ (LGF, 2014), particularly in terms of LGBT young people specifically (Johnson et al. 2007; Youth Chances, 2014) and a tailoring of services to the specific needs of LGBT young people (Kelleher, 2009).
- Attention needs to focus on changing oppressive cultural contexts in which LGBT young people live, and so interventions need to address challenging heterosexism at cultural and individual levels and to promote social change toward inclusivity. Moreover, McDermott et al. (2008) described the difficulties for LGBT young people of negotiating homophobia in everyday interactions, owing to the construction/ reproduction of heterosexuality as the most legitimate sexual orientation. Johnson et al. (2007) emphasise this point: ‘...the term ‘gay’ to refer to something ‘lame’ and ‘rubbish’, or as a form of insult, and the impact this had on their feelings of self-worth. Negative constructions of LGBT lives impact on people’s ability to form a positive self-identity within a heterosexist, homophobic and transphobic climate. This can lead to LGBT people internalising feelings of low self-worth and shame, alongside fear of abuse and rejection, and these feelings are exacerbated by institutionalised forms of discrimination’.

Interventions that are useful to this population are: services and practitioners who focus on bolstering resilience; young people’s support groups; training for staff in delivering tailored health services (e.g. sexual health services) and training in reflective and inclusive language-use, e.g. not assuming pronouns; active engagement and involvement of LGBT young people in the design and delivery of services; and a need for services which engage with the social and political context, and actively redress effects of discrimination, including in terms of institutionalised discrimination.

4 What can we learn to apply in Manchester (in health settings and in the voluntary sector)?

- Adopt and develop services (generic and targeted) which explicitly recognise the specific oppressions that young LGBT people experience, which are tailored to their particular needs, and which also work to enhance the resilience in this population.
- Protect youth provisions for LGBT young people to meet in a space in which discrimination and heterosexism is actively deconstructed and challenged.
- Facilitate discussions involving LGBT young people directly in designing and defining the scope of services, e.g. sexual health and relationships education, health curriculum and mental health services.
- Value-based interventions provided both by the statutory and voluntary sectors, and where possible in collaboration, which actively redress the effects of discrimination and bolster LGBT young people's sense of participation, agency and power in the world.

▶▶▶ Lesbian and Bisexual women

- One recommendation was that LB women's individual mental health difficulties and coping behaviours such as self-injury, need to be viewed within the context of discrimination, othering, and invisibility, of which services currently appear to replicate, with '6% of L&B women reporting that healthcare workers had made inappropriate comments in response to a disclosure of her sexual orientation' (Hunt & Fish, 2008).
- Viewing LB women's rights as a part of a wider context of human rights was emphasised by Formby (2011b) 'a human rights perspective should be used to inform future health service provision. LB women should have the same quality of sexual healthcare as other women in England'.
- There was discussion of wider cultural scripts, with according to Power, McNair, and Carr (2009) a need to write 'a new cultural script that encompasses L&B women ...[to] contribute to making lesbian sexual practices more visible and risks more tangible'.
- Moreover, a specific acknowledgement is required regarding how young LB women face triple disadvantage, given a tendency for practitioners to somewhat dismiss disclosures of sexual orientation because of their young age, and gender (Scherzer, 2000).

- Alexander and Clare (2004), for instance, described a sense of belonging that came about for some of the women in terms of belonging to Lesbian and Bisexual women's groups, which positively impact on their self-esteem and create a sense of having something to fight for, i.e. equal rights. Moreover, for the young women interviewed by Scherzer (2000), identified that targeted, smaller and specific services were preferred, especially in terms of 'the interpersonal interactions' the women experienced with their health care providers.
- Sensitivity and respect from practitioners had a tremendous impact on the perceived quality of the health care interaction, Scherzer (2000). Care was also demonstrated by dialogue and a more inclusive sense of 'health'. Provider sensitivity to the barriers to medical care, especially with regard to gynaecological examinations, unequivocally contributed to a positive health care encounter.
- Tailored services and targeted information, advice and guidance to LB young women's particular needs is essential.
- 'Workers need to be welcoming, understanding, and knowledgeable about lesbians' needs' (Formby, 2011b; Hunt & Fish, 2008); This should happen through 'L B women's sexual (human) rights being respected and protected within much Department of Health, and National Health Service policy and practice' (Formby, 2011b). There should be unambiguous information and guidance in consultations, anti-discriminatory policies clearly displayed for all to see, complaints procedures, clear resources for LB women with details about sexual activities and sexual disease transmission information, along with information about sexual pleasure and healthy relationships.

»»» Bisexual people

- Healthcare services need to better address the needs of bisexual people through engaging in training of staff in awareness of issues pertinent to bisexual people.
- Services need to actively engage bisexual people in devising policies and in consultations regarding service improvements, and not presume that consultation with the lesbian and gay population will provide the same function.

►►►► Gay men

- Healthcare professionals need to be ‘knowledgeable of the issues facing young gay people’ (McAndrew & Warne, 2010), i.e. through initial training and continual professional development that includes the specific needs of gay men.
- Healthcare professionals should be reflexive in their practice, particularly regarding their own prejudices and assumptions. This will hopefully aid the trust underpinning the professional-patient relationship, ‘a gay affirmative stance on the part of a therapist has been found to counteract the effects of homophobia’.
- ‘Doctors and healthcare workers should encourage disclosure by asking open questions and having clear confidentiality policies’. Gay men need to feel confident that their ‘disclosure’ of sexual orientation will be treated in confidence, and also be clear about the anti-discriminatory stance of the service, through posters and clear information.
- In addition, it was recommended that sexual orientation data is routinely collected, and improving the experiences of gay men in health services should be a national policy priority.

►►►► Trans people

- There was a preference expressed towards non-statutory and community services, and services offering helplines, online support, face-to-face support and peer support from other trans people.
- Trans health and awareness training to all healthcare staff is required in order to reduce discrimination and enhance understanding.
- Adequate monitoring and data collection regarding numbers of trans people accessing services is needed.
- Tailored and inclusive services are needed to address the specific needs of trans people, including the high rates of suicide ideation.
- Supportive and timely interventions are recommended, including access to gender reassignment, hormones (and ‘blockers’), as well as patient-centred services with choice and informed consent at their heart.
- Trans people must be consulted about their own care, including at a commissioning and policy level, along with a need to acknowledge and engage with people of more fluid and non-binary gender identities.

PRACTITIONER POINTS

- There is a need for routine gender identity and sexual orientation monitoring in all health settings.
- Practitioners would benefit from sensitively considering the stigmatised context and discrimination affiliated with LGBT identities, attuning their service delivery to actively redress homophobic, transphobic and heterosexist messages (along with considering the intersections of these oppressions with sexism, racism, ableism and ageism etc). An awareness is needed of the resulting isolation, mental health difficulties, suicidal thoughts and self-destructive behaviours that seem prevalent in many LGBT young people.
- Practitioners need to help support and bolster resilience, and promote positive LGBT identities.
- Resources need to be invested into actively combatting ongoing stigma and discrimination towards LGBT people.
- Practitioners should aim to reflect upon their own assumptions and prejudices. Simple changes such as using neutral pronouns and asking people what their preferred pronoun is can make a real difference. They should engage in training and development opportunities with the aim of providing accessible services and tailored services to the specific needs of LGBT young people.
- There are specific needs within the four different identities encapsulated in the term LGB&T. These require tailored responses and consideration; from the underpinning philosophy of the service, to the service's resources, to the training and attitudes of staff.
- There is a need for holistic approaches that attempt to address the needs of LGBT young people. For example, clinical psychology (and other therapeutic services for those in acute distress and experiencing suicidal ideation), must also be aware of housing, education, and sexual health needs and services. Thus, health and social care need to be working together.
- The people directly affected, i.e. LGBT young people, should be actively consulted at all stages of service development, commissioning and delivery.
- There should be a recognition of the desire for specific youth provisions, and creative forms of delivery. This should include multiple forms of engagement including online support, peer support and facilitated group discussions, in combination with one-to-one interventions.

THANK YOU



To all the academic colleagues of The Proud Trust who have helped create and shape this research.

The full document: Fay, V. (2016). 'Lesbian, Gay, Bisexual and Trans* (LGBT) people's health in the UK – key health needs, barriers to access, and implications for best practice: A literature review with a particular focus on the needs of young LGBT people' is in preparation for publication.