HOUSE OF COMMONS

Women and Equalities Committee

Oral evidence: Health and social care and LGBT communities, HC 1492

Wednesday 15 May 2019

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Watch the meeting

Members present: Mrs Maria Miller (Chair); Sarah Champion; Angela Crawley; Eddie Hughes; Stephanie Peacock.

Questions 50–106

Witnesses

I: Helen Jones, Director, MindOut; Dr Igi Moon, Researcher/Practitioner, CliniQ; Dr Joanna Semlyen, Senior Lecturer in Psychology/Medical Education, University of East Anglia.

II: Rosie Stamp, Research Lead on Children and Young People, Healthwatch Suffolk; Niazy Hazeldine, Youth Manager, METRO; Cecily Ward, Service User, METRO.

Written evidence from witnesses:

- CliniQ CIC
- Healthwatch Suffolk CIC
- METRO
- Dr Joanna Semlyen

Examination of Witnesses

Witnesses: Helen Jones, Dr Igi Moon and Dr Joanna Semlyen.

Q50 **Chair:** Welcome to our witnesses and to those who are watching online. This is our second evidence session for our inquiry into health and social care and LGBT communities. Today we are hearing from two panels of witnesses, the first focusing in on mental health, and then the second specifically looking at the needs of young people. We are going to follow the usual practice, so Members have a variety of questions to ask.

I apologise in advance because there will be Members joining us and the usual to-ing and fro-ing, which is inevitable in these sessions. We are going to have Members asking questions, but before Sarah kicks off, could I ask you to say your name and the organisation you represent?

Dr Semlyen: I am Joanna Semlyen, and I am at the University of East Anglia.

Helen Jones: I am Helen Jones, and I am the chief executive of MindOut, the LGBTQ mental health service.

Dr Moon: I am Igi Moon, and I represent the BPS. I am based at Roehampton University and at Warwick.

Chair: Brilliant, that is great.

Q51 **Sarah Champion:** Thank you all ever so much for coming today. We have received quite a lot of written submissions already, and one thing that has come across is a suggestion that LGBT people are more likely to have mental health issues or concerns than non-LGBT people. Is this something you recognise? If so, why do you think that would be? If I can rattle down the panel, I will start with Joanna.

Dr Semlyen: We definitely recognise that there are disparities in mental health experienced by LGB people. We have data that shows that we have potentially four times greater risk of suicide in gay men, for example. We have around two times higher risk of common mental disorder across lesbian, gay and bisexual populations. That is from UK data. What was the second part of your question?

Q52 **Sarah Champion:** Basically, do you think there is a disparity between mental health for LGBT people and non-LGBT people?

Dr Semlyen: I do. By expressing that in terms of population differences, we can definitely observe it.

Q53 **Sarah Champion:** Has your research started to consider why that might be?

Dr Semlyen: There are lots of reasons as to why that might be that have come up within research evidence. Very briefly, we know that minority stress is a very important aspect—that is a repeated exposure to discrimination, to anticipation or fear of rejection, and to anticipation or fear of experiencing

homophobia.

If you think about that as a cumulative effect across somebody's life, it might start at school but might continue throughout someone's lifespan. Every time someone is anticipating coming out, every time someone is anticipating meeting somebody new, there is an anxiety and a potential risk of experiencing discrimination or, indeed, something more extreme, such as homophobia. If we think about that as an experience that someone is carrying with them, that would be a very helpful and, in a way, almost obvious expectation, that would explain that.

It is important to say that, in terms of research, we do not have much that explores what we would call that causal pathway. We have that theory, and there is some evidence that links through the experience of stress or risk factors for disease associated with stress, but we do not absolutely know as yet, from a research perspective, what might explain that, if that is helpful.

Q54 **Sarah Champion:** Yes, that is really helpful. Helen, you are on the coalface of this. What are your thoughts?

Helen Jones: I would echo what Joanna said about the research and what that demonstrates. Some of the statistics are really shocking. For instance, 52% of LGBTQ people who were asked had experienced depression in the last year, compared to 3.3% of the general population. That is a huge disparity. We are also very concerned about the rates of suicidal distress among all sections of the LGBTQ community, but particularly for people who have intersectional identities. We see that a lot—that people who have more than one oppressed, discriminated identity will experience worse mental health.

For instance, we started a project working with older LGBTQ people. Again, the rates of common mental health problems and suicidal distress are so much higher among older people, people over the age of 50, but particularly people over the age of 70. That is one of our main areas of concern at the minute. Yes, the stats really bear that out in practice. Over the last five years, we have seen a vast increase in people coming to us for LGBTQ-specific services, many of whom have not accessed mainstream services at all. People are treating us very much as a frontline primary care service for their mental health issues.

As to why that is the case, I would echo what Joanna said about minority stress. That goes a long way to explaining why the rates are so much higher in LGBTQ communities. The minority stress for people with intersectional identities—I cannot say that enough—is very much worse. I thought that was really borne out in the Government survey that was recently published and the information they found out about people not making public displays of affection. That is part of minority stress: constantly scanning to see if it is

safe to be out in whatever way you want to be or have a choice about. Of course, some people do not have a choice. They are completely outed by their appearance. That can be really hard for people. Yes, minority stress goes a long way to explaining that.

I also think of the kind of heteronormative and oppressive experiences that people have early in life. When you first come out, within your biological family, your school or whatever environment you are in, the kind of reactions you get then can lead to poor mental health later on. They are really formative for people finding a positive identity or not. The amount of shame and remorse that people live with about their identities is still really effective.

Q55 **Eddie Hughes:** Would you expect that to diminish as we see, for example, better role models in films and TV programmes? I appreciate I am approaching this from a different side of the argument, but society seems to be becoming more tolerant and more understanding, and we are better educated, so all those things, I feel, over time will improve. It feels like the direction of travel is a positive one so far. I appreciate we might argue about the rate of change, but you spoke about people over 70, for example. I imagine they grew up in a totally different environment to the one that we see today. They must, to a degree, look at younger people and think, "I wish it had been more like that when I was young," or am I just completely wrong?

Helen Jones: That can definitely have a very positive effect in some ways for some people. I suppose that is very much the public face of greater acceptance. Yes, more media exposure of positive LGBTQ lives is great—bring it on! That is really good, and that will be good for community mental health, but within that there are still an awful lot of people who are incredibly vulnerable. Sometimes, too, it can bring out the backlash; it can bring out the more negative attitudes as well. Despite those very positive things that you have mentioned, the mental health of younger LGBTQ people is of huge concern.

Q56 **Sarah Champion:** Igi, can I turn to you?

Dr Moon: In my work as a practitioner, over probably the past 30 years now, because of societal changes that we can all recognise as happening, for some of the people who present issues, those issues may have changed over the past 30 years. However, within the trans and non-binary community there is still a lot of anxiety. While disparities exist between LGBT and the mainstream, there are disparities that exist within the community as well. I worked within alcohol and drugs for over 20 years in relation to LGBT. We could certainly show the voluntary sector, as well as the NHS, that people need to access those services because they have certain needs that they felt afraid of talking about. There are life experiences in other settings. The

research bears out that professionals are not really clued up about it.

Q57 **Sarah Champion:** I'm interested that, rather than dealing with LGBT, you said that there were disparities within that group. Could you just give a few more examples on that?

Dr Moon: If I go back, for example, to when I worked in a lesbian and gay alcohol counselling service, bisexual and transgender did not even figure in it. As time moves forward, there are more demands for that service, and Governments recognise the needs of different populations, and services like Antidote begin to offer services to more people who may identify as pansexual, as queer, as gay, as lesbian. The way that people are identifying is changing, and, with that, there are more nuanced disparities that someone may have to talk with a practitioner about. Does that help?

Q58 **Sarah Champion:** Kind of. I thought you were going to say you were seeing, for example, higher mental health issues leading to suicide within the trans community, rather than the whole of the LGBT community.

Dr Moon: Yes, I think that is the case. Those variations are happening. Within the trans community, we can say that the level of social aggression is such that people are very afraid of going out into certain places or to certain venues, or of living in certain parts of the UK. Those are very real fears, and fear is what generates a lot of anxiety within our society, and the idea of difference, the idea of "What do we do?" and the panic that can set in. There are disparities. Within the trans and non-binary community, we are beginning to acknowledge some real need to address issues around suicidality, which is showing an increase, especially among young people.

Q59 **Eddie Hughes:** Clearly there is a problem, so what are the best ways to improve the health of LGBT young people?

Dr Moon: Look, it is 2019. I have just turned 60. I have been doing this since I was 24 years old.

Eddie Hughes: You are looking very good.

Dr Moon: Well, it is a hard life out there. It feels to me like this is a wonderful opportunity for changes to be brought about, within these communities, but also within our larger society. It requires radical rethinking at some level. I am often asked, "Why do we need specialist services?" It is not so much that we need specialist services as that we need to recognise that some people have not been able to live a life in our society that has given them access to certain sorts of treatment.

Basically, the leaps that are needed are for younger people to be able to enjoy school, where they can actually begin to feel that it is okay to be how they wish to express themselves, which we are seeing more and more of. With adults, we need to provide services that people can access without

feeling under duress. While I acknowledge that the NHS does a wonderful job, my own research shows that practitioners are lacking in knowledge that helps them to work with LGBT people. That needs to improve a great deal, certainly within training. More walk-in services would be handy.

Dr Semlyen: It is an extremely complex question and an extremely complex answer, but there are different levels at which we could think about how we can address mental health disparities. With a magic wand, we would have a society that made no judgment, where diverse identities were acknowledged and fully accepted. That aside, to pick up the point about access, we need to understand that access to services and barriers to access are a very important element, but we should not make responsibility for that either the population's fault or the provider's fault. Actually, it is a combination. It is a multifaceted issue.

We could think about the fact that we have LGBT people who are not getting any treatment at all and what that will be doing in terms of developing, perpetuating or, indeed, exacerbating mental health. They may be too anxious to attend those services. They may not want to openly seek any support, like many other people might also feel—there are some issues that are general population experiences of mental health treatment. They may have had a poor experience before or know other people who have. We need to think about that in terms of people anticipating, and therefore not going for services. They may not be getting what we would call timely treatment. We know that, if we leave something long enough, and people are not turning up, attending or presenting with a mental health problem, that may well exacerbate. We know waiting lists are long, so that is a general issue, but people may be delaying because of the reasons I have just outlined for why they are perhaps not going at all. They may then be presenting when things are much more serious. We need to understand that aspect of this.

People may not be getting appropriate treatment, in the sense that they are going somewhere and receiving services, perhaps, from practitioners who, as we have touched on and I am sure will be picked up further, are not fully trained. Perhaps, with the best will in the world, they are misattributing someone's presentation with a mental health problem to that person's identity, when in fact that person is attending because they are experiencing a mental health issue that is utterly unrelated. That inappropriate help is not only going to not treat that person, but may potentially put them off seeking mental health services.

The final point about access is that people might then be self-managing. They may be choosing the internet as a source, which is a very positive aspect if it is constructed—let us come back to that—but they might be selecting the internet as a source of support, and they may therefore be ending up in a very unsafe situation. They may also be self-managing in

ways we understand are unhelpful, in terms of substance use. That is just to pick one aspect of what you asked. Access is key. I have lots of other things I could say about concepts of interventions and stuff, and I am very happy to come back to that, or I can pass over, as you wish.

Eddie Hughes: I am just thinking about time constraints.

Dr Semlyen: Indeed, I am very mindful of that. That is fine.

Helen Jones: What we find is very effective, which I think is under-researched and underfunded, is the value of community development around mental health and engaging with our communities to develop peer support. A lot of people want to talk to each other and find safe spaces where they can talk about their experience of mental health issues and being LGBTQ. That part of our work has mushroomed over the last 20 years. It really is phenomenal.

It can be quite transformative for people to find that what you have been through is meaningful for other people. Other people can learn from that. Talking about what has been awful for you can be really supportive for somebody else. That is a really helpful thing, both in terms of preventing mental health issues further down the line and for helping people recover from the crises or difficulties they have been through. I would really advocate more research and more funding for that area.

We also offer advocacy. Having independent support for negotiating mainstream mental health services can be invaluable in helping people get the best out of what services are out there. An awful lot of people come to us because they are nervous about asking for help. That is about both real and perceived prejudice and stigma within the services that they want and need to access. Anything that creates a barrier to getting help we can do a lot to remove. Anything we can do is helpful. Services that are provided by and for LGBT communities are obviously my shtick, but it really does work.

Q60 **Eddie Hughes:** The Government have pledged to tackle body image pressures on young LGBT people as part of their action plan. How much of a priority is that, in your experience?

Dr Semlyen: I could answer that in regards to very recent research showing that gay and bisexual men have unhealthy BMI. They are underweight, so they are below what we would call a healthy weight range of BMI. It is highly probable—again, we have no causal pathway data, but we have a very good understanding of the gay and bisexual male community—that that comes from pressures within that community around body image. That is a very important piece of evidence that might mean this needs to be looked at.

I appreciate that body image is one of a range of mental health issues, and I think that is an understandable question, but when we have evidence

indicating at a population level in the UK that we have that health disparity for that group, perhaps it is something that needs to be looked at.

Q61 **Eddie Hughes:** Within that multiple range, I am thinking of the priority element of the question. Is it because of the lack of data that you might have no feeling of where that would be in terms of how significant the issue is.

Dr Semlyen: It is significant because it is linked to physical health. I am mindful that we do not have an answer as to what would be most significant, in terms of having analysed that at a research level, but we can look at prevalence of certain mental health conditions.

My feeling would be that, if we were addressing mental health per se in terms of provision of services, access and some of the other issues around making them accessible, it might be possible for a range of multiple mental health issues to be dealt with. Bearing that in mind, if I was asked to say what I thought was a priority, it is fairly obvious, with the high levels of suicidality, that we need to be thinking about that as a particular issue for this population, but not so that other issues are side-lined.

Of course, those two things are completely related. The existence of mental health problems is an indicator, and is directly linked to the possibility, of suicidality. Sometimes it is understandable to want to simplify. That is a completely understandable thing—to think about what we should prioritise—but if we understand the relationship between mental health and suicide, perhaps the issue is mental health as a whole and making services available for anybody, regardless of what their presenting problem is.

Dr Moon: In relation to body image issues within trans and non-binary communities, it is particularly prevalent and has a great deal of bearing on why services need to change at some level. For example, I have worked quite recently with a number of people from the trans and non-binary community who, because they do not particularly like their body image, and the way that they do not feel comfortable with their body, have developed eating disorders and substance use disorders. At some level, when they accessed treatment, that was not recognised. In terms of eating disorders, they were seen as the sex that they were born with, rather than the gender that they wish to present as. This has caused far more distress and has led to even more problems around body image.

Secondly in relation to body image, a number of people within the trans and non-binary community in particular are finding it more and more difficult to access treatment. It is very, very difficult, and I can say this from personal experience of people I have worked with. For someone who has reached their 30s or 40s and is just coming round to the idea that the body they do not feel comfortable in is not the gender they wish to present as, the first

place they want to access is not the GP. Yet we usually expect people to access the GP in order to have a referral to a gender identity clinic, which itself can take several months.

Q62 **Eddie Hughes:** Through the GP is the only gateway to the gender identity clinic.

Dr Moon: Yes. I am finding in my own practice, and from anecdotal evidence, that some people are now taking hormones illegally, accessing hormones online. We are about to start some research to find exactly what those figures are across the UK. Basically, the idea of one's body image for people who are trans and non-binary can be incredibly distressing, to the point that it is causing people to want to die, and they are dying. We need to recognise that some of these issues that are arising are very real problems for people. They simply do not know where to go.

I was looking at the LGBT Foundation, and I thought that the online material was absolutely superb. I only hope that people can access something like that on a more national basis. These are people who may be in their 30s or 40s. They may work as an MP or as an engineer. They simply want to find out, "Where do I go to talk about this horrible feeling that I have, that this body is not how I want my body to be?" It is very difficult to know where to tell people to go.

Q63 **Sarah Champion:** You said they are rarely presenting first at their GP. Do you have any understanding of where they are presenting? Are they not presenting, or is the first presentation when they attempt suicide and they are in A&E?

Dr Moon: Many of them will try to find what is online.

Sarah Champion: That would be the normal first port of call.

Dr Moon: That might be a starting point. In London, we have CliniQ, and people can contact CliniQ. It is a walk-in holistic service, but, unfortunately, only for three hours on a Wednesday evening and now on a Tuesday evening. It has the largest number of trans and non-binary people accessing it across Europe. That, as a service, provides an idea of what we need more of in the UK.

People need something that helps them to find a safe space where they can begin to feel that they can talk about what is happening for them, as well as beginning to access the thinking around hormones, or maybe even where they may even wish to go further down the line. That really needs to be updated, I feel, because at the moment, from the people I am working with, the evidence quite strongly suggests that there are a lot of people feeling as though there is nowhere to go, and they really do not know where to start. GPs, with all due respect, are also struggling with what to say and what to

do.

Q64 **Eddie Hughes:** I think I understand the problem. I am not sure I understand the solution from the Government's point of view. Where would they start with regard to improving? If they are going to tackle the pressure of body image, where should the Government start in terms of making an improvement? Should they be highlighting some way of not needing access through a GP? What would you do if you were the Minister?

Dr Moon: I would like to look at what we have available in terms of services like CliniQ, which do not need to be attached only to sexual health but are a counselling service. We need more online services like Gendered Intelligence provides, where people can ring up and find out where to go next. The GP is not always the most sensitive person for somebody to be discussing their gender identity with, or their body image in relation to a gendered body or a sexed body, where they do not feel this person will understand what they are talking about. Waiting rooms do not seem to be easily accessible.

If I was the Minister and I had that fortunate position, I would probably want things to be far more sensitively and creatively open to LGBT people across the board, but trans people and young people in particular. There are many ways that can be done, by bringing on board the organisations that are already doing it but probably need to be heard a little more.

Helen Jones: Following on from what you were saying, if I were the Minister, I would cut waiting times in gender identity clinics. Quite often, people have been through an agonising process to get as far as a referral to a GIC, and then have to wait and wait and wait, and have appointment after appointment cancelled. You get your hopes up.

Q65 **Eddie Hughes:** Can you give me a feel for it? You say "wait and wait and wait". How long would people typically be waiting?

Helen Jones: It can be two years.

Dr Moon: It is 12 months or longer. It was four years at one time at Leeds. Sorry, I do not mean to interrupt too much, but I do have to say that waiting times are increasing mental health distress. We are working now with people, young people and older people, who are accessing hormones illegally, from friends, because they simply want to feel differently in their body.

Helen Jones: Sorry to interrupt. There was an initiative to enable GPs and endocrinology departments to prescribe bridging hormones for people who were waiting. Unfortunately, nobody will prescribe bridging hormones, because they do not have the expertise. It is not happening.

Chair: Can I draw us back slightly onto mental health issues rather than

gender identity clinics particularly?

Eddie Hughes: Sorry, I got caught up in the fascination.

Helen Jones: In terms of body image, that is really important. Yes, to go back, body image was the original question, was it not? For an awful lot of people, their mental health is very tied up with their body image. One way or another, body image will come into it. For people who are trans and non-binary, that is going to be a massive part of their mental health struggle, coming to terms with what is happening to them and how much their physicality is involved in that. That is very true across LGBTQ communities.

For instance, another group we are very concerned about is older gay men, men reaching their 40s or 50s, and how they feel about their bodies. They might not feel as confident in their physical presentation as they did when they were younger men, if they have put on weight or they are not so fit. That can be involved in the really low self-esteem that some of these men have, and a constant, underlying suicidal distress: "What am I going to do? Are things ever going to get better for me?" Feeling excluded from sites of community support that you accessed when you were younger, and feeling like that is not available to you any more, can be very depressing. There are not very many alternatives for people. I would like to raise them as an example of what can happen around body image.

Q66 **Chair:** When it comes to mental health provision for LGBT people, it is sometimes offered by charities, like the ones you come from. What are the benefits and drawbacks of using charitable organisations in that way, rather than NHS primary care?

Dr Semlyen: I do not work in the charity sector, but I will respond to that, thinking about capacity alone. It feeds into the previous question; I was going to say this to that one. The provision of services through charities is part of the way forward. We must also invest in our existing, extremely skilled mainstream services. In regards to the body image question, in a way, which is an example to use, there will be a huge number of very skilled people working on that particular issue for people, but, if that organisation or those skilled professionals are undertrained in terms of understanding the specificity of an LGB, T or Q presentation and its relation to body image, some very good training could increase and improve that existing service and make it better able to meet those needs.

The charity sector, which will be described perfectly by Helen, is already a very skilled set of people who understand the population. I propose working together, allowing particular districts to commission charity services because of their skill, but not forgetting the NHS skill set in terms of addressing mental health, so working together. That is somewhat pragmatic, but also maximising our skill set in both sets of organisations.

Chair: Dr Igi, would you have any thoughts on that?

Dr Moon: Some of the differences are as Jo is suggesting, but access to services also varies. In a charitable organisation, people's expectation is that they will access those services relatively quickly. It is not always the case, but within four to six months people can be moved from a waiting list into therapeutic care. There are a number of things in this that are quite interesting. The NHS and the more mainstream primary care services tend to have a certain model. It is wonderful that they do. I train young psychologists, and I am very aware of IAPT and the services that are offered.

In terms of therapeutic services, though, the charities can offer a wider range of models. It is really vital that they are not fixed to a set number of sessions, six to 12 sessions. They may find that they can offer more sessions, they can offer a different type of model or they have a far greater number of volunteers. Those volunteers tend to be in training, so it is quite reflexive. It means the trainees can bring their knowledge into the charitable sector, and can be quite reflective and reflexive in that sector to move back into the academic setting.

Q67 **Chair:** Can I just be devil's advocate here? Are you risking marginalising mental health for LGBT people into some quirky little charity over there—I am being very argumentative—rather than saying, "For the most part, these issues should be dealt with in the mainstream"?

Dr Moon: That is one of the debates that is often around. The mainstream tends to be predominantly, not exclusively but predominantly, heterosexual and cis-gendered.

Q68 **Chair:** What if we are going to change that, or if one is going to make that more inclusive?

Dr Moon: We should work as a partnership. A partnership would be an ideal situation. At the moment, if you look again at CliniQ working with King's, those partnerships work exceptionally well. I would be rather fearful, and my experience in the past has been, that when voluntary sector agencies and the NHS come together, at times the voluntary sector agency is lost in terms of recognition. Those services offer something quite unique and nuanced that we should not lose sight of either.

Q69 **Chair:** Are there particular skills that mental health professionals need to develop to be able to support LGBT people, either in the NHS or in non-mainstream provision? Are there particular skills that are different?

Dr Moon: Yes. For example, if you were to think of reproductive technologies, a colleague of mine is presently working on trans men who become pregnant. That would be quite challenging for some NHS services that have a particular view about pregnancy, reproductive rights. The

knowledge from that particular area of work should be fed into the NHS around reproductive rights, but also to help people recognise issues around reproduction.

Language is fundamental to some of this. The idea that we talk about bodies in a binary way, male and female, is problematic when you have a population who do not wish to use or describe their body in the way that is taken for granted in more mainstream services. It is about language, it is about time and it is about making sure we hear each other on both sides. It does not need to be a ghetto, but I found in my own research that, in training, issues related to intersexuality are often ghettoised. Then the mainstream of training excludes what that language was trying to bring to the table.

Q70 **Chair:** In this area, are there any quick wins that you think could be adopted to help improve the situation, in terms of the skills of health professionals?

Dr Moon: Obviously, in terms of young people—this is an area that we might talk about later—that is the ideal starting place, because people can recognise life in a very different way, and then it is not a shock later on.

In terms of training, some of the issues we are talking about should be made more mainstream in the training rather than sectioned off. I work with doctoral students who, up to the point that they come into training, have never thought about trans-related issues, lesbian, gay, bisexuality. It is just not something that has been on the agenda of the curriculum development. It often is a bolt-on. It needs to be much broader than that.

Chair: And much earlier on.

Dr Moon: Yes.

Chair: We could go on, but we should move on.

Q71 **Stephanie Peacock:** The Government, as part of their action plan, have pledged to end the practice of conversion therapy. Do you support this? If they are going to do it, what would you suggest the Government need to do? What sort of therapy should be included under this banner?

Helen Jones: Absolutely, the ending of conversion therapy must happen. It is shocking what the survey has revealed about how much there is and where it is taking place. It has revealed the extreme end of conversion therapy, but there is an awful lot more to it as well. It goes back to a bit of what you were saying about the need for training, because we still find that, even in mainstream NHS services, for a lot of practitioners, at the back of their mind when they are talking to LGBTQ clients, is how much of people's distress is linked to their identities: "If only they were a 'normal' heterosexual or cisgender person, they would feel much better." That is not

conversion therapy. It really is not, but it is on the same spectrum as conversion therapy—"If only we were normal, everything would be all right".

We also find some practices within mainstream mental health services where nurses—the examples are nurses; no research has been done to see how widespread it is—are praying with clients that they will become heterosexual and then feel better. This is happening in mental health services, as we speak, in the NHS. That is not acceptable. Any of those practices needs to be addressed, along with the extreme of conversion therapy.

Dr Semlyen: To follow on from that, one of the things we need to be mindful of is that LGB and T people may be presenting for therapy, if we are talking about particular therapy provided by psychotherapists as an example, because they are considering their identity. They may be arriving with an identity issue to discuss, and it could be—I am saying this intentionally to offer a broad perspective—that it is sheer ignorance and misunderstanding that the therapist is acting in that way. That is really echoing Helen's point that there is quite a lot of nuanced and grey area, rather than people who are actively trying to alter somebody's sexual orientation or gender identity.

In terms of addressing that, we need to think about regulation and legislation. That is probably quite straightforward, in a way, within therapy settings. However, conversion therapy is happening in lots of settings that are not in any way either regulated or, in fact, known about. It could be this image of a bedside nurse, but it is also happening an awful lot in faith settings. That is where the difficulty is in terms of regulation. I know that there is a move towards legislation around conversion therapy. We just need to be very careful about what it is we are defining that as in regards to settings as well as process, so that legislation can be meaningful.

Dr Moon: I am the chair of the coalition to bring an end to conversion therapy. We launched our memorandum of understanding with Ben Bradshaw last July, and 16 organisations have signed up to the idea of bringing an end to conversion therapy. We have used that particular term because the idea of trying to define conversion therapy is incredibly difficult, we have found. We do have a definition, which I do not want to bore you with, but I can send round the document if you want it. The idea is to protect the public—that is, LGBT people as well as asexual people—because as the LGBT survey found, in terms of sexual orientation, asexual people were the most likely group to undergo and be offered conversion therapy. More trans men had been offered conversion people than non-binary people or trans women, but more trans women had undergone conversion therapy.

Equally, while the survey showed that the numbers having undergone conversion therapy may have fallen, the numbers being offered it are rising. As Jo has just said, by far the greatest numbers of people offering it are in

faith organisations. Second on the list were healthcare or medical professionals, which we probably need to tackle. That comes back to that idea of training. The organisations that have agreed to this document, including NHS England and numerous therapeutic organisations, are trying to make sure that we monitor how sexuality and gender is placed in training quite early on, so that people are aware of what conversion therapy may mean and are able to say that no gender identity or sexual orientation is better than any other.

Now, while that is a great way forward at the moment, we have some issues where organisations are saying, "However, if we offer hormone suppressants, are we engaging in conversion therapy?" We have to accept that this debate is really quite complex for medical practitioners in particular. Unfortunately, while we have the debate, the people who need protection are the ones who are suffering and in increasing distress. I am trying to get people round the table, including the Royal College of GPs, to make sure we can thrash out an agreement about bringing an end to conversion therapy, but under an umbrella term that allows people to be medical practitioners.

It is very complex. The idea of conversion therapy is not easy to define, because every time one group asks, "Is it reparative therapy or conversion therapy?", once it is defined, other organisations with a different way of thinking move away from the table. It could be about saying, "We simply want to explore gender fluidity, but from the perspective that it is not acceptable to be anything other than either male or female." Within counselling, psychotherapy and psychology, we have made very big efforts to move towards making sure we bring an end to it, but we look at how training is being rolled out.

Q72 **Chair:** Can I ask a supplementary question? Do you think, for professions within the regulated sector, to use your words, an end has been brought to conversion therapy?

Dr Moon: Such as—

Chair: Psychologists are regulated, are they not?

Dr Moon: Psychologists, yes. No, not really. First, in order to help psychologists understand what conversion therapy is, as with many professionals, it has to be drawn to their attention. We are finding in the coalition that, while organisations are very pro the idea of bringing an end to conversion therapy, mandating that in training is something rather different.

Q73 **Chair:** Regulated professionals are still undertaking conversion therapy.

Dr Moon: .Yes.

Q74 **Chair:** I know it is not ideal, but tackling that is something the Government definitely could be doing by working with the regulatory bodies.

Dr Moon: Yes. The HCPC, which has not been at these meetings—and it would be wise for it to attend them, as a regulatory body—could bring on board something about bringing an end to conversion therapy.

Q75 **Chair:** The regulatory body is not engaging with the conversation around ending conversion therapy.

Dr Moon: No.

Q76 **Chair:** Given the fact that the Government have set it out as an objective, that is quite disappointing.

Dr Moon: It is very disappointing.

Q77 **Sarah Champion:** We have discovered that we are fascinated by all of this, but because of time I am going to focus in on a particular thing around commissioning. In Rotherham, we have some amazing, passionate people who have fought for some really good LGBT health services. We have had some great people in the NHS who have done the same. We are doing okay for a little town, but I am very minded that it tends to be individuals who fight and get the right services. As a service user, it is very much a postcode lottery as to whether you are in an area that has the services you are looking for, if indeed you can find those services.

Looking at the commissioners, if you were coming up with a tick-list table of what "good" looks like for the LGBT community, specifically looking at mental health, what would be on that list? What should we give as guidance to all commissioners so that, wherever you are in the country, you can get access to good mental health services? Joanna, I will start with you and do my rattle down the panel.

Dr Semlyen: It reiterates the point about whether the services can be provided at mainstream or charity level. There needs to be an openness to look at what is available in the different areas around that and to work with mainstream services. Using mainstream services as an example, which is what I will focus on, they need to be appropriate for LGBT users. You understand, I am sure, the term "heteronormativity". So this is about the idea that services are not expecting the person turning up to be a heterosexual. That is an important first step, because we need to encourage LGBT people to feel that they want to access those services.

Any kind of mental health provision needs to be, at the bare minimum, what we would call LGBT affirmative—that is, accepting of the identity—with that being important when it is necessary and not important when it is not. That would involve a very well-trained staff. There needs to be the possibility for and inclusion of e-provision or m-provision—mobile or internet services—potentially as an adjunct, or maybe as a standalone as well. That is because a lot of LGBT people feel safer accessing services through the internet, but of course there is very little regulation. Face-to-face support in

relation to that would also be important.

We need to think about whether those interventions understand something really important that has not been mentioned, but is a given and needs to be said explicitly. A huge amount of isolation is experienced by LGBT people. There is something about the provision of a service for LGBT people that in and of itself can create a sense of connectedness and a reduction of social isolation. It is important to keep that in mind. For those services, the aim is to ameliorate the presenting mental health problem, but also to think about increasing resilience, increasing buffers for people who are navigating what is ostensibly a heteronormative world that privileges heterosexual people, and to be mindful that that is what they will be taking out with them. That is part of the LGBT-affirmative label. That will do, because I am mindful of time.

Helen Jones: Everything she said! I also think every mental health service that is commissioned should have a responsibility to monitor for LGBTQ identities. We have not really spoken about monitoring, but that is really important because otherwise we do not know how many services are being provided and who to.

Suicide prevention strategies can be very helpful, because LGBTQ communities are specified in the national suicide prevention strategy—not high enough up the list for my satisfaction, but they are there. Every local public health department has to have a suicide prevention strategy. That can be a very good way of looking at LGBTQ mental health and focusing people's attention on it. All services that are commissioned must have LGBTQ affirmative practice training and, separately, trans awareness training, as a separate training item. I would put those in as well.

Dr Moon: Sorry, what was the question?

Q78 **Sarah Champion:** If you were creating a guideline for all the clinical commissioning group commissioners that commission mental health services, so that the LGBT community were included and recognised within that, what would it look like? Would it be specialist services? Would it be changing the mainstream? How would you make that happen?

Dr Moon: I would like there to be more co-operation and a more co-operative system, so that charities would not need to give up their specialist knowledge, but neither would it need to be ghettoised away from the mainstream. Those two can work very well together in partnership, in those very strategic ways.

I would like to see more research. I would like to see that in a more reflexive way. There are quite a lot of universities where student practitioners are also expected to conduct a piece of research within certain communities. That could be far more useful sometimes, to make sure it is conducted within

LGBT services, and reflects back and is reflexive back, both into the community and into the academic world. There is often research conducted, and then it does not feed that well into local services as a form of knowledge or into our NHS, where it could really have a stamp of approval for the findings that are coming out of it.

Equally, on therapeutic services, my experience is that therapists need to be able to access services where they can be volunteers and provide a lot more support to local services, which commissioners may be able to give weight to in terms of more voluntary sector support. That is it; I will not go on.

Q79 **Angela Crawley:** My question is specifically about the regulation of mental health professionals. It was basically to ask who you think should be regulating the mental health services in the first instance.

Dr Moon: In terms of therapy, counselling and psychology, at the moment, psychology has HCPC. I am very aware that, in the UK, anybody at the moment can set themselves up as a counsellor or a psychotherapist. We are not in an ideal time. For regulation, it is worthwhile asking those different bodies that are on the coalition, for example UKCP, BACP, BABCP and BPS, who they think needs to regulate mental health professionals.

My own opinion is that we may have got to a point where we need to really rethink what it is that we are trying to regulate. I am aware that, while the HCPC offers some very good regulation, there are some areas that it does not quite hit the mark with in terms of counsellors, psychotherapists and psychologists that work in clinical and counselling psychology. I would like to see those organisations coming together with HCPC to provide maybe a more nuanced regulation for those people.

Helen Jones: The BMA could be doing more. We need to think about the regulation of clinical services in this conversation as well, because that is where a lot of people will come up against attitudes that are not helpful. There is the Royal College of GPs as well. GPs badly need more training.

Dr Semlyen: I think all of that. I am going to point out the idea that there are mental health services being provided outside of trained professionals, just to raise that. It is not my area of expertise, but we have people offering lay interventions without any qualification. People can set themselves up, or people can describe what they are doing in a faith setting as mental health support. That is a very complicated situation. I am afraid I do not have any advice on that. I just wanted to flag, in response to your question, that, as well as all the existing colleges and bodies, there are quite a lot of people who are not sitting under that umbrella but are providing mental health services and offering them right now.

Q80 **Sarah Champion:** They are charging for them.

Dr Semlyen: They are charging for them and therefore raising expectations, and potentially—let us be honest—doing quite serious harm.

Dr Moon: There are issues about ethicality. In all of this, we need to be looking at the politics of our ethics and asking ourselves, "What ethical teaching is available?" I was on an ethics committee just two days ago. Some of these issues really are for ethics committees of different organisations to begin challenging.

Q81 **Angela Crawley:** You are absolutely right. I am grateful for you raising that point, Joanna. It is important to remember that there are services outside healthcare that are also presenting these services. In my own personal experience, as a lesbian woman going to a GP or going to a doctor in services, there is generally a lack of knowledge and understanding there. There is always a presumption—I do not know how many times I am asked if I could be pregnant, which is pretty unlikely. But that is just an example.

How do service users know what regulatory regime their healthcare provider is under and where to go if they have a complaint? If I had a complaint, I can honestly say I would not know where to go.

Helen Jones: We need more advocacy services. Independent advocacy is really vital for people to be able to complain. We run a lot of advocacy services in Brighton and Hove, and even where people do not want to take the issue forward themselves—for all sorts of reasons they may not—we can take issues forward as collective concerns. That can be really useful.

Dr Moon: It goes back to the idea of why we have specialised services. It is not that they need to be so specialised, but it is a recognition that there may be a need for advocacy. I was very fortunate to visit Callen-Lorde in New York last summer. As a service, that would be an example. They are 20 years ahead of the UK, and they offer a wonderful service to the LGBT community. Their website is really fantastic in terms of knowledge and information. The Sherbourne Clinic in Canada is the same.

Going back to being Prime Minister for a day, I would say, "Let us really recognise those services and build them into our society." In terms of regulation, ethical treatment and providing wonderful access that is understanding, they are fantastic services. I was rather upset when I talked to a commissioner, because although in Callen-Lorde they have informed consent, and I was told, "That will never be part of the NHS." It is like, "What, never? We will never think about that for our NHS?" It is about our people. We are here to improve the lives of our people, whoever they may be, across the board, and to keep them safe.

Dr Semlyen: Your question was about being able to make a complaint. In a way, it echoes Helen's point earlier, which was on my list of things to say if I got an opportunity, about monitoring and data collection.

If we think about the possibility at the moment—I have not needed to make a complaint about a GP, for example, so I do not know this, but I would imagine this is the case—and I was to fill out a basic form, it probably would not ask me about my sexual orientation or gender identity as a standard. If we usualise the question of sexual orientation and gender identity in every single area where we ever ask for demographics—if we think about that as a movement—that usualises sexual orientation and gender identity as part of our demographic profile. I am using the question as an opportunity to make that very clear point.

For complaints about a GP or any health service, or indeed any way in which we are recording demographics, we could include sexual orientation and gender identity as the norm. If I was to fill that out as a member of the LGBT community because I was upset with my GP, and it was asking me, "What is your identity?", I would feel as if it was important that that was known. In knowing that, I might feel more confident about filling out that form. That is just, in my view, a way in which we might be able to usualise that identity.

Q82 **Angela Crawley:** As a supplementary to that, my understanding is that sometimes these questions are asked, but then they are put in a coded form in a system. Therefore, if you go to another nurse, practitioner or GP, they do not necessarily know what that code means. They might have to click into that code, but it might not explain what it means. I agree that data gathering is important and might make people feel heard, but what if the general day-to-day practitioners do not understand the coding system that is being used?

Dr Semlyen: That is a training implication, is it not? My understanding is that sometimes it is quite difficult to record that and it has to be put under another aspect on the form, which might even be to do with someone's presenting complaint rather than their identity. There is a huge cost implication about overhauling systems that collect that, but I would be so bold as to say I am not sure that that should be a reason for us not to do it. There is a training issue, but we also need to think about our IT systems. Just because we are not collecting it, that does not mean we should not start to.

Q83 **Chair:** Can I ask one very final question? It is going to have to be a bit "yes" or "no", because we are overrunning. It is really going back to where we started. If discrimination in wider society disappears, will mental health disparity disappear as well? Should we therefore be looking at society as well as the health service to try to find some of the answers to the problems we have been talking about?

Dr Semlyen: Yes, and in fact I said that earlier. I said that, in an ideal world, if there was a society where LGBT identity was just part of a range of

diverse identities, that would go a long way to addressing the disparity. Without research evidence, we do not know the answer to whether that would remove it all, but I would go so far as to say it would make a big difference.

Helen Jones: Yes, it would make a big difference, but I am not sure it is completely the answer. Just to become part of the mainstream does not necessarily get rid of the feeling of difference. It is what interpretation is put upon difference and minority status that matters. To really get rid of mental health problems, LGBTQ identities should be very highly valued, not just equal, not just part of the mainstream, but much more valued.

Dr Moon: Yes. Nobody would have thought, 20 years ago in this country, that two women, two men or trans people could have any access to rights, never mind get married. As for the idea that we can create a different mainstream, that is something our Governments are hopefully elected to do —to create a freedom where we can feel safe. By feeling safe, we retain our freedom. These things act as a step towards that, but, equally, the idea of difference will always be multiplied. We always have to be very present and aware that things will challenge us, but we can create a society where we can tolerate challenge.

Chair: On that note, we will end this first panel. Thank you so much for your time. We really appreciate it. We will now move on to our next panel. Thank you very much.

Examination of Witnesses

Witnesses: Rosie Stamp, Niazy Hazeldine and Cecily Ward.

Q84 **Chair:** Could I welcome you to our second session here today? Thank you for taking the time to be with us. We are really grateful for that. We know it takes a lot of time to prepare for these sorts of things, so huge thanks from all of us. Before we start and Sarah asks the first set of questions, could I ask you to say your name and the organisation you represent?

***Rosie Stamp*:** I am Rosie Stamp. I am a researcher at Healthwatch Suffolk.

***Niazy Hazeldine*:** I am Niazy Hazeldine. I manage the youth domain at METRO charity.

***Cecily Ward*:** I am Cecily. I go to the METRO youth group.

Chair: Brilliant, that is great. Sarah is going to start us off.

Q85 **Sarah Champion:** Hello, I am Sarah Champion. I am the MP for Rotherham. Cecily, can I start with you? Thank you ever so much for coming today. We really appreciate it. It is important to us to hear first hand from

people who are at the coalface, so the three of you coming today is really beneficial to us. Cecily, in your opinion—and I know it is only your opinion—what are the biggest health problems that young LGBT people are facing right now?

***Cecily Ward*:** It is around mental health. I genuinely do not think I know a young LGBT person who has not had some problem with their mental health at some point, and it is not like I do not know many. That is causing big problems because then you have young LGBT people coming up with mental health problems and they are finding it harder to access education, because they have had mental health problems through their whole adolescence. It will then change the demographic growing up in professions and where LGBT people are if, during adolescence, people are struggling to do their exams because they were too worried about trying to stay alive. It is not that uncommon.

Q86 **Sarah Champion:** Why do you think it is?

***Cecily Ward*:** I started primary school in 2004, just as Margaret Thatcher's legislation disappeared.

Q87 **Chair:** You are just making us feel very old at that point.

***Cecily Ward*:** Technically, the whole way through my education, schools have been allowed to say it is okay to be gay. However, that is not necessarily what is happening in schools. My primary school was homophobic. I do not know if the teachers knew about it, but it was a normal insult to say, "You are so gay. You should not do this. You are so gay." I left primary school in 2011, and it was still going on then. Teachers just tell you not to say it—"Do not say that"—but it is never explained, so children go through primary school experiencing homophobic abuse right from the start of very early years. There is this idea: "Being gay is wrong. I should not be gay. I need to try to be straight to fit in."

You go into secondary school and, for some kids, it stays really homophobic. I had a friend who still experienced homophobic bullying right up to leaving year 11. For me, my secondary school was fine. It was not homophobic at all, bar the first couple of years, when primary school stuff began to end. However, as soon as school was okay and school felt safer, you were coming to an age when people were starting to date and go out. You go out with someone just as you have become okay with being gay again, and you are shouted at and told to go to hell on the street. That creates a real issue with mental health, where people just never feel like they fit in or that it is safe to go out.

Q88 **Sarah Champion:** I am really sorry to hear about your experiences, but I am really grateful that you are sharing them so that we can try to make a difference.

Niazy, is that the experience of other young people? Has that resonated with you? Is that common? What are the main health issues they are facing?

***Niazy Hazeldine*:** Absolutely, yes. There is so much research to back up what we see within our youth groups and with our young people and to show that the mental health of LGBT young people is a really significant problem. If we are thinking about healthcare, life chances and life experiences in general, that mental health underpins everything. I have spoken to young people specifically about their experience of healthcare over the last couple of weeks in preparation for this, and a lot of young people will say, "I am too anxious to access healthcare. I am too anxious to speak to someone at CAMHS. I have had bad experiences in the past, so I do not want to go along to my GP." That then underpins young people's experiences of accessing any kind of healthcare, so it is really important that we see mental health as underpinning everything. That is the main focus and it has to be interwoven into everything.

Q89 **Sarah Champion:** Do you think it is a particular issue for LGBT children? When I was at school, if you were ginger, if you were poor or if you were too bright, there would be all these subgroups of terrorism that was going on against you. Do you think it is a particular thing that LGBT children are experiencing?

***Niazy Hazeldine*:** Absolutely, yes, and we have all the evidence to show that. For example, from Stonewall's recent 2018 report, 52% of LGBT experienced depression in the last year. If we are talking about trans people, it is 67%. In non-binary people, it is 70%. If we think intersectionally and look at whether someone is disabled or BME, it is heightened again. It is also significantly higher than it would be for the general population. There is a lot of evidence to show that it is heightened and that experiences of anxiety, specifically, are very high. There is a direct correlation between the things that Cecily has been mentioning—not feeling safe in the street and not feeling safe at school from a very young age, and being taught that who you are is not okay and that you are going to be targeted for that—and very high levels of anxiety specifically.

Q90 **Sarah Champion:** Cecily, when that was going on, did you think, "I need to go and get some help with this. I need to get some support"?

***Cecily Ward*:** No. It is not like, at primary school age, you can understand that your experience is not necessarily that of your friends. You just do not have that awareness yet, so it was only much later. I am on a year out at the moment and going to uni in September. I am working at an after school club at a primary school, and the conversations around that are very different. I do not hear homophobic slurs anywhere near as much as I used to hear them at primary school. It is only hitting this point where I am going, "So that is not normal. My straight friends did not have to experience

that." I am only realising that now, at 18 or 19.

Q91 **Sarah Champion:** Realising that now, is it something that you would like to explore and get support on, or is it something where you just think, "I have to put it in my backpack and keep on walking"?

***Cecily Ward*:** I do not really talk about it. I have had mental health problems for other reasons anyway, so I have had support for other stuff, and maybe that will come up, but it feels like a normal part of growing up.

Q92 **Sarah Champion:** Rosie, you are from Healthwatch. When people go and get support, is the provision there? Is it good enough?

***Rosie Stamp*:** From the research we have conducted, both last year and this year, we are finding that, as these guys have said, LGBT young people are really struggling with their mental health. To give you some stats, 11% of young people who are not LGBT said they currently had a mental health issue when we asked them. However, 36% of LGBT young people had a mental health difficulty, so that would suggest that the services are not meeting the needs. They are more likely to have self-harmed and more likely to report having no self-esteem, so, from what we are hearing, there is a gap in provision for this particular group.

Q93 **Eddie Hughes:** You may have heard me asking the first panel this. What are the best ways to improve the health of young LGBT people?

***Cecily Ward*:** If you can get some teaching to children really early on, as they are starting to come into primary school, that not being straight is okay, that would drastically improve the way children see themselves as they grow up. You have that stage at four or five. I remember overhearing a conversation between a bunch of four-year-olds, where they were going, "A boy kissing a boy is disgusting." Before I told them off, I asked, "Is a boy kissing a girl disgusting?" and they said, "Yes, they are both disgusting".

At that point in time, where children are holding both of these things equally and they do not like them both, they have heteronormative media, their parents, their friends' parents and all these different role models in books and everything they are consuming. Slowly, the idea that a boy kissing a girl is disgusting disappears. They do not get that for a boy kissing a boy or a girl kissing a girl at all. That does not exist. If that can come in, children will grow up not thinking there is something wrong with them, and that stage of "everything is disgusting" will, hopefully, start to shift so that it does not exist any more.

Q94 **Eddie Hughes:** That is a start. Do you have other thoughts?

***Cecily Ward*:** Around—

Eddie Hughes: How do we improve the health of LGBT people from a

mental health point of view? That is the early-stage thinking. Do you have any other thoughts?

***Cecily Ward*:** There is an issue with accessing services for a lot of young people. At least, that has been my experience. It has not mattered if you are LGBT or not. It is very hard, at least in my London borough and the neighbouring one, to access mental health services. That is an issue across the board. If you then have lots of LGBT people who really need it, and access is really difficult for everyone, and they are still not getting in, that is causing big problems. Changing access for all children will make a huge difference to LGBT children because they will start being able to access services.

***Niazy Hazeldine*:** My background is in education, so I am really passionate about making sure that schools are usualising these identities and all that kind of stuff. I could go on about that for ages.

Focusing on healthcare, ways to make access easier and how to treat people who have health issues right now, from speaking to lots of young people specifically about services for mental health, they are absolutely echoing the same things that Cecily has said: that it has been very hard to access those services, with really long waiting lists and having to meet a certain threshold. Young people are saying that they have exaggerated certain things because they have heard that that gets them on to the list more quickly, and those kinds of situations.

If you are a person who has been let down by teachers, and maybe your parents are not supportive, or if you have seen examples of homophobia or transphobia in the general media or on the street, you are likely to have a very difficult time trusting professionals. We hear a lot of young people saying that, even when they do get to the top of the list and are given access to CAMHS or have links to mental health services, it is very hard for them to trust those services and think that that person is going to respect their identity enough for them to be able to use that service and get what they want out of it.

Q95 **Eddie Hughes:** Is that because they do not have an affinity with the LGBT community, or because they have not experienced it themselves? Why would they not have that trust?

***Niazy Hazeldine*:** Because it is a bit of a gamble. We have examples of healthcare professionals discriminating against LGBT people. An example off the top of my head is that, within the national LGBT survey, there were some statistics around the number of lesbians who have been told specific things within mental health services: "The fact that you are gay is directly because of childhood abuse" or trauma or things like that. If you have experienced any of those kinds of things, or even if you have a doubt that you might

experience those kinds of things, it is going to be very hard for you to access that service with trust. That makes it very difficult to create a feeling of trust where people can access services.

At the moment, a lot of young people, specifically, will only trust services that are LGBT specific. If they are given someone through CAMHS and they are not 100% sure that that person is going to be respectful of their identity, they would rather not engage but wait until they can get an LGBT-specific counsellor, or just not turn up to sessions. That happens a lot. It is about thinking of ways in which we can train those professionals to a standard where we can really trust that they are going to be respectful of all identities and then communicate that to young people so they know they can trust those people. That is a difficult journey.

***Rosie Stamp*:** In relation to how we can fix things, all these ideas are fantastic. We definitely need more access to specialist services. I do not think it should be limited just to the health system. For young people who are LGBT, education is a key part of their lives. They spend most of their time at school. Particularly in rural areas such as Suffolk, it is often the only connection they get to peers or their friends. We hear from schools that they are very aware that young people who are LGBT struggle with their identity, their body image and related anxiety and, as a result, need more pastoral support within the school.

Ideas for solutions could include support within schools; for example, we have heard of secondary schools implementing LGBT support groups. There is a school in Suffolk that, every time it gets new people in who are questioning their gender identity or have transitioned, creates a transition plan with the young person. They set out a vision: "How do you want things to look at school?" They talk about what might seem like really small things —how their names appear on registers, and the situation around toilets and changing rooms for PE. Small changes like that can be implemented, and that can make a really huge difference to the wellbeing of a young person. Educational settings could be a key area to work with.

Q96 **Eddie Hughes:** With regard to body image pressures, how significant do you think that is? I imagine that, with regard to the issues you have described at school, it would be an area of concern.

***Rosie Stamp*:** Definitely. From the research we have done, which has so far looked at around 14,000 young people in Suffolk and is still ongoing, results to date show that body image is a far bigger concern for LGBT young people. Of young people who identify as straight, 38% said they worry about their body image, compared to 60% of LGBT young people. When we break that down by gender, 62% of young people who do not identify as male or female said they worry about their body image, compared to 21% of males and 55% of females, so there is a discrepancy there. The reasons why they are

struggling with their body image are that they are struggling to find their identity at that age; they have concerns about how other people perceive them; and they feel a sense of shame for being LGBT, like they do not fit in.

I really think we can do something in schools to educate young people about body image. There is a clear desire among young people to learn more about body image in PSHE and RSE lessons, for example. If we are able to educate not just LGBT young people about body image, but also the wider cohort of young people, it will improve general views and attitudes towards the LGBT community.

Q97 **Eddie Hughes:** Is there anything else that the Government should be doing? The Government have made some pledges as part of their action plan to tackle this. To the question I asked earlier, what would you be doing if you were the Prime Minister?

***Rosie Stamp*:** The LGBT action plan is a brilliant start, but if I were Prime Minister, I would like to really focus on young people. The action plan is quite broad. It has excellent recommendations, but I feel like it did not directly apply to young people, so I would look to, either as part of the action plan or as a separate action plan, have an LGBT youth plan that directly targets young people who are LGBT, because, as we are seeing, the issues they are facing are quite significant.

Q98 **Chair:** How would that differ from the LGBT bullying in schools plan that they have in place at the moment? The Government have a particular plan around LGBT bullying in schools. Do you not think that goes widely enough?

***Rosie Stamp*:** Bullying is definitely a factor. We have found that LGBT young people are more likely to be bullied, so that is certainly key, but there are so many other issues that they are facing. We know that their self-esteem is much lower than their peers'. They spend a lot more time using social media. It seems to be a form of support. I am speaking on behalf of young people in Suffolk, so it may be different in more urban areas, but we found that those online communities provide a lifeline for these young people. The use of drugs and alcohol is higher among LGBT young people. Lastly, the reluctance to seek support and help, and the fear of opening up to teachers and to services, are also issues. It goes beyond bullying.

***Niazy Hazeldine*:** Could I speak on that as well? I led the anti-HBT bullying project funded by the GEO before I did this role. Having done that, I think the action plan around bullying goes a really long way towards changing things for LGBT people within schools, but it is really important that we recognise all the issues outside of bullying and that there will be young people who are not out at school, especially trans people, who tend to come out later.

There are some people whom that will directly affect and help, but there are

other people for whom bullying is not the main issue. It might be self-esteem issues, mental health, addiction or body image, so we need to think about all those things and not just focus on bullying necessarily. A way of doing that would be to think carefully about mental health services that we provide within school settings and to ensure we are tackling bullying but also giving support and recognising that, while not all LGBT people will be victims of bullying necessarily, they will still need support.

Q99 **Eddie Hughes:** Cecily, what are your thoughts with regard to the prioritisation of body image pressures? If you were the Prime Minister for the day, what would you be doing as the Government to help address this?

***Cecily Ward*:** First, I would like to comment on what Niazy said earlier about accessing CAMHS, before I forget about it. A lot of young people accessing services—CAMHS or whatever—will do it through their parents. The parents send the emails. The parents go to the GP visits with them. The parents help to chase when they do not come up. If you are not out to your parents, and the reason you are accessing CAMHS is because you are trans, or because you are gay and you are being bullied, your parents are not there to help you do it. It is really hard to work out how to send an email at 16 to a CAMHS worker, to know what to say and what is appropriate or not appropriate, or to know where your information will go.

I was going home with a friend at METRO, and he was saying his uni had contacted him to say he had got lower entrance requirements. He was not sure if that was because he was gay, because he did not really understand where that data went. It probably is not; it is because he is state school educated and probably in a postcode, and universities will help access there. But young people do not know where this data you are collecting goes. It is great that you are collecting it, but we do not understand that. We just see a tick box, and we do not know who sees the answer to that tick box, so why would I want to declare something if I do not know whether that is going to become an online thing that exists forever? We spend so much time at school going, "Everything you put online goes on the internet forever." What if I am filling in an anonymous form, but I do not understand that it is an anonymous form that is not going to go on my record somewhere? That really affects access to services as well—the lack of parents.

What was the question around body image again?

Q100 **Eddie Hughes:** Let us dwell on that for a second. How do you tackle that? There is an age of consent in terms of parents' relationships with their children, so how do you get round the fact that you could be 14 and you might want to access those services, but the way through it would be with your parents? There is a flip side to that coin, which says there is an element of protecting, relating not necessarily to this issue but to other issues, where you might say, "Surely, children need some sort of protection from their

parents."

***Cecily Ward*:** To start with, you can disclose stuff to your doctors at 14, for example. You still have confidentiality as a teenager, even under 16, in healthcare. You are allowed to have conversations with your doctors away from your parents, and they do not necessarily access that information automatically. What would help there is having people who are adults, who young people know, who understand LGBT issues, who have been signposted to people and who can help with these roles that sometimes parents would take. From there, if there is a safeguarding issue around their parents or anything else, a safeguarding team can make that risk assessment. The child should not be making that risk assessment for themselves. At 16, you are not in a position to work out whether it is safe to go here or safe to go there. That is not a fair thing to be asking children to do.

Eddie Hughes: No, I agree.

***Cecily Ward*:** If there is a feeling that they have to risk-assess that for themselves, and there is nowhere for them to go first to help them get into services that can then help support them with their parents, kids just are not going to go. They are not going to risk it. They are not going to risk getting outed. If there is a reason why this information getting out could make you or your friends unsafe, believe me, you will not do it, not as a kid. You will wait and you will stick it out until you feel safe enough to do it, but it is just getting worse in the meantime. If there is nowhere for people to go where they feel like they have help in accessing services, people are not doing it.

Q101 **Eddie Hughes:** What would it look like—my Prime Minister question—if you were redesigning this?

***Cecily Ward*:** Youth groups and places for children to go, not just for LGBT people, but for anyone who is hanging around the streets. At least in London, streets are not safe. It is not safe to be out at night. If there was funding that went into safe youth services that lots of kids could access—whether it is issues on sexuality, gender identity, family problems or issues around racism—and you had youth groups with adults who specialise in all of these, and people had access, that would be really useful. At the moment, we are really lucky that METRO exists. Lots of kids do not have access to that.

Q102 **Stephanie Peacock:** What is the role of third sector organisations in the health and social care of LGBT young people? How is the function carried out? What are the good bits and what are the challenges?

***Cecily Ward*:** Please can you explain what you mean by "third sector"?

Q103 **Stephanie Peacock:** Charities and support groups, not necessarily a standard institution like a school or healthcare.

***Cecily Ward*:** Sorry, please can you repeat the question?

Q104 **Stephanie Peacock:** You may not have had experience of it, so it might perhaps be something for the rest of the panel, but, if you have been to a youth group or a charity that helps young people, what role can they play outside of going, perhaps, to school or to your doctor?

***Cecily Ward*:** Charities are really useful because they feel safer than schools sometimes. At school, you do not know what gets back to your parents, and confidentiality rules are never explained to you, whereas charities are often really safe places to go. It is away from school and exam pressure. It is away from home. These charities are really, really, really important because they feel safe, and because people feel comfortable and make new friends. You just get lucky if you find them.

Sure, it would be great if schools could help, but also if there were more funding of charities, and schools were able to refer children to charities. I know that schools refer vulnerable young people to cadet forces that are not LGBT specific. If systems can work like that for LGBT young people, and there is still communication there between safeguarding organisations and the school, that is a really good way of there being somewhere to go, away from school, where you are safe, as long as kids can find it. Schools can play a part in signposting it, if it is outside of their realm to help.

***Niazy Hazeldine*:** METRO has a really long history of working specifically with LGBT young people. We were founded in 1983, and we have been working closely with young people and running these kinds of youth groups ever since. There is also a lot of knowledge within our charity specifically, and in other charities, that is very specialist towards working with people, because of that long history. I would echo what people said in the previous panel about the importance of things being co-produced. Using our specialist knowledge, with funding, and working alongside mainstream organisations is really important and would be a really good model for things like mental health services. We have funding to deliver counselling for LGBT young people within METRO.

Very often, we find young people who build up the courage and the knowledge through that to feel like they can trust mental health services and then can go back to CAMHS. That transition is often about young people asking us, "Can you go and meet with this CAMHS person and tell us that this person is going to confirm that they do accept my identity?" They want our accreditation, as a charity that they trust, to know that they can trust that health professional. Partnership between charities like METRO or specialist services and mainstream services could help build trust that we need to see in those services.

***Rosie Stamp*:** I agree. The VCS is absolutely vital in supporting LGBT young

people. Talking on behalf of the Suffolk area, we have a fantastic charity called Outreach Youth, which is a very small charity that provides support and signposting to young LGBT people or young people who may be questioning their gender identity. From what we have learned about this group, the young people who use it find that support absolutely vital. This charity provides the only safe space that a lot of young people get. They go through school with their friends, without really feeling like they have space to talk about their identity. There are weekly sessions. For example, a weekly support group provides that space that they really need.

However, to put this in context, of the 5,000 VCS organisations in Suffolk, Outreach Youth is the only charity that supports specifically LGBT young people. Looking at the data we have, there are around 120,000 young people in Suffolk, and we know that around 8% are identifying as LGBT, which, if I am correct, is around 9,500 young people in Suffolk who this single charity is trying to look after. They cannot cover the whole county. It is incredibly rural. There are pockets where they can work, in more urban areas like towns such as Ipswich and Bury, but there are still a lot of young people who do not have access to VCS support.

I spoke to them prior to meeting today, and they really wanted to highlight how important local support is for young people. There are lots of really good examples of national support. For example, I know that Stonewall can come into schools and deliver excellent one-day training to staff and students. But what young people need afterwards is ongoing local support from people who know them, and to join groups that they can attend consistently and to build relationships within that community. In particular, local VCS is really key.

We should not forget the role of Healthwatch as a third sector organisation. Along with the other 150 Healthwatch organisations around the country, we provide a voice to people who use health and social care. We are involved with CCGs and attend meetings where new service deliveries are taking place. I am involved with the transformation of young people's services in Suffolk. Using the data that we have gathered about LGBT young people, we are then able to make sure that it is heard at the right level and by the right people.

Q105 **Stephanie Peacock:** I have a final question, perhaps to bring together the whole discussion. What do you think the priority of the national adviser for LGBT health should be? Is there one single one, or should there be more than one? Who wants to jump in first?

***Niazy Hazeldine*:** One thing we have not mentioned, which has been spoken about a lot when I have been speaking to our young people, is the journey through counselling and access to gender identity clinics. It has been a really difficult conversation to have with a lot of young people over

the last couple of weeks, because I knew that that was a real issue for some people. Talking to them openly and letting them know that they had the chance, in this forum, to express their views about that, there was a lot of emotion, a lot of anger and a lot of difficulty for them talking about it. A real priority should be developing that and having trans voices as part of that development, so that they lead the way in changing things and making it a service that is more for them, rather than at them and about them.

A lot of young people were saying that, especially when you are young, the timings are really important. If you are a young person initially coming out and saying that you need support around transition at the age of 14, you have probably spent a good number of years building up to asking for that support. Then if you have to wait for two years to even get in the door to have that initial conversation, by that point you might be 16 and a lot of changes have happened within that time.

A couple of young people spoke about that initial meeting when they go into the gender identity clinics. One person described it as an hour's worth of verbal abuse, because, after waiting for a really long time, they felt that they were just being analysed and questioned. They were not validated; they were being checked upon, and there were hoops that they had to get through and tick boxes that they had to answer, to get the support that they really needed and had been waiting a really long time for.

Within the conversation that I know is going to be had about changing what that journey looks like, and within the consultations that are happening around the Gender Recognition Act and things like that, it is really important that we include younger trans voices in that, so that they are part of that conversation, they can have their views heard and they can shape the way that that service is, because it is a service that should be for them. That would be a top priority. They could give some ideas about ways that that could happen. I know that we went on a little bit from potential solutions, but I have some that I can go back on, if that is useful.

Especially given that a lot of young people will be rural, although a lot of the people we support are within London, there is a huge amount of people who do not have access as easily to services like ours. Developing online support and ways that that can happen through technology, such as FaceTime and things like that, could be part of how we rethink that service and how we can develop online solutions and use technology to access people who are further out, to make sure their views are heard and they can access things more easily. I could go on.

Eddie Hughes: We need a longer session.

Q106 **Sarah Champion:** Rosie, I am still reeling from there being one LGBT charity for Suffolk, so I am putting some responsibility on you as an

advocate, I am afraid. In the last panel, we spoke quite a lot about the disproportionately high levels of suicidal thoughts and suicidal attempts within the LGBT community. One of the suggestions, as each local authority has its own suicide action plan, was to push specific services, support and recognition for the LGBT community within that. Is that something that you have done or could do as Healthwatch?

***Rosie Stamp*:** It is not something we have done so far, but it is something we would be able to get involved with, if we can access the right people in the right departments. The LGBT findings that we have gathered recently are relatively new, so we are really gathering momentum in terms of raising awareness about what we are finding. It is an excellent idea to try to contribute to that.

Chair: Thank you so much. That is the end of our second panel. Huge thanks from all of us for the time that you have spent with us today. It was really interesting information and a really great addition to our inquiry. Thank you very much.