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Public Health England

Strategic framework to promote the health and wellbeing of gay, bisexual and other men who have sex with men

About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

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Executive summary

Gay, bisexual and other men who have sex with men (MSM) constitute an estimated 5.5% of the UK male population. This diverse population continues to experience significant inequalities relating to their health and wellbeing. Addressing the inequalities affecting MSM is a key part of improving public health in England, as well as being a legal requirement under the Equality Act, and a human rights and moral responsibility.

There are three distinct but overlapping areas in which MSM bear a disproportionate burden of ill health and harm: sexual health and HIV, mental health and in the use of alcohol, drugs and tobacco. Through identifying and tackling the structural and direct determinants of this triad, we aim not only to reduce these specific inequalities but also to improve the health and wellbeing of MSM generally.

It is the framework's vision for all MSM to enjoy long healthy lives, and create and sustain respectful and fulfilling social and sexual relationships. The principle objective of the framework is to halve the number of new HIV infections acquired by MSM each year by 50% from 3,000 in 2012, to 1,500 in 2020.

Using an evidence based approach, we set out key recommendations to reduce health inequalities, and specifically, to decrease HIV incidence. Personal recommendations for MSM are set out, so that they become empowered with the knowledge and resilience to make healthy choices. Recommendations are also set out for educational facilities, health services and the wider community. This is to ensure MSM are supported through contact with services that are welcoming, and appropriate for their needs.

During 2014-15 we will work with national and local partners to develop implementation plans to realise these recommendations, identifying areas of responsibility and positive actions for all relevant stakeholders.

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ACMD	Advisory Council on the Misuse of Drugs
ART	Anti-Retroviral Therapy
BAME	Black, Asian and other minority ethnic groups
C&YP	Children and Young People
GUMCAD	Genitourinary Medicine Clinical Activity Dataset
CVD	Cardio-Vascular Disease
HARS	HIV and AIDS Reporting System
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
IPED	Image and Performance Enhancing Drugs
JSNA	Joint Service Needs Assessment
LA	Local Authorities
LGBT	Lesbian Gay Bisexual and Transgender
LGV	Lymphogranuloma Venereum
MSM	Men Who Have Sex With Men
NDTMS	National Drug Treatment Monitoring System
NHS	National Health Service
NSP	Needle and Syringe Programme
NPS	Novel Psychoactive Substance
PHE	Public Health England
PHOF	Public Health Outcomes Framework
SRE	Sexual and Relationship Education
STI	Sexually Transmitted Infection
UAI	Unprotected Anal Intercourse
UNODC	United Nations Office on Drugs and Crime

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1. Section One. Introduction

1.1 Setting the scene

This document sets out a framework for all gay, bisexual and other men who have sex with men (MSM) to enjoy longer, healthier lives and create and sustain respectful and fulfilling relationships. It identifies and targets the direct, structural and overlapping determinants of health inequalities in MSM to improve specific outcomes and overall health and wellbeing.

Almost 50 years have passed since sex between two consenting adult men was decriminalised in the United Kingdom[1]. Since 1967, the creation of legislation that protects[2] and upholds the rights[3],[4],[5],[6] of lesbian, gay, bisexual and transgender (LGBT) individuals has been substantive. While there is more work to do, there has been significant improvement in the social attitudes and acceptance of homosexuality. In 2010, 48% of men and 66% of women believed sex between men was "not wrong at all" [7]; this compares to 22% and 28% respectively, in 1991.

Despite these gains, MSM continue to experience inequalities related to their health, wellbeing and socio-economic circumstances compared to the rest of the population. MSM have higher rates of cardio vascular disease (CVD), asthma and diabetes[8] and may be more likely to be in receipt of housing benefit and income support[9]. The stark nature of the extent of health inequalities affecting MSM has been drawn out in the Public Health Outcomes Framework LGBT Companion Document[10].

There are three interrelated areas in which the inequalities for MSM are most apparent: sexual health[11], mental health[12] and use of alcohol[13], drugs[13] and tobacco[14]. Through addressing the direct and structural determinants of this triad, we aim to address these specific health inequalities and improve the health and wellbeing of MSM more generally. Today, one in 20 MSM in the UK are living with HIV infection; we also set out key recommendations to enhance the health and wellbeing of HIV positive men and to reduce onward HIV transmission.

This is not the first framework that has been developed to improve the health of MSM using a holistic approach. First published in 1998 and regularly updated since, the "Making it Count Framework"[15] has been a useful resource that aimed to prevent sexual HIV transmissions through tackling structural and direct determinants of HIV. This current framework builds on the legacy of previous work by tackling the determinants of health and wellbeing as they relate to each life stage of MSM, from early childhood, through adulthood and into their senior years (the "Life course Approach"). Through full engagement with key partners and community representatives we use an evidence based approach to make public health recommendations for people by life stage, places and communities.
The primary objective of the framework is to improve the general health and wellbeing of gay men, we will track progress against this objective through our ambition to:

- halve the number of new HIV infections in MSM by 50% from 3,000 in 2012 to 1,500 in 2020
- halve self reported incidents of homophobic bullying in schools from 50% in 2011 to 25% in 2020

- halve the proportion of MSM with poor mental health, measured through those who report feeling recently unhappy or depressed from 21% in 2011 to 10% in 2020
- reduce the proportion of MSM with damaging use of alcohol, are reflected in those concerned about their alcohol use reducing by a fifth, from 21% in 2011 to 17% in 2020
- Reduce the proportion* of MSM reporting the use of a range of illicit substances associated with harm, including those associated with 'chem sex', by 2020.
- Reduce the proportion of MSM who smoke to be no more than 10% higher than the rest of the male population by 2020

This framework is the first of a series to which PHE has committed in addressing the health inequalities in specific minority groups.

* PHE will work with the Home Office to establish the baseline and then set an appropriate ambition

1.2 Defining men who have sex with men (MSM)

Throughout this framework, we use the phrase "men who have sex with men" (or its acronym "MSM") to define men who have ever had male-male sexual contact. This definition, (also taken by the United Nations and the World Health Organisation[16]), is used because it describes sexual behaviour, regardless of how men perceive their sexual identity. It is estimated that 5.5% of men have had genital contact with another man in the previous five years[7], though the percentage of men who have ever had any sexual experience another man is higher, at 7.3%.

It is acknowledged that the term MSM is not necessarily a term with which the male gay community identifies. It is also understood that a sexual identity extends beyond sexual behaviour[17] and is inextricably linked to cultural and societal self-identification; these have important implications for self-esteem, health and wellbeing[18]. MSM constitute a diverse group in terms of their age-profile, ethnic background, faith and disabilities. The interaction of these varied identities has significant implications in the likelihood that such men will self-identify as gay and disclose their identity. Such subgroups may be particularly vulnerable within their communities and not targeted by public health interventions aimed men who identify as "gay" or "bisexual".

For the purposes of this framework, an inclusive definition is needed to ensure that men who do not identify as gay but who have had sex with other men are not excluded[19]. Where relevant, the term LGBT (lesbian, gay, bisexual and transgender) is used to describe issues that are relevant for the wider gay and bisexual community, however, the focus of the framework relates to MSM only.

1.3 Policy context

The Equality Act 2010 places a duty on all public authorities to tackle discrimination and advance equality of opportunity for people with protected characteristics. This includes sexual

orientation, and means that all healthcare organisations and local authorities should minimise disadvantages suffered by those with protected characteristics, they should also take active steps to meet their needs.

Since the Equality Act, Government has increased the visibility of the needs of lesbian, gay and bisexual individuals and populations in key policy documents, including the current Department of Health *Framework for Sexual Health Improvement in England* (2013), the national policy on mental health: *No Health without Mental Health.*

Public Health England supported the publication of the LGBT Companion Document to the Public Health Outcomes Framework (2013) which drew together the evidence base linked to the PHOF indicator set, and highlighted the inequalities affecting sexual identity and gender identity minorities in the UK.

1.4 Life course approach

This report mirrors the approach being taken Public Health England's forthcoming *Health and Wellbeing Framework*[20]. Both frameworks take a "Life course Approach" (Marmot[21]) and make public health recommendations for people, places and communities in tackling health and wellbeing, and reducing health inequalities. This approach recognises that the way people's health evolves over time and reflects the accumulation of risks or protective factors throughout their lives (Figure 1). It emphasises that many of the determinants of health in mid and later life have their foundation laid in earlier years. Additionally, it demonstrates that health is not just the result of individual behaviours but is also shaped by the context and circumstances of interaction with homes and families, schools, faith organisations, work and communities.

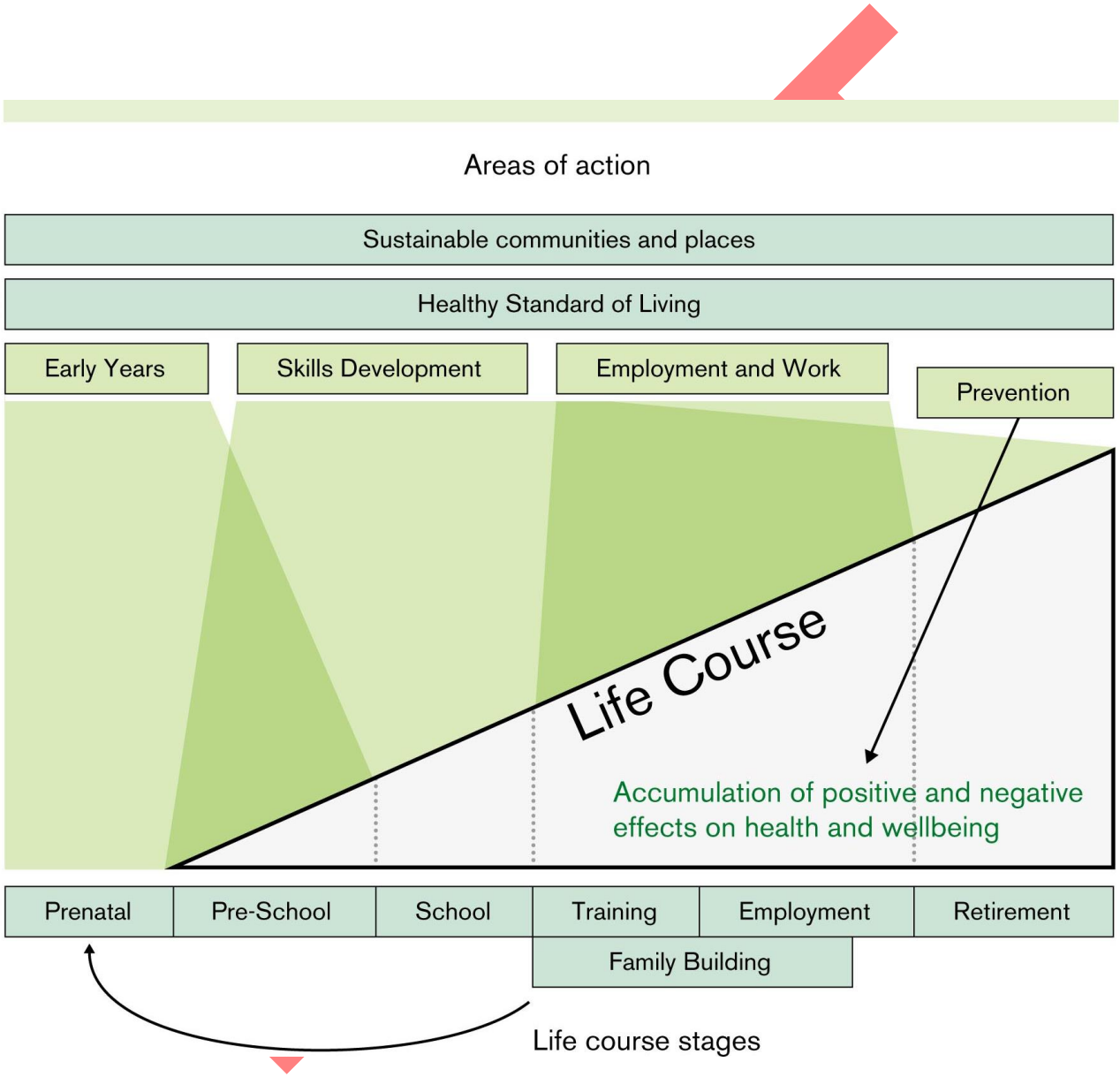
The life course approach provides a useful tool through which appropriate health promotion and prevention messages can be targeted. It also enables structural public health interventions to be delivered in the settings and facilities with which MSM have the most contact. Throughout this framework, we identify and tackle health inequalities among MSM, focussing on people (starting well, living well and ageing well), places (schools and health services) and communities.

For MSM, it is vital to recognise specific key events that relate to the development of sexual identity, relationships and behaviours over a lifetime. Sexual identity as with other aspects of identity may change over a personal lifetime and the way in which they express and prioritise this aspect varies in different settings and environments. While the stage at which key events occur will vary considerably, many MSM will experience, often repeatedly and in different ways, the following over their life course: awareness of own sexuality; development of gay or bisexual identity; acceptance of sexual identity, first same-sex experiences and relationships; coming out to close friends and/or family; coming out to wider acquaintances and colleagues; and for some, the establishment of a committed relationships which may or may not lead to civil partnerships, marriage and/or children.

The relative ease with which MSM transition through these events will largely depend on men feeling accepted and supported from an early age and into adulthood. Such support is vital, especially from, but not restricted to family[22]. For MSM, stigmatization, discrimination and marginalisation, perceived or real, makes it difficult to develop resilience, which may significantly impact mental health. Similarly, negative experience of health and social care

services creates barriers for access which exacerbates and perpetuates health inequalities. The role of media, including social media, religion, education and the legislative and cultural landscape as well as access to a vibrant, positive and empowering gay and bisexual community is also likely to be important in its potential to reinforce either positive or negative perceptions of sexual identity.

Figure 1: the life course approach (Marmot Report)



2. Section Two. Health and wellbeing among gay and bisexual men and other men who have sex with men (MSM)

2.1 Overview

Framework vision:
For MSM to enjoy longer, healthier lives and to establish and sustain respectful and fulfilling social and sexual relationships.

The term MSM encompasses a very diverse group of men of varying age, ethnicity, education, social economic status, health and disability and types of relationships. However, despite these differences, collectively MSM continue to experience substantial health inequalities compared to the rest of the population both within the UK and globally. These inequalities, and the direct and structural determinants of these inequalities, are explored below together with objectives to reduce them.

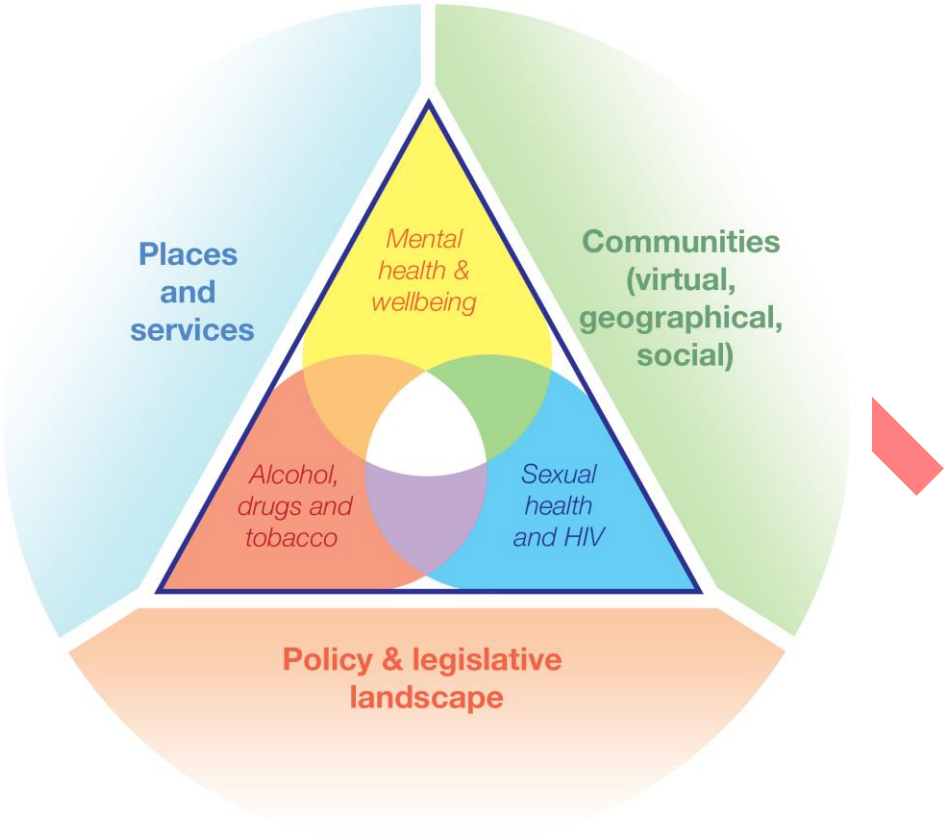
2.2 The triad of inequality: mental health, sexual health and alcohol, drugs and tobacco

This framework tackles the structural determinants of health inequalities for MSM through focussing on three distinct, but overlapping dimensions of health and wellbeing: which we have chosen to refer to as the "triad of health inequality". The triad consists of: sexual health including HIV; mental health and wellbeing; and use of alcohol, drugs and tobacco. This approach is taken for three reasons.

Firstly, it is within these three areas that the health inequalities between MSM and the general population are most apparent. Secondly, the three dimensions frequently co-exist as a syndemic and influence each other[23]. For example, there is some evidence that shows depression is associated heavier use of drugs and alcohol[24] and a small study found men reporting drug use to mask low self-esteem and/or self-confidence issues[25]. In turn substance use may increase sex drive, impair the negotiation of safe sex and enable sex that men later report they regret[25].

Finally, the determinants of the triad of health inequalities are also bound up with more general health determinants of MSM. The health inequalities triad are influenced by a range of factors including family and friends, schools, colleges and universities, workplaces, faith organisations and the wider community. There is also a wider influence from media, social media, legislation and the background global context of sexual identity and human rights. Consequently, through tackling the direct and structural determinants of the triad, the framework also improves the health of MSM more generally. Figure two below sets out the triad and illustrates influence of structural determinates of these risk factors.

Figure two: direct and structural determinants of the health inequalities triad:



It is important to note that health inequalities are not restricted to the triad, but impact across the context of chronic diseases such as cardiovascular disease, asthma and diabetes[8]. Further information of the health inequalities affecting MSM has been drawn out in the Public Health Outcomes Framework LGBT Companion Document[26]. It is anticipated that impacting the triad of inequalities will also reduce the inequalities in wider aspects of health generally.

2.3 Starting well

Framework vision:
For MSM to feel safer and supported as they develop their sexual identity, and to be empowered to make healthy choices as they become sexually active.

A safe and secure home, a balanced diet and physical activity, and feeling supported and accepted is vital for the health and wellbeing of all young people as they transition from infancy, to childhood, adolescence and beyond[20]. The earlier life stages in particular, are fundamental for the development of good mental health and resilience.

However, the development of a same-sex attraction within young people can carry with it a risk that acceptance and support may be withdrawn by those closest to them. A survey of LGB pupils found that almost two thirds had experienced bullying in schools and three quarters in faith schools, and 97% had heard homophobic language in the school[27]. Some schools, including faith schools[28], are doing excellent work to tackle homophobic bullying in schools, but the surveys suggest there is still much to be done. Bullying of any child has a damaging impact on their health and wellbeing which can last across a lifetime, every child and young person deserves a bully-free educational experience, including every gay, bisexual or trans young person.

Consequently, young MSM are less likely to develop the resilience and confidence to achieve their full potential, and to make safer choices about drugs and alcohol and their sexual relationships[29]. The opportunities to support skill development in schools is limited by the current state of Sex and Relationships Education which was found in a recent Ofsted report to require improvement in over a third of schools[30], and by the aspiration to fully implement the evidence base[31] and guidance[32] for holistic development of social and emotional skills and wellbeing, including sex and relationship education and preventing bullying and violence across all schools to give every young people the best start in life.

SPECIFIC OBJECTIVE FOR STARTING WELL

Halve self-reported homophobic bullying in schools from 55% in 2011 to 25% in 2020.

Sexual health including HIV

The Department of Education's Sex and Relationship Education Guidance (ref) makes it clear that schools must meet the needs of all pupils, regardless of their sexual identity. Despite this guidance, 85% of pupils had never been taught about the biological or physical aspects of same sex relationships. This puts young MSM at greater risk of being unable to negotiate sexual activities with which they feel comfortable and sex using condoms. A recent survey found that MSM aged 16-24 years know consistently less about HIV than those aged 25-54 years[33].

Data from Australia show that on average, young MSM become sexually active earlier[34] compared to heterosexual counterparts. In the UK, younger MSM also have higher rates of STIs; one in four of STI diagnoses (gonorrhoea, chlamydia, syphilis, HSV and HPV) among MSM are reported from men aged 16-24 years in 2012[35]. There is also increasing evidence of higher human papillomavirus (HPV) prevalence in MSM[36], compared to heterosexual men, which is associated with the majority of anal[37], and a proportion of oral, throat and penile cancers[38].

The number of new HIV diagnoses among younger MSM increased by 30% from 340 in 2008 to 440 in 2012[11]. Around a quarter of MSM who were diagnosed under the age of 25 years had acquired their infection in the previous six months; this is indicative of ongoing HIV transmission in young MSM[11].

Mental health and wellbeing

Homophobic bullying, and by extension, transphobic bullying is the deliberate and often repeated victimisation of individuals who are or are perceived to be lesbian, gay, bisexual or transgender[39]. A British survey in 2012[40] found 99% of gay and bisexual men had heard the term “gay” be used in a derogatory way or heard other homophobic language. Within the same survey, 55% reported homophobic bullying. Of those who had been bullied, 44% reported deliberately missing school as a consequence. Teachers report that boys who behave ‘like girls’, girls who behave ‘like boys’, young people with gay parents, friends or family members, and young people merely perceived to be gay can be all victims of homophobic bullying[40.]

LGBT youth with poor mental health are less likely to develop the resilience and confidence, which impacts on their long term resilience and life choices as well as their immediate choices about use of drugs and alcohol and their first sexual relationships[41]. UK data suggest greater experience of discrimination including verbal, physical and sexual abuse in schools in MSM compared with heterosexuals, with many young MSM not reporting incidents and little support offered[42],[43].

Poor mental health in young LGBT populations is related to inadequate social support[44] as well as homophobic victimisation, perceived discrimination, bullying at school[43,] stress and family rejection[45]. Population based studies suggest LGBT adolescents are at greater risk for depressive symptoms and suicidal ideation compared with their heterosexual counterparts[46]. A systematic review in the United States of America found an almost three-fold risk of suicidal ideation or attempts compared to heterosexuals; among bisexuals, the risk was almost five-fold (ref).

Alcohol, drugs and tobacco

A systematic review in the United States (ref Marshall 2008) found LGB youth were almost twice as likely to use drugs and alcohol compared to heterosexual peers. They were also more likely to use harder drugs such as cocaine and injection drugs. Substance misuse was most strongly associated with homophobic bullying, lack of supportive environments, negative disclosure reactions and internalising and externalising problem behaviour.

A recent analysis in the UK found MSM aged 18-19 years were 2.4 times more likely to smoke and almost twice as likely to drink alcohol two times a week or more compared to heterosexual men[47].

There is a lack of data on smoking amongst young LGB&T in the UK. Research in the United States found that people aged 15 years who reports being bisexual are twice as likely to smoke regularly as their heterosexual and homosexual peers[48].

2.4 Living well

Adult gay, bisexual and other men who have sex with men (MSM) are the group most affected by HIV in the UK. The availability of anti-retroviral therapy (ART) since the mid-1990s has transformed HIV from a fatal disease into a treatable lifelong condition[49]. Like all people living with HIV, provided HIV is diagnosed promptly and effective treatment is taken, HIV positive MSM can expect a near normal life expectancy[50]. However, the legacy of HIV means that much of the health research on MSM has focussed on this area.

Framework vision:
For MSM to feel respected and valued by the community, and to have the control and opportunity to make healthy choices about their lives.

The experience of MSM in the early years and during adolescence will have an impact on their experiences and ability to 'live well' as they move into adulthood. While at working ages, MSM may be more likely to have accepted their sexual identity and established supportive networks the legacy of homophobic bullying, and the continuing potential for discrimination in adulthood still exists. It is likely to bring with it the associated impact on sexual behaviour and use of alcohol, drug and tobacco use. Further work is needed to better understand the determinants of health inequalities in this age group.

SPECIFIC OBJECTIVES FOR LIVING WELL:

Halve the number of new HIV infections in MSM by 50% from 3,000 in 2012 to 1,500 in 2020.

Halve the proportion of MSM with poor mental health, measured through those who report feeling recently unhappy or depressed from 21% in 2011 to 10% in 2020

Reduce the proportion of MSM with damaging use of alcohol, are reflected in those concerned about their alcohol use reducing by a fifth, from 21% in 2011 to 17% in 2020

Reduce the proportion* of MSM reporting the use of a range of illicit substances associated with harm, including those associated with 'chem sex', by 2020.

Reduce the proportion of MSM who smoke to be no more than 10% higher than the rest of the male population by 2020

* PHE will work with the Home Office to establish the baseline and then set an appropriate ambition

Sexual health including HIV

The types of sexual relationships MSM experience varies considerably. While many MSM maintain monogamous, stable partners, many other MSM report high numbers of partners, both regular and casual compared to heterosexual men, and as for heterosexual men these relationships patterns may change across their individual life-course. It is a combination of these partnership patterns[52], and the risks associated with anal sex without condoms[51] that determines the high prevalence and incidence of HIV and STIs in this group. In 2008, 47% of MSM recruited in bar settings in London reported practising unprotected anal intercourse (UAI) in the past year, compared to 29% in 1996[52], however the proportion of MSM using bars is only a proportion of the overall gay, bisexual and wider MSM population.

While only 5.5% of the male population is estimated to be MSM, about 78% of syphilis, 58% of gonorrhoea, and 17% of chlamydia diagnoses were reported within this group[53] in England in 2012. Over the past decade, there have also been outbreaks of *Lymphogranuloma venereum* (LGV) and *S.flexneri*[54], which are diagnosed almost exclusively in MSM[55]. Furthermore, compared to heterosexuals, MSM are at increased risk of human papillomavirus (associated with anal cancer, and may also be associated with penile, oral and throat cancers) and hepatitis B and C (associated with liver cancers)[56].

One in twenty MSM are living with HIV in the UK with up to one in 12 in London[11]. This compares to one in 667 in the general population. The number of MSM living with a diagnosed HIV infection has doubled from 16,180 in 2003 to 33,960 in 2012; this rise is due to the availability of ART which increases life expectancy and continuing HIV transmission.

The number of MSM newly diagnosed with HIV each year continues to rise. Between 2011 and 2012, the number of new HIV diagnoses increased by 10% from 2,960 and in London by 14% from 1,400 to 1,600[11]. Trends in new HIV diagnoses are influenced by HIV testing patterns, migration as well as underlying transmission. The number of MSM that had an HIV test in sexual health services in England increased by 13% (from 64,270 in 2011 to 72,710 in 2012), while in London, the increase was 19% (from 28,640 in 2011 to 33,980 in 2012).

Modelling methods suggest that the number of new infections has remained stable at around 2,500-3,000 each year[57], this is despite high and increasing proportions of HIV positive MSM receiving ART[58]. Nearly 90% of MSM living with a diagnosed HIV infection are receiving treatment and of these, almost 90% are virally suppressed[11]. Such individuals have only a negligible risk of passing on their infection through sex[59]. Consequently, it is likely that the HIV epidemic among MSM is largely due to new transmission from men unaware of their infection. Increased and frequent HIV testing is therefore vital to control transmission. Of the 41,000 MSM living with HIV in the UK, nearly one in five are unaware of their infection.

Sex without a condom among MSM living with HIV has resulted in high rates of other STIs in this group. About 80% of MSM diagnosed with LGV, 60% diagnosed with *S. flexneri*, and almost a third diagnosed with syphilis are HIV positive[54]. Surveys conducted in gay commercial venues and gyms demonstrate that while overall patterns of sexual behaviour are complex, there has been an increase in the proportion of MSM reporting UAI with partners of unknown or of a different HIV status to themselves[52],[60]. The rise in “serodiscordant partnerships” may be

influenced by a high coverage of ART and extensive viral suppression among HIV diagnosed MSM, which has reduced the perceived risk of HIV transmission[52]. Furthermore, both HIV diagnosed MSM and men who have previously tested HIV negative may adopt "seroadaptive behaviours" (selecting partners perceived to be of the same serostatus). The increasing reports of UAI may be facilitated through social media applications for meeting sexual partners[69].

For men living with HIV, there is emerging evidence of increased risk of chronic diseases compared to the HIV negative population. This is both from HIV infection but also the side effects from ART. Specifically, research highlights increased risk of CVD, metabolic disorders and cancer[61].

Mental health and wellbeing

An individual's mental health and wellbeing may fluctuate and vary across their lifetime, unhappiness is usually a more fleeting experience whereas clinical depression is more protracted mood alteration by definition with associated clinical characteristics e.g. as per ICD-10, and across this spectrum there are inequalities experienced by gay, bisexual and other men who have sex with men.

MSM repeatedly report worse mental health and greater levels of psychological distress than heterosexuals, with the risk for depression and anxiety disorders (over both the short term and over a lifetime) at least 1.5 times higher in lesbian, gay and bisexual people[62].

Twice as many gay and bisexual men report moderate to severe levels of mixed depression and anxiety compared with men in general[40]. Understanding Society found that 21% of MSM reported feeling recently unhappy or depressed compared to 12% among heterosexual men[63].

Approximately 50% of MSM experience a major episode of depression in their lifetime; this is twice the rate of heterosexual men. Panic disorders and generalised anxiety disorder are also more prevalent in MSM compared to other men. A recent study in the UK found that 21% of MSM reporting feeling recently unhappy or depressed, compared to 12% among heterosexual men.

The reasons for these inequalities have been only partially explored. The UK has been at the forefront of anti-discrimination and other laws which recognise the sexual identity of its population. As a result of this legislation and societal changes over the past decades, the wellbeing of MSM in the UK is generally good with relatively few reports of discrimination. Nevertheless, gay employees report more than double the levels of bullying in the workplace compared to heterosexuals[64]. It is also noted that homosexual stereotyping impacts on the decision for people to disclose their sexuality, an issue that has been associated with the wellbeing of MSM.

Social support that signals approval of a specific romantic relationship is important for wellbeing. Research has examined how this applies to the context of same-sex relationships, and has found that peer support for same-sex relationships predicts emotional wellbeing[65].

Where stigma and discrimination are apparent, the effects are clear and include: internalised homophobia leading to increased risk of depression and substance use[24]. There is suggestion that some MSM, particularly older MSM, black and minority ethnicity MSM, and MSM of faith are especially disadvantaged in this respect[66].

There is a growing body of evidence around the higher levels of violence and abuse experienced by MSM, and on one national survey over half of gay and bisexual men reported violence or abuse from a family member or partner since the age of 16 years, yet four in five (78%) did not report it[67].

Furthermore, wider inequalities experienced by MSM may also impact on mental health. Overall, MSM may be more likely to receive income support and housing benefits[9]; there is also evidence that MSM have a relatively high risk of homelessness and being victims of sexual and domestic violence[40]. There is a paucity of robust data on the extent of and links between homelessness and sexual orientation, but community-based assessments suggest gay men are over-represented in the homeless population[9].

Alcohol, drugs and tobacco

In 2011, a survey found that 42% of MSM drank on three or more days in the last week and 67% of MSM had ever smoked; this compares to 35% and 50% respectively, in the heterosexual male population[40]. A study in 2008 found that MSM were 50% more likely to be dependent upon alcohol compared to the rest of the male population[68]. UK data from the Home Office indicate that 21% of MSM reported that they were concerned about their alcohol use in 2011.

In 2003, 53% of MSM reported using recreational drugs in the past month; this compares to 45% in the heterosexual population[40]. Data from the home office indicate that in 2009, 13% of MSM reported using class A drugs. MSM are also likely to use drugs differently compared to the heterosexual community. This includes “poly-drug” use (taking combinations of drugs) and using a wider range of club drugs such as GHB[13]. Specifically, methamphetamines, poppers and cocaine are associated with unprotected sex and acquisition of HIV[69].

Recent research in London has identified a growing trend for ‘chemsex’, a term commonly used by gay or bisexual men to describe sex that occurs under the influence of drugs, which are taken immediately preceding and/or during the sexual session. The drugs most commonly associated with chemsex are crystal methamphetamine, GHB/GBL, mephedrone and, to a lesser extent, cocaine and ketamine. A small London study found that although chemsex was reported to increase sexual arousal and facilitate more adventurous sex, many men were using drugs to mask self-esteem or self-confidence issues[25].

British research has found that a third of respondents who scored as substance dependent would not keep information, advice or treatment, even if they were worried about their drug or alcohol use. It was identified that significant barriers existed in seeking information, advice among LGB people[70].

Smoking rates are higher for MSM communities compared to their heterosexual counterparts. LGB people aged over 16 year are more likely to be current smokers, less likely to have never smoked and less likely to have given up smoking compared to the general population[71]. A study of UK MSM in 2010 reported a 31% prevalence of smoking[72]. In another study, 67% of MSM reported smoking at some point of their lives with 26% reporting current smoking. This compares to 22% in among heterosexual men[40].

Tobacco use is an important modifiable lifestyle factor for anyone whose health is already compromised; this includes people living with HIV. Compared to HIV positive people who do not smoke, tobacco use among HIV positive people significantly increases the likelihood and rate of developing oral thrush and bacterial pneumonia[7]. Furthermore, protease inhibitors (part of an ART combination frequently used to treat HIV) can raise blood lipid (fat) levels; smoking exacerbates an already elevated risk of heart disease[27].

2.5 Ageing well

Older MSM constitute men at very different phases of their lives, ranging from MSM in employment, living well in retirement and those requiring support at home or in care. Many will have experienced far more acute stigma and discrimination than today's cohort of young MSM, and as a result, may have come out in later life, or carry this experience of stigma and fear with them creating additional barriers to accessing services. This group is also far more likely to have suffered loss and bereavement from AIDS prior to effective treatment for HIV infection.

Framework vision:
For older MSM to lead longer, healthier lives, to feel supported by the community, and receive appropriate health and social care support as they age.

The major concerns that affect older LGBT communities are the same as those that affect older heterosexual populations: loneliness, ill-health and financial issues[73]. However older LGBT people report feelings of frustration around assumptions of heterosexuality, particularly when they come into contact with health and social care services for the first time.

Sexual health including HIV

Older MSM remain at risk of STIs. In 2012, 14% of diagnoses of chlamydia, gonorrhoea, syphilis, HSV and HPV in MSM were reported among men aged 45 years and over in the UK; this compares to 8% in heterosexual men.

In 2012, 28% of all MSM living with a diagnosed HIV infection in the UK were aged over 50 years, with 6.7% aged over 65 years. This reflects improved survival following the ART but also continuing transmission among those aged 50 years and over. Approximately half of people living with diagnosed HIV infection aged over 50 acquired their infection aged 50 years and over[74].

Older people are more likely to be diagnosed with HIV at a late stage of infection (a CD4 count <350 cells within three months of diagnosis); in 2012 54% of MSM aged over 50 years were diagnosed late, compared to 24% among those aged under 25 years. A late diagnosis is associated with a ten-fold risk of mortality within 12 months of diagnosis compared to those diagnosed promptly[75]. The impact of late diagnosis and delayed treatment on mortality and clinical outcomes is more profound among older people[76].

Mental health and wellbeing

It is estimated that at least 36% of older men report hiding their sexual identity throughout their lives and recognise this had led to internalised homophobia[77].
There is very little research on the mental health of older MSM, but there are indications that older MSM have elevated levels of depression compared with older adults in the general population[78].It is also suggested that the lack of traditional family structures and concern over ageing alone for some MSM could exacerbate mental health outcomes [79]. Data from the UK suggests that MSM are 2.6 times more likely to live alone compared to heterosexual men (Ref), which may impact on feelings of isolation.

Alcohol, drugs and tobacco

There is some evidence for higher rates of alcohol and drug use among older MSM[40]. In 2011, 35% of LGB individuals aged 55 years and over reported drinking alcohol three days a week or more, compared to 31% of older heterosexuals.

In this age group, 9% of LGB reported taking recreational drugs in the past 12 months compared to just 2% of heterosexuals, and there is limited understanding of the impact of drug use in this age group, particularly around the interactions with prescription medication and chronic disease.

Little is known about tobacco use in older MSM, or the impact of the increased prevalence on rates of lung cancer or cardiovascular disease.

2.6 MSM minority groups

The MSM community includes individuals from different faith groups, ethnicities, disabilities, gender identities and individuals with caring responsibilities. However there is limited data and research reflecting the diversity of the gay, bisexual and other MSM populations, although in general research into individual with multiple minority identities suggests that there is potential for further marginalisation and isolation. There is also limited understanding and evidence exploring the differences in identity between gay, bisexual and other men who have sex with men.

Individuals from some ethnic and faith communities face additional challenges as their sexual identity forms and may experience more actual, and perceived risk of, discrimination, rejection and isolation from their ethnic and faith communities, and potentially from the mainstream LGBT community. This may be further compounded by the lack of recognition within policy documents of the inherent diversity within the MSM community.

The varied nature of disabilities will also impact on the extent such MSM will identify and participate in gay and bisexual sex and relationships. However, this group may be less likely to access MSM-appropriate services due to assumptions of heterosexual or asexual identity at first contact with health and social care services. National surveys in the UK have found significantly higher inequalities affecting disabled gay and bisexual men compared to gay/bisexual men without disabilities[80], and these inequalities are reflected across the life course.

Sexual health and HIV

BAME MSM report higher rates of multiple partnerships, and sex without condoms, compared to white MSM. Barriers such as a lack of access to culturally and linguistically appropriate services may exacerbate the problem[12,19]

Over the past decade, the ethnic composition of the UK MSM HIV epidemic has expanded with greater numbers of men originating from Asia and central and Eastern Europe. While the number of new HIV diagnoses increased by 40% between 2002 and 2011 in the UK, the numbers diagnoses among black African MSM has remained stable at about 50 cases a year, and the number among black Caribbean MSM has decreased by a third from around 90 to 60. While numbers are small, the numbers of Asian MSM newly diagnosed has increased by over 400% over the decade, from around 20 to 140[81].

In 2011, one third of MSM diagnosed with HIV in the UK were born abroad. Migration to the UK to avoid high levels of decriminalisation and criminalisation of homosexuality may account for the observed increase[24]. Importantly, it is estimated that 64% of men born abroad probably acquired their HIV infection in the UK in 2011[81].

Reassuringly, in the UK, there are no differences in clinical outcomes or quality of care received by BME[81.] MSM living with diagnosed HIV infection; this is in contrast to the United States where African American MSM experience poorer access to HIV care and treatment outcomes[26].

Mental health and wellbeing

The development of sexual identity during early years is particularly difficult for minority groups[82]. Specifically, homosexuality remains highly stigmatised within some religious communities and within some BAME groups[83]. Adolescents in these communities may be more likely to feel shame, guilt and denial, all of which negatively impacts on their mental health. There is evidence from BAME MSM communities that psychological distress and risk taking behaviour may result in part from early childhood experiences such as physical and emotional abuse from families, peers and community leaders. (Mayer 2012).

Comparisons from population surveys of gay and bisexual men found that disabled gay and bisexual men were three times more likely to self-harm and three times more likely to have attempted to take their own life than gay and bisexual men without[84]. Similar inequalities existing in the experiences of domestic violence and abuse – nearly two thirds of gay and bisexual men reported violence or abuse from a family member or partner since the age of 16yrs compared to nearly half of gay and bisexual men in general, and disabled gay and bisexual men are twice as likely to be assaulted (16% compared to 8%) and significantly more likely to be threatened with physical violence than gay and bisexual men without disabilities[85].

Alcohol drugs and tobacco

Little is currently known about the patterns of alcohol, drugs and tobacco use among BAME groups. However, it is plausible that the increased risk of discrimination and homophobia in this group may lead to risky behaviour.

Research has found slightly higher levels of recreational drug use amongst disabled gay and bisexual men (55%) compared to the wider gay and bisexual male population (51%) and compared to men in general (12%) [86].

3. Section Three. Public health interventions

The ambition of this report is to set out the evidence base for what works in improving the health and wellbeing of MSM. Most of the interventions and best practice highlighted have been evaluated and shown to be effective and acceptable. But in many cases, we lack sufficient evidence that these interventions can be implemented successfully at scale and for some areas, the data are not available.

Where possible, we highlight the potential both of "direct" interventions (for example: how to improve the offer and the uptake of HIV testing) as well as interventions that focus on the wider determinants of health (for example: reducing homophobia in schools).

3.1 Sexual health including HIV

Sex using condoms, and regular sexual health screens, is the most effective way to prevent the transmission of STIs including HIV. Regular STI screens including HIV tests, at least once a year, are a vital way to prevent transmission and provide an opportunity to offer behavioural interventions. A diagnosis of a bacterial STI provides access to treatment that can eliminate infection and risk of further transmission. For HIV, a positive diagnosis provides access to treatment. People living with HIV who adhere to ART and achieve an undetectable viral load have a negligible risk of passing their infection onwards[59].

PHE recommends that MSM have a sexual health screen including an HIV test at least annually, and every three months if having sex without a condom with new or casual partners[11]. While the number of MSM who had an HIV test at a sexual health clinic increased by13% from 64,270 in 2011 to 72,710 in 2012, further work is required. Community surveys found that in 2011, 58% of MSM reported having had an HIV test in the past 12 months, and 8% of MSM reporting never having an HIV test[11].

The Joint Committee for Vaccination and Immunisation (JCVI) recognise that the current HPV immunisation programme will provide relatively little benefit to MSM. Given the higher rates of HPV-related cancers and genital warts in MSM, a review of the likely cost-effectiveness of HPV vaccination of MSM is underway.

3.2 Mental health and wellbeing

For everyone, regardless of sexual identity, good experiences in childhood help to build the resilience that can be drawn on in difficult times and can lay down patterns of behaviour that will build wellbeing throughout the life course. The literature suggests training school personnel, and counselling of parents, guardians and carers to support the health and wellbeing of young MSM can have a positive response to mental health[22,87], and substance misuse[22], but no clear association with sexual risk behaviours.

In the UK, there are a number of interventions aimed at reducing victimisation of young LGBT people in schools but not all have been evaluated for evidence of effectiveness. The interventions range from training (for governors and leadership teams)[88], to learning resources for teachers[89], and class room based programmes focussing on bullying prevention and social

emotional learning skills[90]. There are also a number of British generic and LGBT specific programmes that can help and support young MSM as they develop their sexual identity. For instance, the Rise Above programme provides the skills and confidence in young people to develop resilience[91].

Such interventions must address the specific needs of MSM from BAME and faith backgrounds. Interventions for BAME groups need to be focussed on skill building and information provision[92,93]. In addition, culturally and linguistically sensitive interventions that incorporate positive cultural role models are reported to have a more positive effect in this group compared to adapted mainstream intervention[94,93] Finally, creating support groups for parents of BAME MSM where they can get relevant information and advice on how to support their child in building a healthy sexual identity is important.

The influence of social media on the mental health of young MSM cannot be overemphasised. There is evidence that the internet can play a positive role in the development of sexual health of young men by enabling them to forge connections to the gay community and find support during the processes of coming out as well as accessing sexual health information[95].

Many of the concerns of older LGBT populations reflect those of general ageing population. It is important to implement the recommendations from the Living Longer report from the Department of Health. In addition, health and social care services should provide training to prevent “heteronormative” assumptions about people in their care and ensure services are appropriate and welcoming to the LGBT community.

It is important for health and social care staff that come into contact with disabled people to understand that regardless of their disability, every person in their care also has a sexual identity which is not necessarily heterosexual. Services need to be appropriate for LGBT communities and individuals be supported to enable them to express their identity.

3.3 Alcohol, drugs and tobacco

Making “every contact count” is an evidence-based strategy that uses the premise of brief interventions to assess alcohol, drug and tobacco use at each contact within the health service. This is particularly pertinent in the sexual health care settings where MSM may feel more able to speak about their drug and alcohol use in the context of their sexual identity and behaviour. There is evidence that this approach works for alcohol[96], drugs[97] and tobacco[98]. Once assessments are made, it is important that prompt referrals are made to alcohol and drugs services which are culturally competent to work with MSM. Good treatment pathways, close liaison and partnership between alcohol and drug services and health settings most frequently used by MSM are important.

Part of the Picture is a five year partnership which aims to establish an England wide database of LGB people’s use of alcohol of drugs. The database will be used to directly inform local and national partners in addressing the drug and alcohol use of LGB people. This resource will also provide an improved knowledge and understanding of the needs of LGB drug and alcohol users amongst drug and alcohol agencies, through dissemination of the research findings[41].

As smoking contributes to additional health problems and increased death rates in the HIV-infected population, brief advice and referral to stop-smoking support services should be considered a core part of HIV health care provision[44].

4. Section Four. Recommendations for people, places and communities

4.1 People: starting well

Feeling supported and accepted is vital for the health and wellbeing of all young people from infancy, to childhood, adolescence and beyond. For young people who are developing a gay, bisexual and/or transgender identity, there is a risk that this support may be withdrawn by those closest to them. Homophobic bullying, and perceived or actual rejection from families, carers or guardians negatively impacts upon the mental health of young LGBT individuals.

These events are likely to be contributory factors in LGBT youths being twice as likely to use alcohol, and take recreational drugs compared to their heterosexual counterparts LGBT youths have a higher risk of self-harm, suicidal attempts or ideation and higher levels of depression. LGBT youths with poor mental health are less likely to have the resilience and confidence to make safe choices about their first sexual relationships. This is exacerbated by the fact that SRE, which should include same sex relationships, is only partially implemented nationally, with poor coverage in faith schools.

However, with support and resilience, young people are able to make healthy choices about their lives as they develop their sexual identity. Through ensuring that the services and/or institutions with which young LGBT come into contact are welcoming and have staff trained in LGBT health, we hope that LGBT will be more confident to talk about and address key issues that affect their health and wellbeing.

Key facts

- 55% of LGBT students say they have experienced homophobic bullying.
- Young LGBT are twice as likely to drink and use drugs compared to their heterosexual peers
- One in five young MSM newly diagnosed with HIV acquired their infection in the last

SPECIFIC OBJECTIVE FOR STARTING WELL

Halve self-reported homophobic bullying in schools from 55% in 2011 to 25% in 2020.

Framework vision:
For MSM to feel safer and supported as they develop their sexual identity, and to be empowered to make healthy choices as they become sexually active.

Young gay, bisexual men and other men who have sex with men can:

- Believe that a long, healthy life with committed relationships and free from HIV and STIs is possible.
- Use condoms correctly and consistently until all sexual partners have had an STI screen including an HIV test.
- Have a sexual health screen, including an HIV test, every year and up to four times a year if having sex without a condom with new or casual partners
- Understand that they have control over their sex life, alcohol and drug use
- Talk to a trusted adult about any problems they are experiencing relating to their sexual identity
- Speak to their GP about concerns relating to their mental health, or drug and alcohol use
- Understand the dangers of chemsex and other class A drugs
- Utilise online resources to stay informed about health issues that affect them.

Families, guardians and carers can:

- Be open to the possibility that the young person in their care may be LGBT
- Ensure early conversations relating to sex and relationships include frank and open discussions about homosexuality.
- Recognise that LGBT young people need explicit reassurance that they are accepted and supported
- Access the support and parenting training available

Health services can:

- Provide LGBT awareness and policy training at all settings and integrate recognition of the needs of MSM youth into all directly commissioned services.
- General practice and outpatient services should offer an HIV and STI screen at each attendance
- Sexual health services can:
    - Offer sexual health screens including an HIV test annually
    - Rapidly assess alcohol, drug and tobacco use and promptly refer to appropriate services if required
    - Rapidly assess anxiety and depression and promptly refer to appropriate services if required
    - Establish care referral networks for LGBT youth with mental health or alcohol, drugs and tobacco needs

Public Health England will:

- Develop PHOF measures of mental health and wellbeing by sexual identity
- Support alcohol, drug and tobacco, and mental health services to collect data about sexuality
- Provide support to national partners by producing evidence and expertise in public health interventions
- Monitor HIV incidence and prevalence in young people
- Monitor rates of STIs, and identify and manage outbreaks
- Provide evidence to inform appropriate use of HPV vaccines among MSM
- Develop the FRANK and Rise Above drug education and prevention campaigns and ensure they are relevant to the needs of young MSM.

We encourage national partners to:

- Establish core requirements in national contracts for sexual identity monitoring in public services

- Integrate recognition of the needs of MSM youth in all directly commissioned services
- Ensure anti-homophobic bullying policies are developed implemented and promote resilience
- Provide information on how drugs and alcohol affect sexual risk taking behavoiur and mental health
- Have an LGBT positive role model, or point of contact with whom young people can connect

Local government can take action by ensuring there are:

- Condoms and lube for young MSM at primary care facilities
- Interventions to improve resources and training for families, guardians or carers with LGBT young people
- Development of evidence based alcohol and drug prevention programmes which build young people's resilience and life skills and are relevant to the needs and lifestyles of MSM
- Evidence based research into the determinants of initiation behaviours for alcohol, drugs and tobacco
- Contracts for alcohol, drugs and tobacco services to target young MSM as high risk groups
- Joint Strategic Needs Assessments (JSNA) which recognise the needs of young LGBT within their area and inform Health and Wellbeing Strategies which address them.

The community sector can:

- Provide insight into equality gaps of LGBT youth and support local commissioning and development of JSNA and Health and Wellbeing Strategy
- Integrate prevention messages and support in social media and face to face contact with LGBT youth
- Work with partners to improve accessibility and uptake of services among LGBT youth.

Key resources, references and case studies to be confirmed

PLEASE NOTE: THIS IS A DRAFT. CONTENT AND DESIGN WILL BE REVISED IN THE FINAL PUBLICATION.

4.2 People: Living Well

MSM are at risk of worse health and wellbeing compared with the general population. They have higher rates of HIV and STIs, are at greater odds of poor mental health and are more likely to smoke, drink alcohol and use drugs than non-MSM men. Inequalities are particularly pronounced for MSM from ethnic minorities.

Some of these health issues are inter-related, which highlights the importance of interventions that take an integrated approach. For instance, recent survey data in London found that drugs could have an impact on men's ability to negotiate safe sex.

We have a lot of evidence of what works to support MSM in improving sexual health outcomes – ranging from behavioural interventions on HIV testing to effective HIV treatment. But MSM have other health needs and priorities, and we are focused on finding better ways of meeting these needs, which are important in their own right as well as contributing to our ambition to reduce the incidence of HIV in MSM.

Key facts

- One in 20 MSM are living with HIV
- MSM are twice as likely to be depressed
- MSM are twice as likely to be alcohol dependent

SPECIFIC OBJECTIVES FOR LIVING WELL:

Halve the number of new HIV infections in MSM by 50% from 3,000 in 2012 to 1,500 in 2020.

Halve the proportion of MSM with poor mental health, measured through those who report feeling recently unhappy or depressed from 21% in 2011 to 10% in 2020

Reduce the proportion of MSM with damaging use of alcohol, are reflected in those concerned about their alcohol use reducing by a fifth, from 21% in 2011 to 17% in 2020

Reduce the proportion* of MSM reporting the use of a range of illicit substances associated with harm, including those associated with 'chem sex', by 2020

Reduce the proportion of MSM who smoke to be no more than 10% higher than the rest of the male population by 2020

*PHE will work with the Home Office to establish the baseline and then set an appropriate ambition

Framework vision:

For MSM to feel respected and valued by the community, and to have the control and opportunity to make healthier choices about their lives.

Adult gay, bisexual men and other men who have sex with men can:

- Have a sexual health screen including an HIV test at least annually, and every three months if having sex without a condom with new or casual partners
- Use condoms correctly and consistently until all partners have had a recent sexual health screen (unless their regular partner is HIV positive, compliant to treatment and has an undetectable viral load)
- Speak to their GP if they are concerned about their alcohol, drug and tobacco use, or their mental health
- Inject safely, be aware of dangers of chemsex and other party drugs
- Engage with the community for peer support and healthly social interaction
- Utilise online resources to stay informed about health issues that affect them.

Families and friends can:

- Be open to supporting those who identify as LGBT and access the information and materials available to help support and understand those closest to them.
- Support friends and family to make positive changes in their lifestyles.

Health services can:

- Provide LGBT awareness and policy training to all staff and integrate recognition of the needs of MSM adults in all directly commissioned services.
- Integrate into health and social care professional training explicit reference to the needs of LGBT communities including training on culturally competent ways to ask about sexual identity and relationships.
- Offer and recommend a sexual health screen and an HIV test at each episode of sexual health care or at each contact elsewhere in the health system
- Assess MSM for alcohol, drug and tobacco use and promptly refer to appropriate services if required
- Assess MSM for anxiety and depression and promptly refer to appropriate services if required
- Provide access to integrated multi-discplinary response to MSM who have attempted suicide or self harm.
- Provide access to sexual assault and domestic violence advocacy and support services through primary and secondary care in addition to emergency services.

Public Health England will:

- Develop PHOF measures of mental health and wellbeing by sexual identity
- Support alcohol, drug and tobacco, and mental health services to collect data about sexuality
- Provide support to national partners by producing evidence and expertise in public health interventions
- Monitor HIV incidence and prevalence in MSM
- Monitor rates of STIs, and identify and manage outbreaks
- Publish and support the implementation of a series of the National Implementation Frameworks to support local areas aiming to achieve large scale changes in health outcomes for adults
- Provide tailored advice and tools to suport effective commissioing of health and wellbeing interventions including sexual health, smoking cessation, drug and alcohol treatment services.

- Ensure that support and prevention interventions for a wide variety of health conditions and behaviours (e.g. drug, alcohol weight management smoking cessation and sexual health and mental wellbeing) are accessible to LGBT and delivering effective and long term results.
- Support targeted programmes for specific high risk groups e.g. MSM suicide prevention among adult men, and integrated alcohol, drugs and tobacco services.
- Ensure social marketing programmes and information campaigns, such as Change for Life are relevant and appropriate for the MSM community.
- Enhance the data and intelligence on the prevalence of alcohol and drug use (including 'chemsex' among MSM to support local areas in assessing need.
- With the Home Office to establish a baseline from the Crime Survey for England and Wales on the proportion of MSM reporting use of illicit substances associated with 'chemsex' and the MSM community, and set an appropriate ambition to reduce use from that baseline by 2020.
- Work with other agencies to mitigate the availability of chemsex drugs.

We encourage national partners to:

- Establish core requirements in national contracts for sexual orientation monitoring in public services
- Integrate training, and examination, of skills for brief interventions and motivational interviewing techniques for lifestyle modification into all health care professional training, including allied health professionals
- The principles of Make Every Contact Count should be adopted to enable Brief Interventions on tobacco use to be undertaken.
- Smoking cessation campaigns should be developed to target MSM communities as a high-risk group.

Local government can take action by:

- Ensuring that the needs of MSM are identified in their JSNAs and subsequent health and wellbeing strategies
- Provide services that are relevant to the needs of MSM adults, are developed through engagement with MSM community members and that are staffed by individuals who are culturally competent to work with MSM.
- Dedicate focus to leading the NHS Health Check programme, ensuring access to LGBT communities
- Assess alcohol and drug prevention, early intervention and treatment need among the local MSM population, and commission services and interventions to meet that need.
- Commission alcohol and drug treatment services that are culturally appropriate.
- Provide targeted LGBT appropriate interventions such as smoking cessation services in the mental health and prison/offending populations
- Commissioners and providers should actively consider how local stop smoking services are delivered and how they are perceived by MSM service users.

The community sector can:

- Provide positive role models and support networks for gay and bisexual staff
- Integrate prevention messages into everything they do, working across disease and topic silos to make every contact count

Key references and case studies to be confirmed

4.3 People: ageing well

Older MSM include men at very different phases of their lives, spanning men in work to men requiring support at home or in care. Many will have experienced far more acute stigma and discrimination than today's cohort of young MSM. They are also far more likely to have suffered loss and bereavement from the AIDS epidemic before antiretroviral therapies revolutionised treatment for HIV.

We know that older MSM are more likely to live alone than non MSM and that living alone can be linked to problems with accessing social care and general support. We also know that many older MSM fear they may encounter discrimination at the hands of the services they expect to rely on as they age. What we lack is better evidence of the specific needs and priorities of this group and how best we can build on the positive experiences of ageing.

Key facts

- Over one in four MSM living with HIV are aged over 50
- Nearly a third of older MSM drink alcohol at least three days a week
- Over one third of older MSM have hidden their sexuality throughout their lives

Framework vision:
For older MSM to lead longer, healthier lives, to feel supported by the community, and receive appropriate health and social care support as they age.

Older MSM can:

- Have an annual sexual health screen including an HIV test and up to four times a year if having sex without a condom with new or casual partners.
- Talk to their GP if they are worried about their mental health, or use of alcohol, drugs and tobacco
- Keep active, reach out into the community and volunteer in their retirement
- Talk to friends, family or health and social care professionals about feelings of isolation.

Friends and family can:

- Reach out to older people, include them in social activities so that they feel supported and connected

Health services can:

- Include LGBT awareness training that includes components that recognise people of any age can be LGBT.
- Assume older MSM are still sexually active and continue to offer a sexual health screen including an HIV test at each contact
- Make every contact with an older person count towards improving their overall health, wellbeing and safety
- Provide access to LGBT appropriate integrated multi-disciplinary response to end of life which supports access to specialist palliative care alongside mainstream and community based support

Public Health England will:

- Make the case for sexual orientation data to be collected in the audit and evaluation of services for the elderly community
- Publish and support the implementation of a series of National Implementation Frameworks to support local areas achieving industrial scale changes in health outcomes for older adults and reduce health inequalities for older adults, including LGBT
- Improve surveillance to provide better local understanding of inequalities affecting older people and how to respond to the diversity within older communities and groups in most need
- Support the national work to respond to the impact of the ageing population, including through the Dementia Challenge, Carers' Strategy, etc.

We encourage national partners to:

- Establish core requirements in national contracts for sexual identity monitoring in public services
- Integrate recognition of the needs of older MSM adults in all directly commissioned older people's services including screening programmes such as the NHS Health Check
- Improve competency and skills of health and social care staff to support older people, and provide LGBT awareness training
- Integrate training on elder abuse and neglect into all clinical services core requirements for all staff

Local authorities can help by:

- Ensuring that there is an integrated community wide approach to end of life which is LGBT appropriate, engages beyond palliative care services to deliver dignity, choice and support for individuals dying and those who survive them, stating this publically through signing up to the Good Death Charter
- Working through health and wellbeing boards to ensure integrated commissioning and comprehensive approaches to falls prevention (56), reduction of social isolation, malnutrition, support for carers and individuals affected by dementia
- Ensuring identification of vulnerable older LGBT adults and those most at risk of violence and elder abuse and provide targeted interventions to support them and keep them safe
- Undertake bi-annual equity audits of services to ensure that services are reaching the older LGBT people that need them
- Embedding training and education on sexual orientation and the related inequalities and cultural competency across undergraduate and ongoing continuing professional development for domiciliary and residential care staff, allied health professionals and community and geriatricians.

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Community sector can help by:

- Providing engagement and insight into the needs of older LGBT people to support local commissioning and development of the JSNA and Health and Wellbeing Strategy
- Integrating prevention messages and supporting into everything they do, working across disease and topic silos to make every contact count

References and case studies to be confirmed

4.4 People: Living With HIV Infection

MSM remain the group most affected by HIV in the UK with a prevalence of 47 per 1,000 in 2012. This is equivalent to an estimated 41,000 MSM living with HIV, with nearly 1 in 5 unaware of their infection. New diagnoses among MSM have continued to rise, reflecting both an increase in HIV testing among this group and on-going transmission.

More positively, once in HIV care, outcomes among MSM are comparable to other groups. Linkage to and retention in care are over 95%, with the vast majority on ART maintaining viral suppression. However, MSM living with HIV are vulnerable to poor mental health and have been shown to have higher rates of suicide and drug and alcohol use than their HIV negative counterparts. There has recently been increased reporting of sexualised drug use among HIV positive MSM with a rise in the number reporting "club" drug use, "slamming" and chemsex.

Key Fact
People diagnosed promptly with HIV can expect to have a near normal life expectancy

Framework vision:
For MSM living with HIV to live long healthy lives, to have the confidence and skills to be open about their status and not let it be a barrier in the daily lives and relationships..

SPECIFIC OBJECTIVES FOR LIVING WELL:
For 95% of MSM living with a diagnosed HIV infection to have a suppressed viral load.
To reduce the number of MSM who are unware of their HIV infection by one quarter from 20% to 15%.
To reduce STI co-infection in MSM living with diagnosed HIV from 13% in 2012 to 8% in 2020

HIV positive Gay, Bisexual Men and other Men who have sex with men can:

- Have a sexual health screen every year
- Talk to sexual health advisors about they best way to prevent onward transmission to sexual partners (e.g. though treatment and or condoms)
- Be open about their HIV status to their GP so that they can receive the most appropriate care, including relevant prescriptions and CVD and renal function screening.
- Access smoking cessation services, if relevant

- Talk to their GP if they are worried about their mental health, or their use of alcohol, drugs and tobacco

Partners, family and friends can:

- Reach out to people living with HIV and let them know they are supported and accepted

Health services can:

- Provide ongoing advice and support for HIV positive men as they age to maximise their health and wellbeing
- Sexual health services can discuss strategies to prevent onward HIV transmission to partners including using ART for Treatment as Prevention and condoms.
- HIV services should regularly screen for STIs and rapidly assess for alcohol and drug use, anxiety and depression and refer to appropriate services where relevant.
- Encourage men living with HIV to disclose their HIV status to their GP to enable better communication between HIV outpatient services and primary care
- Sexual health services can consider collecting NHS number to facilitate prompt referral to other services including primary care and other outpatient settings
- Brief advice and referral to stop-smoking support services should be considered a core part of HIV health Primary care and outpatient settings can consider promoting “every contact counts” so that MSM are appropriately assessed for CVD health (for co-morbidities affected by ART)
- Use brief interventions to identify and tackle tobacco use
- Provide ongoing advice and support for HIV positive men to reduce their risk of HIV transmission and other STIs including hepatitis

Public Health England will:

- Monitor the clinical outcomes of MSM living with HIV infection
- Monitor the quality of life and health and wellbeing of those living with diagnosed HIV infection
- Provide information for the commissioning of appropriate services

We encourage national partners to:

- Commission appropriate social care servcies for people living with HIV
- Work with the NHS to identify need and ensure HIV diagnosis and treatment services are well evaluate

References and case studies

TBC

4.5 Places: Education and Training Facilities

Homophobic victimisation and bullying remains an issue for many schools and colleges in the UK with potential long-term consequences for the health and wellbeing of MSM**.**

While levels have begun to reduce, 44% of LGB pupils have experienced bullying. The consequences of homophobic bullying are far reaching. UK and US research has found students who have been bullied attain lower levels of academic success. Students who are bullied are also more likely to report health risk behaviours, such as substance abuse. Long-term effects of homophobic bullying include mental health problems, including self-harm, suicide attempts and depression.

There are a number of interventions, both in the UK and the US, that aim to support teachers in tackling homophobic bullying, to challenge stereotypes and empower students to challenge anti-LGBT bias. However, there is limited evidence or independent evaluation of the effectiveness of such interventions.

Key Fact

Nearly half of LGB school students have experienced homophobic bullying

Framework vision:

For all young LGBT learners to fulfil their academic potential in safe setting where their sexual identity is accepted and supported

SPECIFIC OBJECTIVE FOR STARTING WELL

Halve self-reported homophobic bullying in schools from 55% in 2011 to 25% in 2020.

We encourage education and training facilities to:

- Implement an anti-homophobic bullying policy by 2020
- For all schools to include a non-judgemental same sex component in their sex and relationship education by 2020
- Implement the NICE guidance on promoting emotional and social wellbeing for children and young people
- Publish and support data through its national mental health intelligence network on the mental health of young LGBT in schools.
- Provide comprehensive sex and relationship education including non-judgemental discussion of same sex relationships.

- To provide information on how alcohol and drug use impacts on decisions about sex, including negotiation of safe sex.

:

Public Health England will:

- Publish and support data through its national mental health intelligence network on the mental health of young LGBT in schools.
- Collate and disseminate examples of school-based interventions.
- Assess – and where feasible – commission evaluations and monitoring of school-based interventions to establish best practice.

National partners can:

- Consider reviewing the LGBT content of Sex and Relationship Education (2000) including its strategy to tackle homophobic bullying.
- Ensure that faith schools are bound by the same rules as other schools in applying non-discrimination in the employment of staff.

Local partners can:

- Assess – and where feasible – commission evaluations and monitoring of school-based interventions to establish best practice
- Promoting training programmes in local schools that are tackling homophobia.

References and resources:

TBC

4.6 Places: Health Care Settings

The significant changes to the public health and healthcare systems offer an opportunity to incorporate action on the wider determinants of health to improve the health and wellbeing of all our communities, including MSM. But experts have also warned that we must guard against these changes fragmenting the sexual health care that MSM need.

We have an opportunity, through the strategy of "making every contact count" to mainstream some extremely important health measures, such as HIV testing. It's essential that this opportunity is not lost. The health care system will be at its most effective in promoting the health and wellbeing of MSM if it can ensure that the services it offers and the way it offers them respond to the needs and aspirations of MSM.

Key Fact

Nearly half of LGB school students have experienced homophobic bullying

Framework vision:

For all young LGBT learners to fulfil their academic potential in safe setting where their sexual identity is accepted and supported

SPECIFIC OBJECTIVES FOR LIVING WELL:

Halve the number of new HIV infections in MSM by 50% from 3,000 in 2012 to 1,500 in 2020.

Halve the proportion of MSM with poor mental health, measured through those who report feeling recently unhappy or depressed from 21% in 2011 to 10% in 2020

Reduce the proportion of MSM with damaging use of alcohol, are reflected in those concerned about their alcohol use reducing by a fifth, from 21% in 2011 to 17% in 2020

Reduce the proportion of MSM using recreational drugs as reflected in reductions in reported use of class A drugs in last year by a quarter, from 13% 2009 to 10% in 2020

Reduce the proportion of MSM who smoke to at least the same level as heterosexual male counterparts, i.e. from 26% in 2011 to 20% in 2020

We encourage National Partners to:

- Incorporate LGBT awareness as part of routine training in all settings
- Make Every Contact Count; for MSM to be tested for HIV, and to be rapidly assess for alcohol, drugs and tobacco use and for mental health
- Develop rapid referral pathways for MSM requiring alcohol, drugs and treatment and/or mental health support
- For alcohol, drugs and tobacco services to have LGBT policies and appropriate delivery plans
- For mental health services to have LGBT policies and appropriate delivery plans
- Conduct an equity audit of data with regards to LGBT starting with gay , bisexual and MSM with an aim to improving data collection
- To undertake an audit on the mental health service users data to investigate avoidable mortality in gay, bisexual and men having sex with men with mental health and/or alcohol and drugs problem

Public Health England will:

- Publish and promote briefings to support local authorities to meet needs of MSM involved in “chemsex”
- Include the monitoring of sexual identity in national surveys and health and social care datasets to ensure apprpriate and adequate understandig of healther detemrinants and outcomes
- Work to include NDTMS sexual identity data fields and support local areas to use the data effectively in needs assessments and commissioning cycles.
- Support and contribute clinical expertise to Project Neptune (clinical guidelines on the acurate management and treatment of club drug use)
- Map relevant prevention interventions programmes and guidlines to the UNODC summary of prevention evidence and support Centre teams to disseminate to Local Authorities
- Collaborate with the ACMD and NICE work on prevention evidence and disseminate to Local Authorities
- Continue to work with the C&YP team to develop a PHE wide approach to prevent risk taking behaviours
- Work with social marketing team to support the development of FRANK and RISE ABOVE and ensure appropriate for LGBT communities

- Include the monitoring of sexual identity in national surveys and health and social care datasets to ensure appropriate and adequate understanding of health determinants and outcomes.

Local partners can:

- Update diversity materials relating to how local areas meet the alcohol and drug treatment and mental health needs of the LGBT community
- Update JSNA material to support local areas responding effectively to the needs of MSM
- Support implementation of NICE needle and syringe programmes guidance to ensure the needs to injectors and performance enhancing drugs and novel psychoactive substance are met by NSP and appropriate for LGBT communities

4.7 Communities

Strong communities, families and social networks protect and promote health and wellbeing and help address inequalities. A lack of support, or even outright rejection, from families, communities and social networks for gay or bisexual individuals can be a significant cause of social isolation, mental ill health and health risk behaviour.

Community development gives a voice to the most vulnerable in society. It addresses imbalances in power and brings about change based on social justice, equality and inclusion. It empowers communities to play a positive role in democracy, civil society and improve the quality of their own lives, their health and wellbeing and the communities of which they are a part. Communities are also powerful agents of change through the norms that spread through social networks. While social attitudes don't shift spontaneously: legislation and campaigning – often over long periods of time – help to influence these norms

Key Fact

- One in six lesbian, gay and bisexual people – 630,000 - have been the victim of a homophobic hate crime or incident over the last three years.
- Approximately 7% of clients in an average project for homeless people identify as being lesbian, gay, bisexual or transgender
- Half of lesbian, gay and bisexual people would expect to face barriers to becoming a magistrate because of their sexual orientation and almost half similarly expect they would face barriers to

Framework vision:

- For all MSM to live within a supportive community environment that provides opportunities to develop their potential, contribute to society, and participate in creating their own and their neighbours' health and wellbeing

Individuals can:

- Support family and friends who are gay, bisexual and/or transgender
- Increase their wellbeing and quality of life by volunteering in local programmes
- Influence decisions in local planning - using their rights enshrined in the Localism Act
- Look out for neighbours and keep in contact with those living around

Public Health England will:

- Develop and disseminate the evidence base and learning from community development programmes targeted at reducing HIV and STI risk among gay and bisexual men[99].
- Brokerage stronger partnerships at national level between voluntary, academic, public and private sector to build the evidence base for interventions aimed at building social networks and capital for gay and bisexual men and other men who have sex with men[100].
- Use its leadership role to champion community approaches which are inclusive and respond to the needs of the diverse community of gay, bisexual and other men who have sex with men, e.g. older MSM[101], BAME MSM, and disabled MSM.
- Use its expertise in social marketing, digital media and behavioural sciences to support mass campaigns to increase social connectedness, respect and reduce discrimination against individuals based on sexual orientation or gender identity.
- Be an exemplar in promoting and supporting an inclusive and diverse workplace.

National government could:

- Build a stronger infrastructure to support development of a sustainable and diverse LGBT third sector[102][103],[104].
- Develop strands within national programmes on the use of social and digital media to increase civic participation, citizenship and trust in democratic processes, to engage specifically with gay, bisexual and other men who have sex with men.
- Ensure that government consultations and engagement take specific steps to enable engagement with diverse MSM individuals and communities[105].
- Support the inclusion of gay and bisexual role models in national government and across national communication[106], to reflect the national population.

Local government can:

- Consider the needs of gay communities in planning and development decisions, and the potential to further marginalise this group through spatial design[107].
- Utilise the democratic process and leverage stronger partnerships between businesses, voluntary sector, education sector, public services and citizens to develop sustainable and strong communities that offer mutual trust, learning, recreation and work to protect and build community assets for improved health and wellbeing[108]
- Adopt an evidence based framework to community participation, development and empowerment, utilising a range of community engagement approaches that strengthen social networks and promote social justice[21]
- Foster a wide range of universal social activities, services and neighbourhood networks to build community connectedness and prevent social isolation throughout the life course, and at points of transition e.g. luncheon clubs, libraries, youth groups, community centres[109]

Health Services can:

- Engage citizens, in particular groups and communities that are most disempowered because of social disadvantage, in local service development, including consultation or collaboration with the community about intervention design and empowerment models where communities identify health need and mobilise themselves into action[110]
- Support peer support interventions so that people can learn and gain support from others who have had similar experiences or conditions, extending to communities with largest inequalities. These can include both group-based methods and one-to-one mentoring

- Establish strong care pathways that connect people with non-clinical needs to community resources and social activities that will enhance their wellbeing and improve their social support
- Be an exemplar change agent in the community building on the NHSE volunteering national event of 2014

The voluntary and community sector:

- Highlight the needs, assets and aspirations of gay and bisexual men and other men who have sex with men and work with public services and across the third sector to reduce barriers to inclusion[111]
- Increase the awareness of the rights of citizens in the Localism Act in local communities
- Ensure demographic monitoring of sexual orientation is included in all evaluation and monitoring and staff is supported to undertake evaluation and monitoring[112],[113],[114].
- Ensure volunteers have the appropriate support and training to work with gay and bisexual men, both as colleagues and service users.
- Build social capital within their local communities and invest in community development approaches that foster neighbourliness and break down barriers of culture and identity.

5. Next step: Implementation

By December 2014, PHE will lead and support key national and local partners to develop and implementation plan which align with the recommendations provided. Through implementation of evidence based interventions and engagement with the community and services, PHE will ensure that the recommendations developed in this framework are realised.

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