

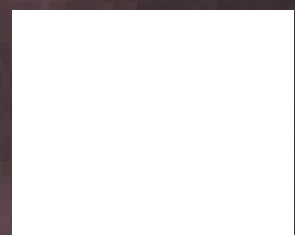


invisible

w o m e n

A Review of the Impact of
Discrimination and Social Exclusion on
Lesbian and Bisexual women's health
in Northern Ireland

Marie Quiry



Published by **Lesbian Advocacy Services Initiative**
PO Box 3
Ballymena
BT42 9AA

Tel 028 2764 1463

e-mail info@lasionline.org
website www.lasionline.org

October 2007
Funded by: DHSSPSNI Investing for Health

Published by **Lesbian Advocacy Services Initiative**
PO Box 3
Ballymena
BT42 9AA

Tel 028 2764 1463

e-mail info@lasionline.org

website www.lasionline.org

Printing Shanway, Belfast

Design evilpeanut design

Photography Delia Marín Sánchez

lasi
lesbian advocacy
services initiative

*The right to a private life is
enshrined in Human Rights
Legislation; what lesbians,
gay men and bi-sexuals lack
is the right to a public life.*

Dr Julie Fish

*Understanding Heterosexism in
Health and Social Care. 2007*

Acknowledgements

I would like to thank all those involved in the review.

These include the members of the Review Steering Group:

- Barbary Cooke, Director, Community Development Health Network
- Mary Deehan, Counsellor
- Orlaith Hendron, Out and About Group, Youth Action
- Paula Keenan, Independent Consultant
- Anne McGlade, Equality Manager, Eastern Health and Social Services Board
- Maria Noble, Equality trainer and researcher
- Pauline O'Flynn, Lasi Board member
- Rita Wild, Director of Lasi

Thanks are also due to those women who attended the four focus groups and the organisations that gave their support including Indigo, Youth Action, Greenbow Deaf Lesbian, Gay, Bisexual Transgender Society of Ireland, Lesbian Line, Linc (Lesbians in Cork) and the Coalition on Sexual Orientation (CoSo). Caoimhe Gleeson, Health Service Executive also assisted with relevant information.

The review has been funded by Investing for Health, Department of Health, Social Services and Public Safety and by the Eastern Health and Social Services Board.

Marie Quiery

October 2007

Please note that this report is available in alternative formats on the LASI website
www.lasionline.org

Contents

Acknowledgements

	Page		
1. Executive Summary	2	7.11. Older lesbian and bisexual women	23
1.1. Key Findings	2	7.12. Lesbian and Bisexual women in Rural Areas	24
1.2. Access issues	3	7.13. Support and social health	24
1.3. Health Professionals	3	7.14. Recommendations	26
1.4. Increased risk of illness	3		
1.5. Access to services and support in Northern Ireland	4	8. Mental Health	27
1.6. Models of good practice	4	8.1. Stress, anxiety and depression	27
		8.2. Self harm	27
2. Background	6	8.3. Recommendations	28
3. Terms of reference	6		
4. Methodology	7	9. Review of Services and Supports in Northern Ireland	28
4.1. Literature review	7	9.1. Legislative and policy context	28
4.2. Identifying gaps in services and support	7	9.2. Statutory services and support	30
		9.3. Primary health care	31
5. General Health Issues	9	9.4. Secondary care services	32
5.1. Tobacco, alcohol and recreational drugs	9	9.5. Education	32
5.2. Cancer risk	9	9.6. Recommendations	33
5.3. Parenting, reproduction, fostering and adoption	10	9.7. Non-governmental services and support	33
5.4. Food and eating disorders	11	9.8. Counselling organisations	34
5.5. Domestic violence	11	9.9. Recommendations	35
		10. Recommendations	37
6. Sexual health	13	10.1. Sexual health	37
6.1. Recommendations	13	10.2. Emotional and Mental health	37
		10.3. Services and support	37
7. Emotional Health	14	Appendix I Glossary of Terms	
7.1. Coming out	14	Appendix II Ten steps towards lesbian, gay and bi (lgb) inclusion	
7.2. Lesbophobia	15	Appendix III Ten things lesbians should discuss with their health care providers	
7.3. Internalised homophobia/lesbophobia	16	Appendix IV Questionnaire for Voluntary Sector Organisations	
7.4. Heterosexism	16	Appendix V Questionnaire for Counselling Organisations	
7.5. Impact of religious beliefs	17	Appendix VI Health and Social Care Questionnaire for Focus group Participants	
7.6. Bisexual women	17	Appendix VII Lesbian and Bisexual Women's Organisations	
7.7. Multiple identities	18	References	
7.8. Minority ethnic lesbian and bisexual women	18		
7.9. Lesbian and bisexual women with disabilities	19		
7.10. Young lesbian and bisexual women	20		

1.0 Executive Summary

- 1.0.1 Health and illness reflect the nature of the interface between ourselves and the environment and have always been important social indicators of the well being of our society. The technological and social advances of the early part of the 20th century increased both the quality and the longevity of our lives (Wilkinson, 2005). Although many diseases are affected primarily by material conditions, an increasing number of illnesses are powerfully affected by our lifestyles and our social and emotional well being.

“Recent research has revealed that some intensely social factors are among the most important determinants of health in the rich countries. These include the nature of early childhood, the amount of anxiety and worry we suffer, the quality of our social relationships, the amount of control we have over our lives, and our social status rather like the way that receding floodwaters reveal the nature of the underlying terrain, so the influence of psychosocial factors on health has become increasingly visible as the force of material privation has declined.”
(Wilkinson, 2005)

- 1.0.2 The higher people’s social status is the longer and the healthier lives they live. It is therefore understandable that discrimination, prejudice and oppression will have a significant impact on the lives of lesbian, gay and bisexual people. There is still relatively little research on lesbian and bisexual women’s health and none specifically based in the North of Ireland. However, there is a growing body of knowledge that may be useful in guiding health service providers in Northern Ireland when planning strategically to meet the health needs of lesbian and bisexual women and their families.

Lesbian, gay, bisexual and transgender (LGBT) people should be viewed as a cultural minority, with important social determinants of health equivalent to those from specific ethnic or geographic backgrounds.
(McNair & Thomacos, 2005)

- 1.0.3 It is important to note that much of the international research, particularly academic research, tends to draw on a white, middle class and economically secure population in their studies. Economic poverty and class have been shown to have the greatest impact on health (WHO, 1997). Sexual identity and orientation must therefore be viewed as one of a number of factors which impact on women’s health. The lesbian and bisexual women’s community is not homogeneous and many women face multiple discrimination in accessing appropriate health services. Many of the health risks for lesbian and bisexual women are the same as those for heterosexual women, but there are some concerns specific to the lesbian population. Fundamentally, lesbians need access to the same high quality health screening and preventive care that is appropriate for all women throughout the life cycle.

1.1 Key Findings

- 1.1.0 Heterosexism impacts on the lives of lesbian and bisexual people in profound and contradictory ways. At the individual level, evidence suggests that in order to cope with heterosexism lesbian and bisexual women may develop a range of social skills and a high degree of personal resilience. At the collective level, the interaction between lesbian and bisexual women’s experiences of heterosexist discrimination and their alternative sexual and gender identities have resulted in the formation of unique community norms, values and practices. They provide lesbian and bisexual people with social support, connectedness and a positive sense of personal and collective identity. Nonetheless, the major effects of heterosexism on the health and wellbeing of lesbian and bisexual people are negative.

- 1.1.1 While lesbians do experience the same health issues and problems as other women, the social and cultural context of lesbian lives are specific to this community and affect their access to health care, which potentially affects long-term health outcomes.
- 1.1.2 The diversity of lesbian and bisexual women is often not recognised by either voluntary organisations or statutory bodies. The needs and concerns of lesbian and bisexual women who identify as for example; black, minority ethnic, parents, people with disabilities, nationalist or unionist are often unidentified and unaddressed. Indeed lesbian and bisexual women are members of all the groupings identified in Section 75 of the Northern Ireland Act (1998). Many women suffer multiple discrimination not only on the grounds of their sexual orientation but also based on their community and social identity, and are deprived of support from both their birth communities and the lesbian and bisexual womens community, and the limited services that are currently available.

1.2 Access Issues

- 1.2.0 Lesbian and bisexual women experience significant barriers to accessing health services. They:
- are reluctant to disclose their sexual orientation for fear of discrimination by health professionals;
 - lack awareness and knowledge of health risks;
 - access health services less often than other women;
 - delay treatment and follow-up;
 - generally prefer a more holistic approach to healthcare;
 - have a preference for female service providers;
 - are at risk of psychological distress, damaged self-esteem and reluctance to access preventive care if they do not have access to an LGB community;
 - have a high uptake of counselling services which could reflect the homophobic society within which lesbians have to live and/or the value lesbians place on internal and emotional well-being;
 - are up to 2-3 times more likely to attempt suicide and have higher levels of self harm than their heterosexual counterparts;
 - have a 1 in 2 chance of mental illness as diagnosed in the General Health Questionnaire 12 at the age of 16 in Northern Ireland. (Young Life and Times Survey 2005,2006).

1.3 Health Professionals

- are often misinformed or uninformed about lesbian health issues;
- have limited available research on the health status or long-term health outcomes for lesbians;
- have little or no training in lesbian health at undergraduate or postgraduate level in Northern Ireland;
- limit access to existing assisted reproduction services;
- do not facilitate official acknowledgement of lesbian family forms or provide adequate and appropriate care of lesbians and their children;
- can create negative experiences in relation to health care which can directly impact on women's willingness to seek regular care.

1.4 Increased Risk of Illness

- 1.4.0 Research demonstrates that lesbians have increased risk of some illness compared to other women. Lesbians:
- have less frequent health checks;

Lesbian, gay, bisexual and transgender (LGBT) people should be viewed as a cultural minority, with important social determinants of health equivalent to those from specific ethnic or geographic backgrounds.

- are more likely to have poorer screening for cervical and breast cancer;
- have a false belief they have “immunity” against particular sexually transmitted infections (STIs) and cancers because of their sexuality.
- are less likely to have given birth or breast fed;
- delay child bearing until their 30s;
- have less need for long-term use of oral contraception;
- have higher rates of long-term use of substances including tobacco, drugs and alcohol.

1.5 Access to services and support in Northern Ireland

- There are no dedicated facilities within the Health Service for lesbian and bisexual women;
- Few voluntary and community based agencies provide services or support for lesbian and bisexual women and their families - there is only one paid worker to cover the specific needs of lesbian and bisexual women;
- Support services aimed at marginalised sections of the population do not make provision for their lesbian and bisexual members and users;
- There is no dedicated counselling service for lesbian and bisexual women;
- Strategies and policies aimed at marginalised groups within Northern Ireland society do not include the specific needs of lesbian and bisexual women;
- Lesbian and bisexual women’s experience of marginalisation and social exclusion impacts negatively on their confidence and self esteem reducing their visibility and their ability to take leadership roles and advocate on their own behalf.

1.6 Models of good practice

1.6.0 In the course of the review a number of strategies and good practice initiatives were identified both nationally and internationally. Health and social care providers in Northern Ireland could usefully adopt some or all of these policies and practices.

These include:

- The adoption of a Health Strategy for Lesbian, Gay, Bisexual and Transgendered people by the state of Victoria in Australia which incorporates both voluntary and statutory agencies and establishes clear targets and goals to meet the health needs of lesbian, gay, bisexual and transgendered people (Ministerial Advisory Committee on Gay and Lesbian Health, 2003),
- Further research is needed into the needs of specific groups of lesbian and bisexual women e.g. young women, Black and Ethnic Minority women, older women, lesbian and bisexual women with disabilities and lesbian parents and their children;
- The establishment of Lesbian and Bisexual Women’s Resource Centre/s which adopt a social model of health and support the development of support groups are central to the improvement of the health of lesbian and bisexual women;
- The invisibility of lesbian women and their families in health promotion campaigns contribute to levels of heterosexism and lesbophobia;
- It is good practice to incorporate lesbian and bisexual health needs into undergraduate and postgraduate health training at all levels.



2. Background

This review of Lesbian and Bisexual Women's Health has been commissioned by Lesbian Advocacy Services Initiative (LASI) which is a non-governmental organisation which "works to improve the quality of life for, and enhance the voices of, lesbian and bisexual women and our families. Lasi is committed to identifying and addressing discrimination and oppression faced by lesbian and bisexual women in the North of Ireland and to the promotion of social inclusion".

LASI was established in 1996 and secured funding from the Big Lottery in 2004 to appoint a Director to support the implementation of LASI's strategic aims. LASI has six core strategic aims:

- Advocacy
- Capacity building
- Networking
- Outreach
- Organisational development
- Research

LASI is committed to working in partnership with individuals, community and voluntary sector groups and appropriate statutory agencies for the successful implementation of our strategy. The core values underpinning LASI's work are:

- Community development principles
- Empowerment
- Equality
- Diversity
- Interdependence
- Ownership
- Participation
- Social inclusion

3. Terms of reference

3.0.0 LASI decided to conduct a review of lesbian and bisexual women's health in Northern Ireland as there was little information available on the subject making the planning and review of health services a difficult task. The Review has been funded by the Department of Health, Social Services and Public Safety (DHSSPS).

3.0.1 The aim of the review is to:

Ascertain the scope and extent of current understanding and knowledge of lesbian and bisexual women's health with particular emphasis on mental, emotional and sexual health by carrying out a review of all existing literature and best practice (locally, nationally and internationally) and by mapping current local services and supports in order to identify gaps and good practice within these services.

3.0.2 The objectives of the review are to:

- Review existing international, national and local research in relation to the mental, emotional and sexual health of lesbian and bisexual women;
- Identify gaps in knowledge and understanding;
- Develop an understanding of the needs of the families of lesbian and bisexual women;
- Consolidate current understanding and knowledge into one accessible resource to be made available to lesbian and bisexual women and to health service planners and providers;
- Ascertain what services and supports are currently available to lesbian and bisexual women in relation to mental, emotional and sexual health;
- Assess the extent to which lesbian and bisexual women in Northern Ireland access these services;
- Identify available services and supports which can be signposted from the LASI website in relation to mental, emotional and sexual health;
- Prepare available information to be posted on the LASI website.

4. Methodology

4.0.0 Research into lesbian and bisexual women's health presents a number of challenges to the researcher. Firstly, sexual orientation is not routinely monitored or documented within the health service and other public bodies in Northern Ireland. Voluntary bodies and counselling organisations do not ask nor record the sexual orientation of their users and clients. However, in 2005, the Department of Trade and Industry agreed a figure of 6% as the proportion of the population who are lesbian or gay. In Northern Ireland this would indicate a population of approximately 45,000 lesbian girls and women. The Office of First Minister and Deputy First Minister (OFMDFM 2006) have used the figure of 10% for the percentage of the N. Ireland population which is lesbian, gay or bisexual which indicates 75,000 lesbian and bisexual girls and women. Both these estimates are lower than the figure of 90,000 indicated by Young Life and Times Survey (2006) of 2,000 16 year old young people in Northern Ireland which found that 12% of those surveyed stated that they were Same/Opposite Sex Attracted girls (i.e. lesbian or bisexual).

4.1 Literature review

4.1.0 An international literature review also poses a number of difficulties for research into lesbian and bisexual women's health. For the purpose of this Review over 1,500 citations and research papers were read, some in the form of abstracts. Those papers which referred in the main to gay men rather than lesbian experience were excluded from this review. For example, the *Queer Resources Directory* recorded 25,488 files about 'everything queer'. In these files there is only one specific reference to lesbian and bisexual women's health. This area of study is under-researched at local, national and international levels.

4.1.1 Research papers which used a restricted sample (e.g. a mainly white and middle class student population) were also excluded. It is important that research into the lesbian and bisexual women's community reflects the diversity of this group of people.

"Traditionally, much research on LGB communities has involved a narrow range of people, and those who are harder to reach or are not comfortable with current methods of consultation, are too often not involved. If the research aim is to evidence and inform on issues of the LGBT community it is important to ensure that it takes account of the diversity within that community and pays attention to the less visible sectors of that community."

(Kandirikiria, Botfield, Williams & West 2004)

4.2 Identifying gaps in Services and support

4.2.0 A decision was reached and supported by the Review Steering Group to delay contact with the provider Trusts and Commissioners in health and social services until after the research was completed. This reflected and acknowledged an understanding of the changes taking place within health and social services brought about as a result of Review of Public Administration. Contact with key officers within these organisations will be arranged as part of the dissemination process where discussions will be taken forward on how best to implement the recommendations. However, interviews were conducted with representatives from the Health Promotion Agency, Investing for Health and the Equality Unit of the Department of Health, Social Services and Public Safety to ascertain the services and supports available in Northern Ireland to lesbian and bisexual women in relation to their health. These bodies were asked about relevant policies, strategies and projects that addressed the needs of lesbian and bisexual women in Northern Ireland.

- 4.2.1 A postal questionnaire survey (see Appendix IV) was also conducted with 18 regional non governmental organisations (NGO's) with responsibility for health and welfare. A similar survey (see Appendix V) was conducted with 17 regional counselling organisations. There was a relatively low return of the questionnaire surveys with a 15% return from NGO's and a slightly higher response from counselling organisations of 20%; perhaps indicating a low level of awareness of and involvement in lesbian and bisexual women's health issues
- 4.2.2 In an effort to reach more marginalised groups and individuals a questionnaire was sent out to all the member organisations of the N.I. Council for Ethnic Minorities (NICEM) and a meeting was organised to discuss the health needs of their lesbian and bisexual women users and members. Only one questionnaire was returned and the Director of NICEM was the only attendee at the meeting.
- 4.2.3 The review was based on community development principles and involved representatives of the lesbian and bisexual women's community on a steering group to guide the review. Four focus group meetings were also held to enable more marginalised lesbian and bisexual women to comment on the findings of the review and their relevance to the local context in the North of Ireland. While these focus groups are not necessarily representative of the lesbian and bisexual women's community, they enabled the reviewer to explore the findings of the review with a range of women, both in terms of geographical location and diversity. It was also felt that it is important to give a voice to those groups of women who are most marginalised e.g. deaf women. Four focus group meetings were held with 39 women aged between 19 and 66 years old. Recruitment for the focus groups involved utilising the informal networks that exist within the Lesbian, Gay and Bisexual communities. The following is the list of group meetings:
- Derry meeting held in conjunction with Indigo, a resource for lesbian and bisexual women in the North West – 10 women attended
 - Belfast meeting with the support of Out and About, Youth Action's lesbian and bisexual young women's group - 14 women attended
 - Belfast meeting for older lesbian and bisexual women – 8 women attended
 - Belfast meeting for lesbian and bisexual women with a disability which was held in conjunction with Greenbow, Deaf Lesbian, Gay, Bisexual Transgender Society of Ireland. BSL and ISL interpreters were provided with funding from the Eastern Health and Social Services Board – 7 women attended.

5. General health issues

5.1 Tobacco, Alcohol and Recreational drugs

5.1.0 Research on lesbian and bisexual women would indicate they have a tendency to overuse alcohol, tobacco and illegal drugs. Hypotheses for these problems include the importance of lesbian bars for a social life, the use of substances to cope with stress, the social norms of the community and the lack of culturally appropriate treatment centres for this population (EMT Associates, 1991). There is also evidence that the use of alcohol by lesbian and bisexual women does not decrease with age as it does with heterosexual women (Valanis, Bowen, Bassford, Whitlock, Charney & Carter, 2000).

5.1.1 Hillier, Turner and Mitchell in 2004 found that the use of all drugs including alcohol, tobacco, marijuana, other recreational drugs and heroin by same sex attracted young people had fallen between 1998 and 2004. However, drug use remained substantially higher than for heterosexual young people (Hillier, Turner and Mitchell, 2005). A recently published piece of research into *Drug use Amongst Lesbian, Gay, Bisexual and Transgender Young Adults in Ireland* (Sarma 2007) produces the following statistics:

- 65% had some experience of drug taking
- 21% have systematically used drugs (i.e. on more than 60 occasions)
- 56% have had some history of taking cannabis
- 46% engaged in unprotected sexual intercourse attributed to drug taking.

5.1.2 The *Cork Lesbian Health Research* (Community Consultants, 2006) found that 10% of their sample reported previous dependency on alcohol. The research concluded that lesbian and bisexual women who have access to a supportive community are less likely to develop alcohol dependency.

- Higher reported rates of smoking cigarettes place lesbians at higher risk of oral, esophageal, gastric, lung, cervical, and colon cancer (Valanis, Bowen, Bassford, Whitlock, Charney & Carter, 2000).
- In a study comparing lesbian and bisexual women to heterosexual women, more lesbian and bisexual women used recreational drugs than did their heterosexual counterparts (D'Augelli & Hershberger, 1993)
- Lesbian and bisexual women drink alcohol more frequently and in greater amounts than heterosexual women and gay men (Trocki KF, Drabble L, Midanik L. 2005)
- Lesbian women have a higher risk of alcohol-related problems compared to other women (Cochran SD; Keenan C; Schober C; Mays VM, 2000)

5.2 Cancer Risk

5.2.0 In an American study (Cochrane, 2001) lesbians were found to be more likely than women in general to have risk factors for breast and ovarian cancer, including nulliparity (never having been pregnant). The same study claimed that only 28 percent of lesbians had ever been pregnant vs. 67 percent of women in general), no live birth (16 percent vs. 57 percent), and never having used oral contraceptives (36 percent vs. 80 percent).

5.2.1 Cervical screening

Many doctors incorrectly assume that their lesbian patients do not require a cervical smear because they are in a low-risk category, presuming that they have had no sex with males or could not themselves transmit the human papillomavirus (HPV). This was verified by the

The research concluded that lesbian and bisexual women who have access to a supportive community are less likely to develop alcohol dependency.

focus groups where 7 out of 39 women had been told by their G.P.'s that they did not require cervical screening. However, most lesbians have had sex with men (Dolan, 2005) and HPV can also be transmitted by exclusive lesbian sexual contact. (O'Hanlon & Crum, 1996) Additionally, lesbians and bisexual women have been observed to be less compliant with smear screening recommendations than heterosexual women (Valanis, Bowen, Bassford, Whitlock, Charney & Carter, 2000). A higher rate of smoking is another risk factor for cervical dysplasia.

5.2.2 Breast Cancer

Among a Women's Health Initiative population, lesbians and bisexual women had more breast cancer than heterosexual women, despite similar mammography screening rates as study protocol participants (Valanis, Bowen, Bassford, Whitlock, Charney & Carter, 2000). Lesbians possess more risk factors for breast cancer, including nulliparity, alcohol and cigarette abuse, menopausal hormone replacement therapy (HRT), and obesity, and there is some evidence that they may have fewer mammograms than the general population (Fish 2005).

5.3 Parenting, Reproduction, Fostering, Adoption

5.3.0 Donor-insemination clinics and self-insemination procedures are important for lesbian women. A recent *Same Sex Relationship Survey in Australia* (McNair & Thomacos, 2005) indicated very high levels of demands for access to donor insemination, IVF and altruistic surrogacy, as well as high support for legal rights for non-birth parents. The *Cork Lesbian Health Research* (Community Consultants, 2006) also indicated a high degree of concern around this issue, as did the local focus groups.

5.3.1 Many lesbian parents face societal disapproval (Gruskin, 1999). Part of this stems from the assumption that they are inferior parents and that their children will face permanent personal developmental problems. Research has demonstrated (Golombok, 1996, Patterson, 1992) that children reared by lesbian parents are not significantly different from those reared by heterosexual parents. Indeed, research has shown that, in many respects, lesbian parents achieve a more balanced lifestyle:

5.3.2

In lesbian families, both the mother and the co-parent tended to regard parenthood as a combination of mothering and breadwinning. Whereas ideologies of motherhood and fatherhood polarised responsibilities for children among heterosexual couples, single-sex households were able to negotiate more balanced lifestyles."

(Silva & Smart 1998)

5.3.3 However, the invisibility and lack of recognition of lesbian parents results in inadequate services and support for their parenting role and for their children.

"Some of the problems that confront lesbian women, however, are a direct result of their specific position as both lesbians and women, and one of the more striking inequalities to affect them as lesbians is the lack of support and recognition of their family life. It is here that the combination of state apathy and antipathy towards non-traditional family forms serves to deny lesbian women and their children equal rights as citizens."

Community Consultants 2006

.... the combination of state apathy and antipathy towards non-traditional family forms serves to deny lesbian women and their children equal rights as citizens

- 5.3.4 Gruskin (1999) reported that 33% of lesbian parents experienced problems related to their sexual orientation. These problems included: a lack of understanding or acceptance of same sex parents, the need to continually explain their family structure and the exclusion of the non biological parent from emergency care.
- 5.3.5 Currently, lesbian and bisexual women in Northern Ireland have legal rights in relation to fostering and adoption but can only adopt or foster as individuals and not as a couple. Legislation to allow lesbian couples to adopt is currently under consideration.

5.4 Food and Eating Disorders

- 5.4.0 It is difficult to assess the incidence of eating disorders for lesbian and bisexual women. While research reports that there is a higher incidence of obesity this may also be explained by lesbian women being less likely to comply with traditional female stereotypes (Cochrane and Mays, 1995). However, in a study of lesbian and bisexual women in California, only 35% were satisfied with their current weight and 15% reported a current eating disorder; 65% overeating, 16% bulimia, 10% anorexia and 8% anorexia and bulimia (Gruskin, 1995). In another study (Gruskin, 1999), the rate of bulimia nervosa and attitudes concerning weight, appearance and dieting was similar to that of heterosexuals. However, the rate of binge eating disorders was more frequent than that of heterosexuals. A small number of lesbian and bisexual women in the local focus groups recorded obesity as a cause of some concern to them.

5.5 Domestic Violence

- 5.5.0 Although there has been little research to date investigating same sex domestic violence, anecdotal and clinical experiences and the research that *has* been conducted indicate that female couples experience violent relationships at the same rate as heterosexual women (Elliot, 1996).
- The National Coalition of Anti-Violence Programs' 1998 report suggests a domestic violence prevalence rate of between 25% and 33% in same sex couples, comparable to the findings on prevalence in heterosexual couples.
 - Physical aggression for conflict resolution was used by 47% of lesbians and gay men in the Kelly and Warshasky study (1987)
 - In a report from Health Canada (Cynthia 1995) none of the women who self-identified as being in abusive lesbian relationships sought help from police, shelters, or crisis lines.

5.5.1 Lesbian experience of domestic abuse

While the majority of issues will be the same for same sex domestic abuse as for heterosexual people e.g. undermining self-esteem, violence etc., there are a range of other ways that perpetrators attack and abuse LGBT people with whom they have a family, partner or other intimate relationship (Cynthia 1995).

5.5.2 Verbally abusive control

- Threats to 'out' someone
- Undermining sexual orientation
- Belittling transgender (not a real man/woman) and encouraging others to do the same
- Lifestyle control
- Forcing someone to act 'straight'
- Controlling levels of 'outness', preventing being 'out'

5.5.3 Emotional & psychological control

- Placing blame for sexuality (you made me lesbian)
- Blame for loss of family/friends
- Threatening to seek custody of children because of sexual orientation/gender identity

5.5.4 Physical abuse and control

- As with heterosexual domestic abuse physical violence, sexual violence and threatening behaviour

5.5.5 The effects and consequences of domestic abuse

As with other sufferers of domestic abuse, the effects and consequences for lesbians may include:

- Self harm or suicide
- Fear
- Denial
- Withdrawal
- Fear of contact with family or friends
- Barrier to emotional growth
- Long-term effects on emotional, physical and mental health
- Unable to form close relationships and bonds

5.5.6 Additionally, LGBT people may begin to identify abuse with sexual orientation or gender identity (internalising the idea that this is what an LGBT relationship is like), which can be supported by a societal view (what do you expect if you are going to be LGBT?). There is also the potential loss of children due to homophobic co-parent, family and judicial system.

5.5.7 Recommendation

The Tackling Violence At Home Strategy should identify strategies and an action plan to address the incidence of domestic violence in lesbian relationships.

6. Sexual health

6.0.0 The World Health Organization (WHO) has defined sexual health as:

“a state of physical, emotional, mental and social wellbeing related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled” (WHO, 2002).

- 6.0.1 Many young women, in exploring their sexual identity would not necessarily describe themselves as lesbian or bisexual and are resistant to adopting a label that carries a degree of social stigma (Dolan, 2005). Equally many women (who describe themselves as lesbian and not bisexual) also have sex with men. Dolan (2005) in her survey of 162 lesbian and bisexual women in the U.S.A. discovered that over 60% of her sample (who described themselves as lesbian and NOT bisexual) have had sex with a man in the previous year. It is important therefore not to view sexual identity as static or standard. Health providers should not make assumptions about sexual behaviour from the declared sexual identity of individual women.
- 6.0.2 Research has shown that lesbian and bisexual women’s perceived susceptibility (by the medical profession) to sexually transmitted diseases is generally low and may be due to lack of information and knowledge, a dearth of open discussion, misinformation and being ‘closeted’ with health care providers (Dolan,2005). There is little or no evidence that lesbian and bisexual women are more or less susceptible to STI’s (Sexually Transmitted Infections) than heterosexual women. The conclusion would appear to be that the important factor in sexual health is behaviour rather than sexual identity i.e. it is what you do rather than who you do it with.
- 6.0.3 However, the *Cork lesbian Health Research* (Community Consultants, 2006) found that lesbian and bisexual women found it difficult to access information on safe sexual practice. In particular, young lesbians complained that sex education in schools ignored sexual identity and assumed that everyone is heterosexual. This was reinforced by the response of the lesbian and bisexual women in the four local focus groups who all expressed a need for more information on sexual health.
- 6.0.4 Dolan (2005) found that sexual identity is also important in forming social realities. For example, lesbians are not generally believed to be at risk from HIV or STI contraction. When an individual becomes part of the lesbian and bisexual community, she will be most likely to accept the preexisting knowledge and perceptions of that community as natural and real. This may result in many lesbians remaining ignorant about HIV and STI contraction.

6.1 Recommendations

- 6.1.0 Consideration should be given to the specific needs sexual health needs of lesbian and bisexual women in the production and distribution of sexual health information.

7. Emotional Health

7.0 Lesbianism or bisexuality in itself does not result in psychological or personality problems. However, research indicates that the stress that lesbians and bisexual women face may lead to mental health symptoms such as depression, anxiety or various forms of acting out especially during the beginning stages of identity formation (Ross, Paulsen & Stalstrom, 1988)

7.1 Coming Out

7.1.0 There is strong evidence that young lesbians and bisexual women are becoming aware of their sexual identity earlier and also 'coming out' at an earlier age (GCN August 2004: 3). *The ShOut Report* (2003) in Northern Ireland commented:

7.1.1

"Coming out is where a person accepts to themselves their sexual orientation and wishes to share it with someone else. Coming out is a fundamental aspect of the personal and social development of young people who identify as LGBT. It can be a particularly emotionally challenging time for young people, who are caught between their developing sense of sexual identity, which is different to what is around them and wanting to fit in with their peers.

7.1.2

The average age for men to realise they were LGBT was 12 years. However the average age they first told someone else was 17 years of age. For women, realisation was at around 13 years of age, with coming out to another person at around 18 years. This indicates that for many young people there is a substantial period in their lives when they are struggling to come to terms with their sexual orientation ...

7.1.3

With 86% of respondents aware of sexuality in school and 69% involved with youth organisations, it is clear that messages young people get in these places are crucial to their personal and social development and ability to manage the critical transition from youth to adult. These findings emphasise the need to consider the development of specific support for young LGBT people under 16 years old.

(ShOut Report 2003)

7.1.4 This was reinforced in the local focus groups where women revealed that they were aware of their sexual orientation for almost 9 years, on average before they told anyone. This led to feelings of isolation and low self esteem as reported by focus group participants.

7.1.5

"I had a bad reactive depression - I cut myself off from people - the fear was horrific - I was afraid of being rejected by my mother, my family - it was the most horrific period of my life. We need to build up positive networks - we need very little - we need infrastructure"

focus group participant

7.1.6 The *N.I. Young Life and Times Survey* (2005, 2006) reveals the impact of this on the mental health of young people with 1 in 2 same sex attracted young women registering as suffering from mental ill health on the General Health Questionnaire Diagnostic tool.

There is strong evidence that young lesbians and bisexual women are becoming aware of their sexual identity earlier

7.1.7

"For ten years before I became aware of my sexual orientation, I struggled to understand who I was and why no-one wanted to understand other than to tell me I should be like this, I should behave like that, I have to wear these clothes and what was my problem!"

focus group participant

7.1.8 'Coming out' is an ongoing and almost daily experience for lesbian women of all ages and can become a source of stress if they face homophobic attitudes in society.

"I'm 'coming out' all the time - every day I have to do it if I don't want to be invisible - it's hard work!"

focus group participant

"The reality is I'm invisible- I have to make myself invisible - people are obsessed with the sex part of it"

focus group participant

7.1.9 The *Cork Lesbian Health Research* discovered that:

"The requirement for lesbians to come out is constant, exhausting and often stressful. While everyone agreed that coming out is essential to your own and others quality of life, much more could be done by Health Professionals to make coming out an easier, safer and supported experience."

(Community Consultants, 2006)

7.1.10 Lesbian and bisexual women who 'come out' later in life reported in the focus groups that there was no support for them or their families and children.

"I didn't sleep for 3 days before I came out to my son - I was afraid he would reject me or wouldn't be able to cope"

focus group participant

7.2 Lesbophobia

7.2.0 Homophobia, the most commonly used term describing anti gay or lesbian feelings, means, literally, fear of the same; in this case fear of same gendered sexuality. Lesbophobia describes the process of discrimination on the basis of both gender and sexual orientation. This process results in lesbian and bisexual women being largely invisible and silenced within society. They carry the same burden of responsibility for caring for children and elderly relatives without recognition or acknowledgement.

7.2.1 In the 1999/2000 *European Values Survey* over a quarter of Irish people said they would not like to have a homosexual as a neighbour - one of the highest figures in the European Union. (Halman, 2003). The *Eosgallup Survey* (2003) shows that support for homosexual marriage and adoption is still relatively low among Irish people compared to many of our European counterparts (Eosgallup, 2003). However, the LASI MORI Poll (2006) indicated that knowing LGB people reduced the levels of homophobia and fear of LGB people.

7.2.3 Health professionals also express homophobia. A high level of prejudicial and stereotypical attitudes to lesbians was found in a U.S.A. study of attitudes carried out among 278 nursing students' *"the most prevalent stereotypes included lesbians' seduction of heterosexual women, lesbian "boasting," and the "masculine aura" of lesbians"* (Stern, 1993). In the

Cork Lesbian Health Research (Community Consultants, 2006), a lecturer in Nursing Studies, at Dublin City University, argued that teaching health care providers about the specific health requirements of various minority groups, such as lesbians, is the first step towards changing attitudes towards, and service provision for, those groups. Her experience of teaching nursing students about lesbian women's health care needs is often met with resistance, and with the response that *"All women are surely the same?"* even though they accept without question that they should study a module on the needs of other (ethnic) minority groups.

7.3 Internalised homophobia / lesbophobia

- 7.3.0 Most lesbian and bisexual women are exposed, from a young age, to heterosexist and homophobic attitudes in their families and society – often unwittingly. They have few positive role models and do not have access to inter-generational support that is vital in supporting young people to cope with prejudice and bigotry.
- 7.3.1 Research from the United States suggests that gay and lesbian people who are afraid to come out or who are otherwise unable to access the gay and lesbian community, are at risk of psychological distress and damaged self-esteem. (Garnets *et al*, 2002). Straying from the heterosexual ideal can result in the lesbian or bisexual woman being arrested, beaten, killed or verbally harassed, losing the support of her family and friends, or losing her children (Gaskin 1999). She often internalizes negative feeling about homosexuality, resulting in low self esteem, self destructive behaviour such as alcohol use, depression and even suicide (Gaskin, 1999). A significant relationship has been observed between internalized homophobia and depression, substance misuse, guilt, sex difficulties, suicide, HIV-related traumatic stress response, and low self-esteem (Gay HIV Strategies, 2004; King & McKeown, 2003).

7.4 Heterosexism

- 7.4.0 Heterosexism can be defined as the belief that heterosexuality is naturally superior to homosexuality or bisexuality. This belief justifies domination and the imposition of heterosexist values and beliefs. Heterosexist beliefs can be institutionalised in that they can justify social exclusion and discrimination in relation to housing, education, employment and health and social care. While homophobia is often seen as a consequence of individual behaviour and bigotry, heterosexism is deeply imbedded in both practice and policy within society. For example, in the focus groups many women complained about the heterosexism in relation to the questions they were asked, by health professionals, about their sex lives. They were unsure as to how to answer questions on sexual intercourse, contraception and relationships.

"they ask intrusive questions re contraception use with no awareness that I might be gay"

focus group participant

"a smear test is a nightmare 'cos of the questions they ask"

focus group participant

- 7.4.1 While many health professionals unwittingly ask these questions, they reinforce a system of domination and subordination and draw upon a set of values within society that specify the inferior nature of same sex relationships.

7.4.2

“The poor mental health of lesbians and gay men may not be the result of internalised homophobia, but rather the consequence of living in a world which constructs them as inferior. To name suicide as a possible outcome of heterosexism shifts the focus of attention from blaming the victim to the social and political environment which allows the bullying of young lesbians and gay men to go unchecked and which privileges discourses of heteronormative masculinity and femininity”

(Fish 2006)

- 7.4.3 Sexism, racism and disabilism are perpetuated in beliefs about the inherent inferiority of women, black people and disabled people. Similarly, heterosexism is based on assumptions about the inferiority of lesbians, gay men and bisexuals.

7.5 **Impact of religious beliefs**

- 7.5.0 Some lesbian and bisexual women have been unable to resolve the conflict between their sexual behaviour and the teaching of their religions (Gruskin, 1999). The LASI MORI Poll (2006) conducted in Northern Ireland also found a correlation between strongly held religious convictions and homophobia. It may be important for health professionals to examine and then put aside their own personal religious beliefs about homosexuality so that their biases do not interfere with their professional role or, it may be appropriate for them to refer their lesbian and bisexual clients to other providers. Some of the focus group participants did not want to be stigmatised by separate health provision:

“Within a health context do lesbians want to stand out from the crowd? If I’m going to the doctor with a family member, would I want to be going through a different door than my sibling? Surely that would beg the question ‘what’s wrong with her?’”

focus group participant

- 7.5.1 *“Negative religious teachings about homosexuality have created a deeply embedded core of shame and self-loathing which surfaces in a host of dysfunctional attitudes and behaviors ... low self esteem, chronic depression, substance abuse, eating disorders, co-dependency and sexual addiction or sexual dysfunction”*

(Booth, 1995 quoted in Gruskin, 1999)

- 7.5.2 Lesbian and bisexual women need the support of their family and community – including their religious community:

I trained as a counsellor with the churches and I didn’t say I was lesbian – the stress was too much. When I eventually said it in the group – 4 others came out”

focus group participant

- 7.5.3 The churches should consider the impact of their teachings on the emotional and mental health of their lesbian and bisexual members and congregations.

7.6 **Bisexual women**

- 7.6.0 Existing research and literature on bisexuality and health has focused primarily on two topics: HIV/AIDS and mental health, therapy or counselling. Those wishing to find information on other aspects of bisexual health and wellness must sort through the sea of

The poor mental health of lesbians and gay men may not be the result of internalised homophobia, but rather the consequence of living in a world which constructs them as inferior

research and writing on gay, lesbian and bisexual health to try to find any bits and pieces that specifically address bisexuals. Even in research where bisexuals are included they are usually not adequately represented and are not looked at separately. Although sharing some common concerns with both gay/lesbian and heterosexual persons, bisexuals also have specific experiences and needs regarding health and wellness that need to be researched and addressed.

7.6.1

“When asked about the unique issues, experiences and challenges facing bisexual people one of the most common responses was to list the kinds of myths and stereotypes that exist around bisexuality, and which bisexuals must deal with. These include: that bisexuals must have a 50/50 attraction to men and women, that they are dishonest and cheat on their partners, that they can’t be monogamous, that it’s a phase or a transition, that bisexuals are wild and sexual, that they spread STDs/AIDS, that they are selfish, that they’re playing the field, that they can’t make up their minds, that bisexuality doesn’t really exist and isn’t a legitimate sexual identity, and that bisexuals stay in the closet and live a mainly straight life.”

(Bisexual Resource Centre 2002)

- 7.6.2 Local focus group participants also talked about feelings of not belonging in either the straight or gay world, and about experiencing biphobia from gays and lesbians. They pointed out that bisexuals are largely invisible and that there is a lack of bisexual groups or a bisexual community to be part of. They mentioned isolation and loneliness, confusion, and mental health and self-esteem issues. Many felt that bisexuals experience pressure to choose to identify as gay or straight and also others being confused about what bisexuality means or why it is important.

7.7 Multiple Identities

- 7.7.0 The lesbian and bisexual community is not homogenous and many women carry the additional burden of discrimination and social exclusion on the basis of their race, religion, disability and age.

- 7.7.1 Unlike other ethnic, racial and religious minorities, most lesbians and bisexual women differ from their families in their sexual orientation. They often have to cope with intensely negative reactions from within their families, especially when their families first learn about their sexual orientation (Quiery, 2002). Coming out to families may be the most difficult process that a lesbian or bisexual women ever has to face. This process can be particularly difficult for women from minority ethnic groups or women from conservative religious backgrounds (Chan, 1993).

7.8 Minority Ethnic Lesbian and Bisexual Women

- 7.8.0 Minorities have poorer general health, when compared to the rest of the population (Nair, 2005). The relationship between health inequity and a minority status (whether ethnic or sexuality-related) is complex. Factors such as limited access to services, institutional homophobia and racism, language barriers, and religious and cultural insensitivity of services, are some of the social factors that restrict minority ethnic lesbian, gay and bisexual people from accessing health services at the appropriate time.

The lesbian and bisexual community is not homogenous and many women carry the additional burden of discrimination and social exclusion on the basis of their race, religion, disability and age.

- 7.8.1 For minority ethnic lesbian and bisexual women, the 'coming out' process presents challenges in identity formation processes and in their loyalties to one community over another. They need to live within three rigidly defined and strongly independent communities: the LGBT community, the Minority Ethnic community, and society at large. It requires a constant effort to maintain oneself in three different worlds, each of which fails to support significant aspects of their lives.
- 7.8.2 The complications that arise inhibit their ability to adapt and to maximise personal potentials.

"Some communities regard non-heterosexual sexualities as "social deviance", or a "Western disease". Strong familial, cultural, and religious backgrounds, which tend to be heterosexist, may make the process of coming out more arduous. Because sex and sexuality are generally considered suitable to reside in the private domain, open discourse pertaining to these topics has been limited. Furthermore, most traditional societies also look upon marriage and procreation as a familial and social obligation. This fosters a sense of duty, failing to fulfil, which may be fraught with feelings of guilt and shame. Associated to this communal obligation, there may be a sense of fear of rejection from the family, and being ostracised from the larger community also. This is especially pertinent for the black and minority ethnic individual for whom their own ethnic communities form an extended support system in the face of racial and other adversities."

Nair (2005)

- 7.8.3 TAG (Traveller and Gay) has been established as an all Ireland support group for lesbian, gay and bisexual members of the Traveller community. There are no other support systems for minority ethnic people in Northern Ireland who do not identify as heterosexual. The Director of NICEM (N.I. Council for Ethnic Minorities) felt that minority ethnic groups do not have the capacity or willingness to deal with what they see as a 'challenging issue' and felt that the LGB community should be resourced to do this important work.
- 7.8.4 Additionally, minority ethnic lesbian and bisexual women meet with stereotyping and prejudice in the mainstream lesbian and bisexual women's community. Their needs are at best ignored and often rejected as being a minority issue which does not deserve attention. Research in the U.S.A. has shown that this isolation and marginalisation leads to higher levels of reactive depression and anxiety (Mays, Cochrane & Roeder 2004)

7.9 Lesbian and Bisexual Women with Disabilities

- 7.9.0 Disabled people are entitled, like everyone else, to explore and express their sexuality, to form relationships, to leave these when they wish to do so, and to make mistakes along the way. However, disabled people have traditionally been regarded as being asexual and genderless.
- 7.9.1 Since to be homosexual, bisexual or transgendered is regarded as being a primarily sexual identity, the disabled LGB community has been largely invisible. For older disabled people this situation is compounded by the way in which the sexuality of all older people is generally ignored or considered inappropriate to mention (except as a symptom of 'pathology', for instance in dementia).
- 7.9.2 The needs of LGB people with disabilities therefore tend to remain unrecognised within

social care provision. Social care providers need to recognise that all disabled people have the right to express their sexuality and to form relationships, and providers need to cater for the needs of LGB disabled people rather than assuming that all disabled people are heterosexual and have uniform needs.

- 7.9.3 The LGB community in Northern Ireland has little or no provision for lesbian and bisexual women with disabilities and those women consulted as part of this review reported feelings of isolation and marginalisation. None of the LGB social centres or clubs has disability access. One woman reported that she had to be carried up 3 flights of stairs to access a meeting – an experience which she found both humiliating and frightening but didn't feel confident enough to complain.

“The worst barriers for me are venues that aren't wheelchair accessible – I only go to bars and discos that are accessible, so I don't go out very often. I get the feeling that people don't want to talk to me but thought I was paranoid. I put an advert in the spinal cord injury magazine and I got 1 reply – we've been in touch for almost 6 years – there's nothing here.”

focus group participant

“For deaf women, communication is the issue – there's a big barrier there – talking is so dominant – some LGB people don't talk to us because they're embarrassed”

focus group participant

- 7.9.4 Organisations working on the issue of disability do not currently have any support services for lesbian and bisexual women:

“Deaf organisations do not offer support – they don't have anything at the minute – I've never asked for support. I've never tried, to be honest, I'm not confident enough.”

focus group participant

7.10 Young lesbian and bisexual women

- 7.10.0 Family and societal attitudes towards same sex relationships impinge on the development of adolescent lesbian and bisexual girls and young women.

- 7.10.1 Mark McConville (1995) has devised a model of adolescent development which has three major features corresponding generally to the phases of development in traditional models. However he names and describes the processes as follows:

7.10.2 The disembedding process - early - (12 – 14yrs)

The early years of adolescence is primarily taken up with disembedding from the field of family relations, in other words moving out of the life of the family as it has been experienced as a child. Both psychological space and geographical space are dominated by the life of the family. The family is the ground from which its members move to engage with the world. So we can say that the child is embedded in the family. The childhood world is largely one characterised by introjection (Burrows & Keenan 2006). Introjection is the process whereby meaning is organised for rather than by a child – a 'swallowing whole' of environmental input. The child absorbs adult rules, values and beliefs uncritically and does not yet make up her own mind about these matters. For example, a parent may teach a child to obey her elders which the child incorporates as a directive for how she behaves in the world. One such maxim is the belief that the world is heterosexual – reflected also in early reading books at school and on children's television. Young lesbian and bisexual people also internalise the belief that heterosexuality is the 'norm' in their

environment.

Part of the 'disembedding' process is for the child to separate from their family, explore their difference and establish a new sense of self.

"The purpose of disembedding is to establish a boundary between the young adolescent and his/her family and parents, to establish and develop a sense of difference. The young adolescent needs and strives to maintain this difference and to support this new experience of self."

(Burrows & Keenan)

- 7.10.3 Research has shown that the average age for young lesbians to become aware of their sexual orientation is 13 years and the age at which they tell someone else is 18 years. Young lesbians and bisexuals are becoming aware of their difference and do not have the support to be able to explore this safely and develop a strong sense of self. They experience their difference as isolating and alienating from both their family and friends.

"I spend my time worrying about how others (family) are dealing with it - there's anxiety about not saying and anxiety about saying!"

focus group participant

7.10.4 **The process of interiority - middle - (15 - 16yrs)**

This process involves the young person becoming more reflective and more conflicted within as they explore the divergencies of inner, private experience from the outer world of social relatedness. While many young people experience this process as an individual and isolating one, they can often access support through their peers who are experiencing similar feelings.

"Insight always involves reorganisations of the field, and these invariably (at least for a time) diminish the individual's sense of worth and value, and raise the developmental dilemma of whether or where this is even bearable. Where there isn't much environmental support for the young person, it may be that growth carries too high a price. Often young people experiencing this reject the possibility of any contact and may resort to drug use and other methods of 'heightening stimulation to the point of distraction or blunting it to the point of anaesthesia'."

(McConville)

- 7.10.5 For many young lesbian and bisexual women in the North of Ireland, there is no environmental support for exploring this experience.

"I came out at school and kept it to myself for 2 years - I didn't tell a soul- I didn't know any other lesbians for 3 years. "

focus group participant

- 7.10.6 There are currently two youth groups in Belfast Gay, Lesbian Youth, Northern Ireland (GLYNI) and Out and About, for young women who identify as other than heterosexual. Youth Action is developing additional peer support groups throughout Northern Ireland. YouthNet also has dedicated support for lesbian, gay and bisexual young people. There are no dedicated counselling facilities for lesbian young women. It is therefore unsurprising to learn that young lesbian women are involved in high risk behaviour, smoking, alcohol and drug consumption and unprotected sex with men in an effort to deny their developing sexual orientation

(Young Life and Times Survey, 2006).

7.10.7 The process of integration - late - 17 +

Integration involves the young person in a process of integrating earlier experience and creating a new meaning of self. This often includes re-engaging with parents and family in a new and more equal relationship. The young person learns to engage with others and with mutual influence without risking disintegration.

"This is the age when identity formation comes front and centre as the measure of developmental accomplishment"

(McConville)

7.10.8 Often, the young lesbian woman is not able to form her true identity and 'acts in' as a way of containing the strong emotions around her sexual identity.

"Acting in is when strong emotions are turned into actions relating to the self. Generally, young women 'act in' through various kinds of self harm and withdrawal. We tend not to notice acting in as this is more hidden."

(Burrows & Keenan 2006)

7.10.9 The world of the adolescent is a hidden one. Fear of 'coming out', revealing her emergent identity and risking rejection by her family and her peers leads the adolescent lesbian to turn her emotion inwards and high levels of self harm are reported in this age group.

7.10.10 It can be seen that the processes of adolescent development are interrupted in various ways for young lesbian women. The support of sympathetic adults is crucial in supporting the adolescent and the emerging sense of self. It would appear that these women have been left with few resources to enable them to navigate their way through to adulthood.

"In my last year at school there was one girl who had a crush on me - she'd buy me Valentine cards and sweets - the head found out and I was expelled 'cos I was the oldest"

focus group participant

7.11 Older lesbian and bisexual women

7.11.0 Older lesbian and bisexual women have many of the same concerns as their heterosexual counterparts with the additional fear that they and their needs may become more invisible. In a New York research study (Hollibaugh 2005), for example, it was found that older lesbians, gay men and bisexuals have significantly diminished support networks when compared to the general older population. Hollibaugh found that:

- up to 75% of older lesbians, gay men and bisexuals live alone (compared to less than 33% in the general older population)
- 90% have no children (compared to less than 20% in the general older population)
- 80% age as single people, without a life partner or 'significant other' (compared to less than 40% in the general older population)

7.11.1 When compared to their heterosexual counterparts, therefore, older lesbians, gay men and bisexuals were found to be:

- twice times as likely to live alone
- twice as likely to age as a single person
- four times as likely to have no children to call upon in times of need

7.11.2 This translates into a lack of traditional support networks that are not replaced by the strength of other close friendships or the size of informal support networks within the lesbian, gay or bisexual community, with the result that:

- 20% of older lesbians, gay men and bisexuals indicate they have no one to call on in a time of crisis or difficulty – a rate up to ten times higher than that seen in the general older population

7.11.3 This means that older lesbians, gay men and bisexuals are much more reliant on and have a much greater need for professional services and formal support systems in old age than is the case with their heterosexual counterparts. While these figures may not be the same in the North of Ireland they do indicate a need for social care organisations to address the concerns of older lesbian and bisexual women.

The older women in the focus groups revealed that:

- Most of them are not 'out' to their doctor
- They felt ignorant about their own health
- They found it hard to admit to depression
- They want to be mainstreamed in terms of health care

"We pay our taxes too – why shouldn't we have access to good health services?"

focus group participant

7.11.4 They were also concerned about social care in later life and whether or not their sexual identity would be acknowledged:

"Will elder care be relevant to my identity – will I have to re-enter the closet?"

focus group participant

"Will elder care be relevant to my identity – will I have to re-enter the closet?"

7.11.5 Many lesbian women who 'come out' in later life have not established a support network and as they are less likely to be 'on the scene' (going to clubs and pubs) may remain isolated:

"I came out when I was 48 - lesbian community? What lesbian community? There are small groups of lesbian friends and no real community support available to the likes of me"

focus group participant

7.12 Lesbian and Bisexual Women in Rural Areas

7.12.0 There is little available evidence as to the number or needs of lesbian and bisexual women in rural areas in Northern Ireland. To date, few of the organisations tasked with addressing the needs of rural communities have considered lesbian or bisexual women. There is an urgent need for further research into the needs of lesbian and bisexual women in rural areas. The Department of Agriculture and Rural Development (DARD) is dependent upon assistance and advice from a small number of LGBT organisations:

"it is extremely difficult for DARD to establish what the views and aspirations of lesbian/bisexual women are without the assistance of organisations such as LASI. We have previously engaged with LASI and Rainbow in relation to the provision of training, and more recently during the Rural Development Plan Equality Impact Assessment, but without this engagement we would have no insight into the needs of rural lesbian and bisexual women."

DARD spokesperson

However, participants in the focus groups acknowledged the isolation of lesbian and bisexual women in rural areas.

*"If you live in Crossmaglen you're f*****d!"*

7.13 Support and Social Health

7.13.0 Support systems can alleviate many of the impacts of lesbophobia and heterosexism. The *Cork Lesbian Health Survey* discovered that peer support is essential in developing good emotional and mental health for lesbian and bisexual women:

"The primary source of support is friends. It is therefore important that the community as a whole is supported so that individuals can fulfill the role required of them. There are issues relating to sexual orientation that impact across the health spectrum which require an understanding of the social context of lesbian and bisexual women in order to be addressed."

(Community Consultants, 2006)

7.13.1 The table below, taken from the *Cork Lesbian Health Research*, demonstrates the importance of friends and family as a source of support for lesbian and bisexual women.

Support that % of respondents feel comfortable using.
Cork Lesbian Health Research (2006)

Support	%
Friends	88
Family	66
GP	28
Lesbian Community Workers	21
Internet	15
Straight Community Workers	14
Other	12

7.13.2 The focus group participants also reported the need for and absence of appropriate support systems:

"I moved to the U.S. and met other deaf lesbians - I learnt a lot - they had support systems. What I wished for at school was a support system and after school, at college - my girlfriend was the only support I had"

7.13.3 The Indigo Lesbian and Bisexual Women's Group in the North West have also reported, in an independent evaluation of LASI (Havlin, 2007), on the benefits of a group resource to their social health. Members of the group stated the following impacts of joining a support group:

" We each feel:

- strengthened by our sense of belonging to a positively affirming group of lesbian and bi-sexual women. This has affirmed our sense of who we are/ our identity as lesbian and bisexual women;*
- increased our confidence level;*
- less isolated;*
- more empowered; and have taken this positive empowerment into our relationships, our families, our friendships, our work, and our wider lives;*
- our own internalised homophobia has been reduced through the positive interactions we have with each other. An element of this interaction is to do with the positive role modeling both within the Group, and with our individual interaction with Lasi members;*
- encouraged to reach out to other isolated lesbian and bisexual women;*
- the positive benefits of improved mental and emotional health. We each feel happier, more connected and more fulfilled;*
- the support of the Group and of Lasi in our 'coming out' to our families, friends and work colleagues. As we 'come out' and are accepted, this reinforces our sense of acceptance of ourselves;*
- our trust of ourselves and each other grow as a consequence of our positive interactions with each other. This has strengthened our sense of self.*
- we have benefited from meeting other lesbian and bi-sexual women in a warm, friendly and safe environment, not involving alcohol and drugs. "*

(Havlin, 2007)

we have benefited from meeting other lesbian and bi-sexual women in a warm, friendly and safe environment, not involving alcohol and drugs.

7.13.4 The importance of peer support is acknowledged in the mainstream youth service and appropriate support systems should be provided for lesbian and bisexual young people to ameliorate the impact of the lesbophobia and heterosexism that they face.

7.14 Recommendations

- 7.14.0 The Department of Education and the Youth Service Liaison Forum should undertake a review of the effectiveness of current provision (including resource allocation) for young lesbian and bisexual women – in line with the *Youth Work Strategy 2005 – 2008*.
- 7.14.1 The DHSSPS should work in partnership with lesbian / bisexual women’s organisations to develop a strategy for addressing their health and social support needs. This should recognise the multiple identities of lesbian and bisexual women and pay particular attention to the social and health care needs of older women.
- 7.14.2 Support and information for the families of lesbian and bisexual women should be considered by statutory and voluntary bodies, religious organisations and schools.

8. Mental health

8.0.0

“Mental health is the emotional and spiritual resilience which enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of wellbeing and an underlying belief in our own and others’ dignity and worth.”

Health Education Authority 1998

8.0.1 In the *Bamford Review of Mental Health in Northern Ireland* (Mental Health Promotion, 2006) the following factors were cited as essential to good mental health:

- **Feelings** - Confident, understood, respected, empowered, safe
- **Skills** - Life skills, parenting, relaxation, help seeking, keeping fit, accessing information, problem solving
- **Meaningful Activity** - Employment, volunteering, education, leisure, creativity, spiritual growth
- **Social Support** - Self-help groups, opportunities for friendship, faith communities, home visits
- **Access to Resources** - Paid work, adequate welfare benefits, appropriate services
- **Influence** - Opportunities to participate, being consulted, shared decision making, advocacy, and complaints procedures. (Friedli, 2004)

8.0.2 It is clear from the national and international research cited above that many of these factors are absent for lesbian and bisexual women in Northern Ireland. Indeed, it has been suggested by researchers that higher smoking and drinking rates among lesbians may indicate higher rates of depression, stress, low self-esteem, and complications of childhood abuse - all possible effects of being a lesbian in a heterosexual-oriented society (Hughes & Wilsnack, 1997)

8.1 Stress, Anxiety and Depression

8.1.0 Lesbian and bisexual women experience unique stresses, in addition to the stresses all women experience (O’Hanlon, 1996). Stress is a health risk increasing the chances of myocardial infarction, asthma, diabetes, gastrointestinal diseases, viral infections and autoimmune system deficiencies. It may also be a factor in substance abuse, unhealthy eating habits and sleeping problems (Gruskin, 1999).

8.1.1 The stresses of lesbian and bisexual women include decisions about when to disclose their sexual orientation, hiding their sexual orientation, lack of support for their sexual orientation and relationships, absence of role models, identity development and homophobia and heterosexism (Falco quoted in Gruskin, 1999).

8.2 Self harm and suicide

8.2.0 In a 1994 US study of almost 2,000 lesbians, over half of the sample had had thoughts of suicide (18% had attempted suicide), 37% had been physically abused as a child or an adult, 32% had been raped or sexually attacked, and 19% had been in an incestuous relationship while growing up (Bradford, Ryan & Rothblum, 1994). About 75% of the sample had received counselling at some time, half of these for reasons of sadness and depression. Safren and Heimberg (1999) reported that women who identify as lesbian or who have sex with women are more likely to admit to being depressed and to be taking antidepressants. When questioned about causes of depressive stress in their lives, most

lesbians report stress from isolation and social ascription of inferior status and lack of support from families and friends. The *Cork Lesbian Health Report* (Community Consultants, 2006) reported, with some concern, that lesbians in Cork have a higher incidence of self harm than their American counterparts.

- 8.2.1 Self-harm, suicide ideation (thinking of suicide) and attempts as noted in the *Cork Lesbian Health Survey*, American lesbians and their heterosexual siblings

	% in Cork Survey	% American Lesbians	% Heterosexual Siblings
Self Harm (now)	2.8		
Self Harm (past)	23.8	24.5	13.2
Suicide Ideation	49.1	38.4	19.7
Suicide Attempt	14.2	7.9	4.4

Mean no. of attempts 1.92 (2.4)

- 8.2.2 In Northern Ireland, the mental health concerns of young women have also tended to be overlooked as the *Still Waiting* Report has acknowledged:

“To an extent the strong focus on male suicide has skewed the discussion on mental health away from the issues facing young women. Young women themselves made frequent reference to the suicide among young men and, were obviously directly affected when it was a friend or a relative - although this largely goes unrecognised. The myth that women cope better because they are more likely to talk to friends is perpetuated even by young women themselves. Yet, if this goes unchallenged it is unlikely that appropriate support will be provided to young women.”

Youth Action (2007)

- 8.2.3 Lesbians who do not hide their homosexuality report more satisfaction in their jobs and relationships (Griffith & Hebl, 2000. Ellis & Riggl, 1995) although this coming out can result in either greater acceptance or becoming a target for violence. Such a paradox can help to explain why depression and psychiatric illness are more common for lesbians. Although being a lesbian or a sexual minority is not inherently (genetically, biologically, morally) hazardous, risk factors are conferred through what has been called “homophobic fallout.” The process of lesbophobia—the socialisation of heterosexuals against lesbians and concomitant conditioning of lesbian and bisexual women against themselves—must be recognised by health providers as a legitimate and potent health hazard.

8.3 Recommendations

- 8.3.0 Those responsible for managing the NI Suicide Prevention Strategy should conduct further research into the incidence of self harm and suicide ideation amongst lesbian and bisexual women in Northern Ireland.

9. Review of Services and Supports

9.1 Legislative and policy context

- 9.1.0 Lesbophobia and heterosexism, unlike racism and sexism, have developed against a background of the pathologisation of same sex relationships. Until 1973, homosexuality

was listed as a mental disorder in the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 1973). However, it took until the early 1990s before it was removed from the *International Classification of Diseases* (WHO, 1992).

- 9.1.1 The notion that same sex relationships are regarded as abnormal and perverted has survived into the 21st century in the North of Ireland. The fear of lesbians (lesbophobia) and attitudes which assume that heterosexuality is the norm (heterosexism) persist. Lesbians are also impacted by the inequality created by sexism in relation to income levels and health. These attitudes have been institutionalised in Northern Ireland where lesbian, gay and bisexual people were not accorded full human rights until 2006 when same sex partnerships were recognised in law. Employment protection was only introduced in 2003 and the right to equal treatment in goods, services and facilities came into effect in January 2007.
- 9.1.2 Recent years have seen an increase in legislation and government policies which aim to address the discrimination and unequal access of lesbian and bisexual women to health services and support. These include:
- Section 75 of the Northern Ireland Act (1998) which requires public authorities to promote equality of opportunity
 - The Human Rights Act (1998)
 - The Employment Equality (Sexual Orientation) Regulations (NI) 2003
 - The Equality Act (Sexual Orientation) Regulations (Northern Ireland) 2006 which covers equal rights in relation to goods, services and facilities.
- 9.1.4 A number of policy initiatives have also been introduced in recent years which are relevant to the health needs of lesbian and bisexual women. However, very few of these have targets aimed at lesbian and bisexual women. Some do not even mention them. The strategies include the following:
- The *Investing for Health Strategy* (2002)
 - The *Promoting Mental Health Strategy and Action Plan*, (2003) published by the Department of Health, Social Services and Public Safety
 - The *Sexual Health Promotion Strategy and Action Plan* (2003)
 - The *Bamford Review – A Strategic Framework for Adult Mental Health Services* (2005)
 - The *Northern Ireland Suicide Prevention Strategy and Action Plan, 2006-2011* (2006)
 - The *Gender Equality Strategy* (2006)
 - *Tackling Violence at Home*, strategy 2005
 - Strategy and Action plan to promote Equality and Human Rights (to be published in 2007)
 - The Sexual Orientation Strategy which is awaiting publication
- 9.1.5 The Office of First Minister and Deputy First Minister (OFMDFM) have emphasised in *Researching Lesbian, Gay, Bisexual Transgender Issues in N.I.* (2004) that sexual orientation should be an integral part of other government strategies:
- “The interaction of discrimination on the grounds of sexual orientation and on other grounds such as gender, race, disability, etc means that there should be scope for LGBT issues to be included within equality strategies addressing other inequalities, as well as a specific focus being required on sexual orientation issues.”*
- 9.1.6 However there is little evidence that any substantial actions have been taken as a result of these strategies and sexual orientation, as an issue, remains under researched and under resourced.

9.2 Statutory Services and Support

9.2.0 The health needs of lesbian and bisexual women are gradually being acknowledged in government strategies. It has been recognised (Bamford, 2005) that they have a higher risk of mental ill health than their heterosexual counterparts although there are no specific targets outlined in the various governmental Strategies and Action Plans. The Suicide Prevention Strategy has recommended the following action in relation to marginalised and disadvantaged groups:

“To ensure that appropriate support services reach out to all marginalised and disadvantaged groups, in particular lesbian, gay, bi-sexual, and transgender groups, rural communities, ethnic minorities, and those people who are economically deprived”

9.2.1 As yet, Phase I of the Mental Health Public Information Campaign has focused on young men with no direct mention of either sexual orientation or lesbian and bisexual women. However, there have been a small number of initiatives undertaken by statutory bodies which have recognised lesbian and bisexual women’s health needs. These include:

- The Eastern Health and Social Services Board launched *Mum, Dad, I’ve got something to tell you* – a guide for parents who have lesbian, gay or bisexual (LGB) children (2001)
- The Eastern Area Equality Best Practice Forum has a *workingwithdiversity.org* information website aimed at health and social care practitioners
- The Southern Health and Social Services Board have a website *coolsexinfo.org.uk* which contains sexual health information and advice and points them to people, places or organisations where they can obtain further help or assistance in areas such as pregnancy, contraception, sexually transmitted infections.
- The DHSSPS helped to fund *Sex, Drugs, Rock & Dough* a booklet which contains a section on sexuality (2004)
- The Eastern Area Equality and Best Practice Forum has funded a poster to be published by LASI and the Rainbow Project on sexual orientation for display in G.P.’s surgeries 2007
- The DHSSPS has also provided funding (2006/07) of approximately £110,000 towards gay men’s health projects and approximately £21,295 towards lesbian and bisexual women’s health projects (including this report).

9.2.2 In general, the health needs of gay and bisexual men have received more attention despite the higher incidence of mental ill health of lesbian women. Some of the reasons given for this by the DHPSS and Investing for Health officers who were interviewed were the lack of statistical evidence in relation to lesbian health, the lack of capacity to lobby on behalf of the lesbian community and the invisibility of the lesbian community in the North of Ireland. The lesbian and bisexual women’s community should have additional financial support to enable them to voice and lobby for their needs.

9.2.3 Section 75 has had a positive effect in supporting engagement with the LGB community although little in the way of targets or specific initiatives has emerged from this engagement. There is, for example, no regional health strategy in relation to lesbian and bisexual women. The Australian State of Victoria (2003) has recognised the importance of and need for a specific *Sexual Orientation Strategy and Action Plan* and has adopted of a social model of health in relation to sexual orientation:

“Health and illness are effects of how physiological and psychological processes are influenced by and interact with wider social, economic and cultural factors. A social model of health demands that health planning and service delivery take into account the broader contextual

The lesbian and bisexual women’s community should have additional financial support to enable them to voice and lobby for their needs.

factors that influence patterns of health and illness including public policies, environmental factors and different socio-cultural practices and values.”

9.3 Primary Health Care

- 9.3.0 In the *Public Satisfaction Survey* (2004), people of different sexual orientation reported that they were reluctant to ‘come out’ to their G.P.’s as many of them had homophobic attitudes. They felt there was an “over reliance on drugs rather than examining underlying causes”. These concerns were echoed in the focus groups of lesbian and bisexual women with over 40% of those surveyed reluctant to ‘come out’ to their G.P.s. In particular, those women with disabilities were afraid of the impact ‘coming out’ would have on the health service upon which they felt very dependent. All respondents felt that G.P.s were not given sufficient training or information on sexual orientation and ways in which this may impact on their health:

“Doctors tend not to know how to ask questions or engage in communication re sexual orientation”

“I feel I don’t have the confidence to talk to my doctor/nurse about being gay as they have very little knowledge on the subject”

“I feel that my sexual orientation was ignored when I had a bout of depression”

focus group participants

- 9.3.1 Four young women reported that they were told by their GP that they didn’t need a smear test. As a result one of these young women went for 5 years with undiagnosed polycystic ovary syndrome:

“I was told I wasn’t allowed a smear test when I was 18 – I’m 23 now - I had to insist after 5 years – you know the way they ask you – have you had sex? It ended up I had polycystic ovary syndrome and it could have been detected – they even tested me for diabetes – they didn’t even say they were sorry!”

focus group participant

- 9.3.2 The majority of focus group participants reported heterosexism as they were assumed to be heterosexual when asked about their sex lives. Two women reported fear on the part of nurses taking smear tests when they revealed their sexual orientation.

“When I told the nurse I was lesbian- she dropped everything and called for the doctor – I was mortified and changed my doctor after that!”

focus group participant

- 9.3.3 Women suggested that doctors should have posters and leaflets advertising that they are ‘lesbian friendly’ and should phrase questions about sexual activity and the gender of their partners in a more neutral fashion.

“I think Health Promotion agencies – medical practices – Well Women Centres need to be MORE pro-active in recognising, including and acknowledging in public advertisements that human beings have a range of sexual orientations (as norm) and it is okay. That might help older (more closeted) women to feel more comfortable about being more open about

their orientation when face to face with these practitioners. One doesn't have to make a big deal out of one's sexuality but where health and welfare are concerned then women must feel safe and comfortable about being able to trust the practitioners."

focus group participant

9.4 Secondary Care services

- 9.4.0 Hospitals were regarded as more sensitive when women revealed their sexual orientation although some women reported homophobic attitudes. They felt that more awareness training should be provided for hospital staff.
- 9.4.1 The GUM (Genito-Urinary Medicine) clinic in Belfast was regarded, by those members of the local focus groups who had attended, as illustrating a positive experience of health professionals:

"I felt they were not judgmental and were used to all sorts of people".

focus group participant

9.5 Education

- 9.5.0 While schools and colleges do not have direct responsibility for health provision, their roles in promoting good mental health for Same Sex Attracted Young people (SSAY) should not be underestimated. The *Young Life and Times Survey* (2006) reported that 47% of SSAY people had been bullied as opposed to 28% of opposite attracted young people. The Survey found that same/both sex attracted young people are:

- More likely to experience **school bullying**
- Less likely to **get real help** when they are being bullied
- Less likely to report positive **school experiences**
- More likely to experience **peer pressure** to conform with risk-taking behaviours that are adverse to their health
- As a result: more likely to suffer from **poor mental health**
- More likely to want to **leave NI** and not come back

- 9.5.1 This had a clear impact on the lifestyle and risk taking behaviour of SSAY people.

Respondents who say they felt pressurised to: (%)

	Same/both sex attracted	Opposite-sex attracted
Smoke cigarettes	31	21
Drink alcohol	40	28
Take illegal drugs	14	8
Have sexual intercourse	19	5
Lose weight	31	19

Northern Ireland Young Life and Times Survey 2005

- 9.5.2 It is vital that schools and further education colleges tackle homophobic bullying and provide adequate support to those who experience it.

"If someone says you're so gay, the teacher won't stop them"

focus group participant

One doesn't have to make a big deal out of one's sexuality but where health and welfare are concerned then women must feel safe and comfortable about being able to trust the practitioners

- 9.5.3 The young women surveyed in the focus groups for this Review stated that the major support they required was access to peer support groups. They also requested information and support for their parents who had no one they could approach when their children revealed their sexual orientation.
- 9.5.4 One young woman reported coming out in Year Six at primary school so it is clear that information and support needs to be provided at an early age.

“Homophobia creates a lot of anxiety – even for me at primary school”

focus group participant

“The books are about Dick and Dora – why not Dora and Dora? – we don’t get a chance to read books about ourselves”

focus group participant

9.6 Recommendations

- 9.6.0 Further work should be undertaken with staff within health and social services responsible for the provision of training to ensure that future training plans reflect the needs of lesbian and bisexual women. Plans should consider prioritising staff groups for the targeting of training.
- 9.6.1 Health and social care professionals, working in areas such as Health Promotion and Sexual Health and Primary Care should receive advice, guidance and support on the appropriate way to address health issues with patients and clients. In particular staff should be made aware that it is inappropriate to assume that everyone is heterosexual.
- 9.6.2 The DHSSPS under the *Healthier Futures* strategy should consider specific actions and develop an action plan to improve accessibility and responsiveness of services for lesbian, gay and bisexual people.
- 9.6.3 All governmental health strategies and policies should address the needs of lesbian and bisexual women with specific actions and targets.
- 9.6.4 DHSSPS funding to voluntary organisations should require them to devise strategies and action plans to address the health needs of lesbian and bisexual women.
- 9.6.5 Phase II of the Mental Health Public Information Campaign and all health promotion campaigns should reflect the mental health needs of lesbian, gay and bisexual people.
- 9.6.6 Funding should be made available to enable lesbian and bisexual women’s organisations to identify, address and lobby for their health needs.
- 9.6.7 Schools and colleges should address homophobic bullying and provide access to peer support groups for Same Sex Attracted Young people.

9.7 Non Governmental Services and Support

- 9.7.0 Investing for Health (2002) identified the value and input of non governmental organisations and their contribution to health promotion and service provision.

“Homophobia creates a lot of anxiety – even for me at primary school”

- 9.7.1 Indigo, LASI, and CoSo (the Coalition on Sexual Orientation) advocate on behalf of lesbian and bisexual women. Lesbian Line, in addition to advocacy, also provide a telephone helpline, a small counselling referral service and social support. However, none of these organisations have a specific health remit.
- 9.7.2 For the purpose of this review 18 regional non governmental organisations and 17 counselling organisations were surveyed as to the support and services they offer to lesbian and bisexual women. The low return rate of the postal survey is perhaps an indication of the low level of activity in relation to key targets and outputs within the non governmental sector. One organisation stated that they were afraid that they would be viewed in a negative light if they returned the questionnaire. Of the 7 organisations, which completed the survey, all had equality policies in relation to sexual orientation although none of them had strategic targets or outputs in relation to lesbian and bisexual women. However, there are a number of exceptions to this. The Belfast Law Centre has provided legal assistance to lesbian and bisexual organisations, advice to asylum seekers on persecution due to their sexual orientation and training re the impact of the Civil Partnership legislation. Age Concern has recently established an LGBT group to support older people in relation to their sexual orientation. YouthNet and Save the Children are also working in partnership to address homophobic bullying in schools. Another three organisations stated that they knew little about the rights and needs of lesbian and bisexual women and expressed an interest in receiving more information.
- 9.7.3 It would appear that non governmental organisations are dependent on the lesbian and bisexual women's community to voice their needs and advocate on their own behalf. This proves difficult as neither LASI, Indigo nor Lesbian Line (the only lesbian specific organisations) have the capacity to participate fully in policy and practice development due to a lack of resources. The women's sector organisations do not currently offer any explicit services or facilities to their lesbian membership and users. This is perhaps due to the stigma which is still attached to a lesbian or bisexual identity.

9.8 Counselling Organisations

- 9.8.0 Four of the 17 counselling organisations surveyed have projects/services which address the needs of lesbian and bisexual women. These are as follows:

9.8.1 Family Planning Association

- production of Sexual Health resource in conjunction with Out & About lesbian and bisexual young women's group
- community based education programs which aim to challenge social/sexual stigma around sexuality and sexual orientation
- unplanned pregnancy counselling for women who identify as lesbian/gay/bisexual
- training to a range of agencies in relation to sexuality and sexual expression with a particular focus on young men and women with a learning disability
- one to one support sessions for professionals working with 'looked after' young people who may be exploring their sexual orientation

9.8.2 Relate NI

- provides relationship counselling with an estimate of 2% of their clients who identify as lesbian

9.8.3 Contact Youth Counselling Service

- have launched a joint project with the Northern Board to provide individual counselling with young people who may present with sexual health/identity concerns or self harming behaviour

9.8.4 Parents Advice Centre

- are currently working with the Rainbow Project to produce information booklets for parents and their children who are dealing with sexuality issues

9.8.5 Only one of the counselling agencies monitored their client base re sexual orientation and most did not distinguish between men and women in terms of health needs and issues around sexual orientation. All were willing to receive more information in relation to the support and health needs of lesbian and bisexual women.

9.8.6 In conclusion, there is a dearth of counselling and support service and facilities for adult and young women who identify as same sex attracted. All of the participants in the focus groups wanted access to counselling and other services that are 'lesbian and bi' friendly with counsellors who are aware of lesbian lifestyle culture and issues.

9.8.7 The *Linc Lesbian Health Research* (2007) has indicated that the provision of a Lesbian Resource Centre is one of the best interventions in improving lesbian and bisexual women's health. Access to support groups and services can lessen the impact of heterosexism and lesbophobia through improving the confidence and self esteem of users. There is strong evidence (Havlin 2007) that LASI has been able, despite limited resources to establish and support new groups to address lesbian and bisexual women's needs.

9.8.8 While there is a need to resource lesbian and bisexual women's organisations, it is vital that the wider statutory and voluntary sector organisations take the issue of unequal access to resources seriously and begin to address the needs of this section of the community. *The Service Needs Analysis of the Lesbian and Bisexual Community in Cork* (2007) noted that:

"Ultimately, agencies are the ones with the resources (however limited) - budgets and workers - rather than the LGB community. Agencies therefore must initiate contact, improvements and progress within their organisations and the community, rather than waiting for the LGB community which is totally under-resourced, to approach them. Given the nature of the LGB community and its issues, all agencies should be advocating the rights of lesbians, gays and bisexuals."

9.9 Recommendations

9.9.1 Non governmental organisations should, in conjunction with appropriate lesbian and bisexual women's organisations, consider undertaking needs analysis of lesbian and bisexual women.

9.9.2 Non governmental organisations should be required as a condition of grant aid to devise strategies and action plans to address the needs and concerns of lesbian and bisexual women.

9.9.3 Counselling organisations should be required as a condition of grant aid to devise strategies and action plans to address the needs and concerns of lesbian and bisexual women.

9.9.4 The lesbian and bisexual community should be grant aided to act as an advocate for themselves in relation to health issues.

9.9.5 A lesbian and bisexual women's resource centre should be established to adopt a community development approach to lesbian and bisexual women's needs.

Agencies therefore must initiate contact, improvements and progress within their organisations and the community, rather than waiting for the LGB community which is totally under-resourced, to approach them



10. Recommendations

10.1 Sexual Health

10.1.0 Consideration should be given to the specific sexual health needs of lesbian and bisexual women in the production and distribution of sexual health information.

10.2 Emotional & Mental Health

10.2.0 The Department of Education and the Youth Service Liaison Forum should undertake a review of the effectiveness of current provision (including resource allocation) for young lesbian and bisexual women – in line with the *Youth Work strategy 2005 – 2008*.

10.2.1 The DHSSPS should work in partnership with lesbian/bisexual women's organisations to develop a strategy for addressing their health and social support needs. This should recognise the multiple identities of lesbian and bisexual women and pay particular attention to the social and health care needs of older women.

10.2.2 Support and information for the families of lesbian and bisexual women should be considered by statutory and voluntary bodies, religious organisations and schools.

10.2.3 The Tackling Violence At Home Strategy should identify strategies and an action plan to address the incidence of domestic violence in lesbian relationships.

10.2.4 Those responsible for managing the *NI Suicide Prevention Strategy* should conduct further research into the incidence of self harm and suicide ideation amongst lesbian and bisexual women in Northern Ireland.

10.2.5 Phase II of the Mental Health Public Information Campaign and all health promotion campaigns should reflect the mental health needs of lesbian, gay and bisexual people.

10.2.6 Schools and colleges should address homophobic bullying and provide access to peer support groups for Same Sex Attracted Young people.

10.2.7 Counselling organisations should be required as a condition of grant aid to devise strategies and action plans address the needs and concerns of lesbian and bisexual women;

10.3 Services and Support

10.3.0 Further work should be undertaken with staff within health and social services, responsible for the provision of training, to ensure that future training plans reflect the needs of lesbian and bisexual women. Plans should consider prioritising staff groups for the targeting of training.

10.3.1 Health and social care professionals working in areas such as Health Promotion, Sexual Health and Primary Care should receive advice, guidance and support on the appropriate way to address health issues with patients and clients. In particular staff should be made aware that it is inappropriate to assume that everyone is heterosexual.

- 10.3.2 The DHSSPS under the *Healthier Futures* strategy should consider specific actions and develop an action plan to improve accessibility and responsiveness of services for lesbian, gay and bisexual people.
- 10.3.3 All governmental health strategies and policies should address the needs of lesbian and bisexual women with specific actions and targets.
- 10.3.4 DHSSPS funding to voluntary organisations should require them to devise strategies and action plans to address the health needs of lesbian and bisexual women.
- 10.3.5 Funding should be made available to enable lesbian and bisexual women's organisations to identify, address and lobby for their health needs.
- 10.3.6 Non governmental organisations should, in conjunction with appropriate lesbian and bisexual women's organisations, consider undertaking needs analysis of lesbian and bisexual women.
- 10.3.7 Non governmental organisations should be required as a condition of grant aid to devise strategies and action plans to address the needs and concerns of lesbian and bisexual women.
- 10.3.8 The lesbian and bisexual community should be grant aided to act as an advocate for themselves in relation to health issues.
- 10.3.9 A lesbian and bisexual women's resource centre should be established to adopt a community development approach to lesbian and bisexual women's needs.

Glossary of terms

BISEXUAL

A person who is sexually and emotionally attracted to people of both sexes.

LESBIAN

A woman whose primary sexual attraction is to other women. This term often refers to women who are same sex attracted rather than women who have sex with other women but do not self-identify as lesbian.

HOMOSEXUAL

A person whose primary sexual attraction is toward people of the same sex. This term is primarily used to medicalise and/or stigmatise and is a term lesbian, gay and bisexual people rarely use to define themselves.

LGBT

A acronym used for lesbian, gay, bisexual and transgendered people.

QUEER

A term used as an inclusive, unifying sociopolitical umbrella term for people who are gay, lesbian, bisexual, transgendered, transsexual, intersexual, genderqueer, or of any other non-heterosexual sexuality, sexual anatomy, or gender identity. Because of the context in which it was reclaimed, *queer* has sociopolitical connotations, and is often preferred by those who are activists, by those who strongly reject traditional gender identities, by those who reject distinct sexual identities such as gay, lesbian, bisexual and straight, and by those who see themselves as oppressed by the heteronormativity of the larger culture. In this usage it retains the historical connotation of “outside the bounds of normal society” and can be construed as “breaking the rules for sex and gender.” It can be preferred because of its ambiguity, which allows “queer” identifying people to avoid the sometimes strict boundaries that surround other labels. In this context “queer” is not a synonym for LGBT as it creates a space for “queer” heterosexuals and “non-queer” (straight-acting, conformist) homosexuals.

SSAY

Same Sex Attracted Young People – a term commonly used in relation to young people who may be reluctant to define themselves as lesbian or gay or who may not yet have decided firmly on their sexual orientation.

COMING OUT

A commonly accepted phrase that describes lesbian and bisexual women’s experience of disclosing their sexuality. As the coming out process is never over this is an ongoing, sometimes daily decision and can cause the person significant stress.

HETEROSEXISM

The belief that heterosexuality is naturally superior to homosexuality or bisexuality. This belief justifies domination and the imposition of values and beliefs.

HOMOPHOBIA

An irrational fear and dislike of lesbian, gay and bisexual people, which can lead to hatred resulting in verbal and physical attacks and abuse.

INTERNALISED HOMOPHOBIA

For many people, regardless of sexual orientation, homophobia can be internal and not always recognised by the individual. However, internalised homophobia can and does cause many negative effects for lesbian, gay and bisexual people. It can affect the way people see themselves and the way others (heterosexual society) treat them. Internalised homophobia often leads to denial of one's true sexuality in situations that are threatening or require the individual to "come out".

ORGANISATIONAL OR INSTITUTIONAL HOMOPHOBIA, TRANSPHOBIA & HETEROSEXISM

This is systematic discrimination of LGBT people by government, business, employers, public services and other organisations. This includes issues such as invitations to a company event for an employee and their husband or wife, which explicitly excludes same sex relationships or family membership to a fitness club that only mentions opposite sex partnerships. This exclusion is not necessarily deliberate but means that institutions have not considered same sex partners as an option. In schools this can emerge in sex and relationships education sessions which tend to focus on heterosexuality as the accepted norm for all students.

LESBOPHOBIA

An irrational negative response to lesbian women based on the fact that they have sexual/strong emotional relationships with other women. Lesbians suffer a double discrimination by society: the first is society's hostility towards homosexuals because of their sexual orientation; the second is due to sexism, the fact that they are women.

SOCIETAL OR CULTURAL HOMOPHOBIA, TRANSPHOBIA & HETEROSEXISM

This relates to the general assumption of heterosexuality and gender norms in society. This means that social and cultural norms promote discrimination against LGBT people. Homosexuality is always considered as "different" to be welcomed, tolerated, or despised. Media, film, TV, books, holiday brochures, insurance companies, religious institutions and schools all reinforce this.

TEN STEPS TOWARDS LESBIAN, GAY AND BI (LGB) INCLUSION

- 1. Have a named contact**

Consider nominating a member of staff or volunteer as first point of contact for lesbian, gay or bisexual callers. Knowing they are going to speak to a gay-friendly person will help make LGB enquirers feel much more comfortable about contacting you.
- 2. Imagery**

Use images, of for example, same sex couples or the rainbow symbol in your publicity and promotional materials and reception area. Many organisations have found that their users/clients have 'come out' after the introduction of supportive imagery.
- 3. Language**

Use the words lesbian, gay and bisexual wherever and whenever appropriate in your literature. The acronym LGB is sometimes appropriate, but try not to use it by itself as some people don't understand it. Also ensure that you use neutral terms such as 'partner', 'friend' or even 'the person most important to you' as well as husband or wife.
- 4. Trustees**

Appoint an LGB champion to your Management Board or Committee. – it doesn't have to be a lesbian, gay or bisexual person, just someone who is familiar with and prepared to argue for and defend the issues.
- 5. Media**

Use the LGB media, such as *GCN (Gay Community News)* for features about your work, human interest stories and maybe to advertise for staff or volunteers. Include LGB reading material in your reception area. Also use the local media to publicise your work with LGB users/members.
- 6. Events**

Gay Pride (belfastpride.com) events take place usually in the summer months and LGB History Month each February (lgbhistorymonth.org.uk). They provide an ideal opportunity to demonstrate your LGB inclusiveness and reach out to potential lesbian, gay and bisexual users.
- 7. Partnerships**

Make friends with your local lesbian, gay and bisexual groups – this might be a telephone helpline, support group or organisation. The relationship can be mutually beneficial – as well as being your source of expertise on your local LGB community you can also ensure that they are aware of the issues relating to your issue or organisation.
- 8. Legislation**

Make your organisation aware of new legislation in relation to civil partnerships, employment and goods, services and facilities.
- 9. Places**

Make sure your literature is available at places where lesbian, gay and bisexual people will see it, such as LGB centres, bars and clubs.

10. Training and Development

Provide (and/or cascade) training in lesbian, gay and bisexual issues for your staff, volunteers and Board members. Alternatively, invite a speaker to a staff or Board meeting, or consider job shadowing, placements and secondments with LGB organisations.

Adapted from Age Concern training materials on working with older lesbians, gay men and bisexuals © A. Smith

TEN THINGS LESBIANS SHOULD DISCUSS WITH THEIR HEALTH CARE PROVIDERS

1. Breast Cancer

Lesbians have the richest concentration of risk factors for this cancer than any subset of women in the world. Combine this with the fact that many lesbians over 40 do not get routine mammograms, do breast self-exams, or have a clinical breast exam, and the cancer may not be diagnosed early when it is most curable.

2. Depression/Anxiety

Lesbians have been shown to experience chronic stress from homophobic discrimination. This stress is compounded by the need that some still have to hide their orientation from work colleagues, and by the fact that many lesbians have lost the important emotional support others get from their families due to alienation stemming from their sexual orientation.

3. Gynaecological Cancer

Lesbians have higher risks for some of the gynaecologic cancers. What they may not know is that having a yearly exam by a gynaecologist can significantly facilitate early diagnosis associated with higher rates of curability if they ever develop.

4. Fitness

Research confirms that lesbians have higher body mass than heterosexual women. Obesity is associated with higher rates of heart disease, cancers, and premature death. What lesbians need is competent advice about healthy living and healthy eating, as well as healthy exercise.

5. Substance Use

Research indicates that illicit drugs may be used more often among lesbians than heterosexual women. There may be added stressors in lesbian lives from homophobic discrimination, and lesbians need support from each other and from health care providers to find healthy releases, quality recreation, stress reduction, and coping techniques.

6. Tobacco

Research also indicates that tobacco and smoking products may be used more often by lesbians than by heterosexual women. Whether smoking is used as a tension reducer or for social interactions, addiction often follows and is associated with higher rates of cancers, heart disease, and emphysema — the three major causes of death among all women (Emphysema is a condition in which the walls between the alveoli or air sacs within the lung lose their ability to stretch and recoil. Symptoms of emphysema include shortness of breath, cough and a limited exercise tolerance).

7. Alcohol

Alcohol use and abuse may be higher among lesbians. While one drink daily may be good for the heart and not increase cancer or osteoporosis risks, more than that can be a risk factor for disease.

8. Domestic Violence

Domestic violence is reported to occur in about 11-20 percent of lesbian relationships and is similar to the rate reported by heterosexual women. But the question is where do lesbians go when they experience domestic violence? Refuges need to welcome and include lesbians and to offer counseling to the offending partners.

9. Osteoporosis

The rates and risks of osteoporosis among lesbians have not been well characterised yet. Calcium and weight-bearing exercise as well as the avoidance of tobacco and alcohol are the mainstays of prevention. Getting bone density tests every few years to see if medication is needed to prevent fracture is also important.

10. Heart Health

Smoking and obesity are the most prevalent risk factors for heart disease among lesbians; but all lesbians need to also get an annual clinical exam, because this is when blood pressure is checked, cholesterol is measured, diabetes is diagnosed, and exercise is discussed.

Adapted from the Gay and Lesbian Health Association. U.S.A. (glma.org)

Lasi
Lesbian Advocacy Services Initiative
Questionnaire for Voluntary Sector Organisations

Lasi is currently undertaking a Review of Lesbian and Bisexual Women's Health, funded by the Department of Health, Social Services and Public Safety. One of the objectives of the Review is to ascertain the level of services and support available to lesbian and bisexual women and any gaps there may be.

Thank you for your co-operation

Marie Quiry

Name of organisation

1. What percentage of your clients / users/ membership is lesbian or bisexual?

.....

2. What specific services do you offer to lesbian and bisexual users / members?

.....

.....

3. Are you aware of how the sexual orientation of your clients / users/ membership impacts on their health? YES /NO

If YES please indicate what this impact is

.....

4. Please indicate which of the following your organisation has in place:

Equality policies in relation to sexual orientation

Training for staff in relation to sexual orientation

Training for your Management Board/Committee in relation to sexual orientation

Training for your membership in relation to sexual orientation

Service plans / strategic objectives in relation to lesbian and bisexual women

A budget allocated to work with lesbian and bisexual women

Lesbian and bisexual representative(s) on your Board of management / Committee

Regular consultations with lesbian and bisexual clients / users / members in relation to their needs

5. What support would you need to be able to provide/increase appropriate services / additional services for your lesbian and bisexual clients/ users/ members?

.....

6. Do you have any direct contact with lesbian, gay and bisexual organisations / groups?
YES / NO

If YES please give details

.....

.....

7. Are you aware of the specific pieces of equality legislation which protect the rights of lesbian and bisexual women? (please list these)

.....

.....

8. Have these pieces of legislation impacted on your organisations policies and practice?
YES / NO

If YES please give details

.....

9. Any other comments in relation to how your organisation could improve lesbian and bisexual women's access to your services.

.....

.....

Appendix V

Lasi
Lesbian Advocacy Services Initiative
Questionnaire for Counselling Organisations

Lasi is currently undertaking a Review of Lesbian and Bisexual Women’s Health, funded by the Department of Health, Social Services and Public Safety. One of the objectives of the Review is to ascertain the level of services and support available to lesbian and bisexual women and any gaps there may be.

Thank you for co-operation

Marie Quiry

Name of organisation

1. What percentage of your clients / users/ membership is lesbian or bisexual?

.....

2. What specific counselling services you do you offer to lesbian and bisexual users / members?

.....

.....

3. Are you aware of how the sexual orientation of your clients / users/ membership impacts on their emotional and mental health? YES /NO

If YES please indicate what this impact is

.....

4. Please indicate which of the following your organisation has in place:

Equality policies in relation to sexual orientation

Training for staff/counsellors in relation to sexual orientation

Training for your Management Board/Committee in relation to sexual orientation

Training for your membership in relation to sexual orientation

Service plans in relation to lesbian and bisexual women

A budget allocated to work with lesbian and bisexual women

Lesbian and bisexual representative(s) on your Board of Management / Committee

Regular consultations with lesbian and bisexual clients / users / members in relation to their needs

5. What support would you need to be able to provide appropriate services / additional services for your lesbian and bisexual clients/ users/ members?

.....

6. Do you have any direct contact with lesbian, gay and bisexual organisations / groups?
YES / NO

If YES please give details

.....

.....

7. Are you aware of the specific pieces of equality legislation which protect the rights of lesbian and bisexual women? (please list these)

.....

.....

8. Have these pieces of legislation impacted on your organisation's policies and practice?
YES / NO

If YES please give details

.....

9. Any other comments in relation to how your organisation could improve lesbian and bisexual women's access to your services.

.....

.....

Lasi
 Lesbian Advocacy Services Initiative
 Health and Social Care Questionnaire for Focus group Participants

Your responses will remain totally confidential and may be used in the research report, so.....
 be as honest as you can!

Many thanks

1. What age are you?

2. Would you describe yourself as:
 - lesbian
 - Bisexual
 - Other (please specify)

3. Do you identify with any of the following ethnic groups?

White	<input style="width: 50px;" type="text"/>	Indian	<input style="width: 50px;" type="text"/>
Asian	<input style="width: 50px;" type="text"/>	Irish Asian	<input style="width: 50px;" type="text"/>
Black Irish	<input style="width: 50px;" type="text"/>	Black Other	<input style="width: 50px;" type="text"/>
Chinese	<input style="width: 50px;" type="text"/>	Irish Chinese	<input style="width: 50px;" type="text"/>
Irish Traveller	<input style="width: 50px;" type="text"/>	Other (please state)	

4. Do you consider yourself to have a disability? YES / NO
 VISIBLE / NOT VISIBLE

5. At what age did you become aware of your sexual orientation?

6. What age did you come 'out' to the following:
 - friends
 - family
 - at work
 - your doctor

7. What would have supported you in coming out to the following?
- friends
- family
- at work
- your doctor
8. What do you see as the most important health / social care issues for you personally?
-
-
9. What do you see as the most important health / social care issues for lesbian and bisexual women in general? (please list in order of priority)
1.
2.
3.
10. Are there health issues you would like more information about?
-
11. Are there in which ways that you feel your sexual orientation has impacted on how health and social services have responded to your needs?
-
12. Can you give an example of a positive experience you have had with a health professional/service?
-
13. Can you give an example of a negative experience you have had with a health professional/service?
-
14. Which of the following services do you feel would most benefit your health?
- A lesbian and bisexual women's health and resource centre
- A named doctor in your local GP practice with specialised knowledge of lesbian and bisexual women's health issues

A donor insemination service

Specialised adoption fostering service

Lesbian and bisexual service/group to give up smoking

other (please list)
.....

Any other comments
.....

Lesbian and Bisexual Women's Organisations

Lasi

(Lesbian Advocacy Services Initiative)

PO BOX 3

Ballymena

BT42 9AA

T: 02827641463

email: info@lasionline.org

www: www.lasionline.org

Lesbian Line

Lesbian Line provides confidential Helpline, Befriending, Counselling, Information and Support Services for Lesbians and Bisexual Women of all ages across & beyond N. Ireland.

Helpline: 028 90238668

Thursdays 7.30 – 10.00pm

Sunday 'Drop-In' 1st & 3rd Sundays

Cathedral Buildings - 3pm – 6pm

e-mail: admin@lesbianlinebelfast.org.uk

www.lesbianlinebelfast.org.uk

COUNSELLING: Ring in confidence 0779 49 65 275

CoSo

The Coalition on Sexual Orientation brings together lesbian, gay, bisexual and trans (LGBT) groups and individuals to work towards an inclusive society, which embraces diversity and where the rights of LGBT people are fully respected and protected under the law.

Coalition on Sexual Orientation (CoSO)

Cathedral Buildings

64 Donegall Street

Belfast

BT1 2GT

T: 028 9027 8636

- Bamford Review Of Mental Health And Learning Disability NI (2006) *Mental Health Promotion Expert Working Committee Report*. Northern Ireland
- Bradford J, Ryan C, Rothblum ed. (1994) *National Lesbian Health Care Survey: Implications for mental health care*. *J Consult Clin Psychol* 62:228.
- Breitenbach, E. (2004) *Researching Lesbian, Gay, Bisexual and Transgender Issues in Northern Ireland*. OFMDFM. N. Ireland
- Chan, C.S. (1993) Issues of identity development among Asian-American lesbians and gay men in Garnets & Kimmel (eds), *Psychological perspectives on lesbian and gay male experiences* (pp376-387). Columbia University Press. New York
- Cynthia, S. ed. (1995) *Abuse in Lesbian Relationships: Information and Resources*. Health Canada with the authority of the Minister of Health
- Cochran SD et al.(2001) *Cancer-related risk indicators and preventive screening behaviors among lesbians and bisexual women*. *American Journal of Public Health* 2001 Apr 91 591-597.
- Cochran SD; Keenan C; Schober C; Mays VM (2000) *Estimates of alcohol use and clinical treatment needs among homosexually active men and women in the US population*. *Journal of Consulting and Clinical Psychology* 68(6): 1062-1071, 2000.
- Community Consultants (2006) *Cork Lesbian Health Research*. Lesbians in Cork
- D'Augelli, A & Hershberger, S. (1993) *Lesbian, Gay and Bisexual Youth in Community Settings: Personal challenges and Mental health Problems*. *American Journal of Community Psychology*, 21, 421-448
- Department of Health (2007) *An introduction to working with Lesbian, Gay and Bisexual people: Information for health and social care staff*. Sexual Orientation and Gender Identity Advisory Group's Reducing Health Inequalities work stream. London
- Department of Health, Social Services and Public Safety (2002) *Investing for Health Report* DHSSPS. Belfast
- Department of Health, Social Services and Public Safety (2003) *Promoting Mental Health: A strategy and Action Plan 2003-2008*
- Dolan, K (2005) *Lesbian Women and their Sexual Health: The Social Construction and Susceptibility*. Haworth Press. New York
- Dunne,G.A. ed (1998) *Work & Family Life - Add Sexuality and Stir: Towards a broader understanding of the gender dynamics of work and family life*
Journal of Lesbian Studies. Volume 2 Number 4 October 1998.
- Elliot,P. (1996) *Shattering Illusions: Same sex domestic violence in C.M. Renzi & C.H. Miley (eds), Violence in Gay and Lesbian Domestic Partnerships* (pp.1-8) Binghampton, NY:P Harrington Park Press

- Ellis AL, Riggle ED. *The relation of job satisfaction and degree of openness about one's sexual orientation for lesbians and gay men.* Journal of Homosexuality 1995;30:75.
- EMT Associates (1991) *Gay men, lesbians and their alcohol and other drug use: San Francisco.* San Francisco: Lesbian and Gay Substance Planning Group
- EOS Gallup Europe (2003) *Homosexual Marriage, Child Adoption by Homosexual Couples: Is the Public Ready?* www.eosgallupeurope.com
- Epstein, D. (ed. 1994) *Challenging Lesbian and Gay Inequalities in Education.* Buckingham. Open University Press.
- Fish, J. (Oct, 2006) *Heterosexism in Health & Social Care.* Basingstoke: Palgrave.
- Fish, J & Anthony, D (2005) *UK National Health Care Survey Women and Health, Vol 41 (3) 2005.*
- Garnets, L. Herek, G. and Levy, B. (1992) "Violence and Victimization of Lesbians and Gay Men: Mental Health Consequences" in Herek, G. and Berrill, K. (eds) *Hate Crimes: Confronting Violence against Lesbians and Gay Men.* London: Sage.
- Gay and Lesbian Medical Association *Health Concerns for Lesbians.* Gay and Lesbian Medical Association. San Francisco
- Gay Community News* August 2004: 3
- Gay HIV Strategies and the Northern Area Health Board (2004) *Mental Health: Lesbians and Gay Men - Strategies To Promote The Mental Health Of Lesbians And Gay Men.* HIV Strategies Dublin
- Golomboc, S. & Tasker, F. (1996) Do parents influence the sexual orientation of their children? Findings from a longitudinal study of lesbian families. *Developmental Psychology.* 32(1), 3-11
- Griffith KH, Hebl MR. *The disclosure dilemma for gay men and lesbians: "Coming out" at work.* Journal of Applied Psychology 2002;87:1191.
- Gruskin, E.P. (1999) *Treating Lesbian and Bisexual Women: Challenges and Strategies for health Professionals.* Sage Publications. London
- Halman, L. (2003) *The European Values Study: A Third Wave. Source book of the 1999/2000 European Values Study Survey.* The Netherlands: WORC Tilburg University, 2001: 43, in NESF
- Havlin, E.J. (2007) *Lesbian Advocacy Services Initiative: Interim Project Review* January 2007. Belfast.
- Health Service Executive (2005) *Reach Out: National Strategy for Action on Suicide Prevention 2005-2014.* Dublin.
- Herek, G & Berrill, K. eds (1992) *Hate Crimes: Confronting violence against lesbians and gay men* pp149-169 Sage Publications California
- Hillier, L., Turner, A. and Mitchell, A. (2005). *Writing Themselves in Again: 6 Years On.* Australian Research Centre in Sex, Health and Society, Monograph 50, Latrobe University, Melbourne.
- Hollibaugh, A. (2005) *The Post-Stonewall/Baby Boomer Generations' Impact on Aging in Gay, Lesbian, Bisexual & Transgender Communities.* White House Conference on Aging

Hughes TL, Wilsnack SC. (1997) *Use of alcohol among lesbians: Research and clinical implications*. American Journal of Orthopsychiatry 1997; 67:20.

ILGA (2006) *Accessing Health: the Context and the Challenges for LGBT People in Central and Eastern Europe* ILGA. Brussels

Journal of Lesbian and Gay Medical Health Association

Kandirikiria,N., Botfield,J., Williams,L. & West,B. (2004) *Getting It Right: LGBT Research Guidelines*. Inclusion Project. Scotland

Kelly and Warshasky (1987) *Partner Abuse in Gay Male and Lesbian Couples*. Paper presented at the Third National Conference of Family Violence Researchers, Durham, NH July 1987.

King, M and McKeown, E (2003) *Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales*. MIND. London

Lesbian Advocacy Services Initiative *MORI Poll on Attitudes re Sexual Orientation* 2006. Belfast

Lesbians in Cork (2007) *Lesbian health: a study of the general health of the lesbian community in Cork*. Linc. Cork

McManus,E. (2004) *The school-based lives of lesbian, gay, bisexual and transgender (LGBT) youth*. Unpublished M.Sc. thesis UCD. Dublin

McNair, R. (2003). *Lesbian health inequalities: a cultural minority issue for health professionals*. *MJA*, 178(12): 643-645

McNair, R. & Thomacos, N. (2005). *Not Yet Equal: Report of the VGLRL Same Sex Relationship Survey 2005*. Victorian Gay and Lesbian Rights Lobby, Melbourne, July

Ministerial Advisory Committee on Gay and Lesbian Health (2003), *What's the Difference: Health Issues of Major Concern to Gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians*. Department of Human Affairs, Victoria. Australia.

Ministerial Advisory Committee on Gay and Lesbian Health (2003) *Health and Sexual Diversity: A Health and Wellbeing Action Plan for Gay, lesbian, bisexual, transgender and intersex (GLBTI) Victorians*. Department of Human Affairs, Victoria. Australia.

Nair, R. (2005) *Metaminorities and Mental Health: A model of vulnerability for Black and Minority Ethnic Queer Folk*. [www.inter-disciplinary.net/ci/sexuality/s2/nair paper.pdf](http://www.inter-disciplinary.net/ci/sexuality/s2/nair%20paper.pdf)

N.I. Council for Ethnic Minorities (2004) *Delivering on Equality, Valuing Diversity: a report on the impact of ethnicity on health needs and relevant statutory service provision in N.I.* NICEM. Belfast

Oetjen H, Rothblum ED. *When lesbians aren't gay: Factors affecting depression among lesbians*. *J Homosexuality* 2000;39:49.

O'Hanlan KA, Crum CP. *Human papillomavirus-associated cervical intraepithelial neoplasia following lesbian sex*. *Obstet Gynecol* 1996;88:702.

Patterson,C.J. (1992) *Children of lesbian and gay parents*. *Child Development* 63(5), 1025-1042

- Quiery, M. (2002) *A Mighty Silence: A report into the Needs of Lesbian and Bisexual Women in Northern Ireland*. Lesbian Advocacy Services Initiative. Belfast
- Safren SA, Heimberg RG. *Depression, hopelessness, suicidality, and related factors in sexual minority and heterosexual adolescents*. J Consult Clin Psychol 1999;67:859
- Sarma,K. (2007) *Drug Use Among Lesbian, Gay, Bisexual & Transgender Youth in Ireland*. BeLong To Youth Project. Dublin
- Savin-Williams RC. *Verbal and physical abuse as stressors in the lives of lesbian, gay male, and bisexual youths: Associations with school problems, running away, substance abuse, prostitution, and suicide*. J Consult Clin Psychol 1994;62:261.
- shOut Project (2005) *Progress Report 2004-2005* YouthNet. Belfast
- Silva,E & Smart,C (eds) 1998. *The New Family - A Passion for 'Sameness': Sexuality and Gender Accountability* London: Sage.
- Solarz,A. ed (1991) *Lesbian Health: Current Assessment and Directions for the future*. Institute of Medicine US Washington
- Stern, Phyllis Noerager.ed (1993) *Lesbian Health: What are the Issues?* London: Taylor & Francis.
- Stonewall (2003) *Towards a Healthier LGBT Scotland*
- Trocki KF, Drabble L, Midanik L. (2005) *Use of heavier drinking contexts among heterosexuals, homosexuals and bisexuals: results from a National Household Probability Survey*. J Stud Alcohol. 2005 Jan; 66(1):105-10.
- Valanis BG, Bowen DJ, Bassford T, Whitlock E, Charney P, Carter RA. *Sexual orientation and health: comparisons in the women's health initiative sample*. Arch Fam Med. 2000 Sep-Oct; 9(9): 843-53.
- World Health Organisation (1997) *Poverty and Health: an overview of the basic linkages and public policy measures*. Health Economics Technical Briefing Note. WHO. Geneva 1997.
- Youthnet (2003) *shOut Report: Research into the needs of young people in Northern Ireland who identify as lesbian, gay, bisexual and/or transgender (LGBT)*. Department of Education. Belfast

Published by **Lesbian Advocacy Services Initiative**
PO Box 3
Ballymena
BT42 9AA

Tel 028 2764 1463

e-mail info@lasionline.org
website www.lasionline.org



October 2007
Funded by: DHSSPSNI Investing for Health