# The Big LGB & T Community Survey 2014

## Lesbian, Gay, Bisexual and Trans community profiles in the South West

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# Overview of some key results

**Confidence about being Out**

The 2014 survey results confirm that there has been very pronounced social change in the South West since our previous survey in 2006, at least in respect of community profiles of being Out as LGB or/and Trans. Though different cohorts and age-ranges show different profiles, there is a clear overall increase in the likelihood of LGB and Trans people being Out in public and in the workplace, within the family, and to at least some professional colleagues and service-providers.

**Geographical spread of the profiles**

These results confirm our regular long-term findings that LGB and Trans community profiles are pretty well homogeneous across the South West.

**Health needs**

The report highlights several areas of limited satisfaction with various health provider services, and other health issues.

In particular, it is clear that the need for mental health care is much more prevalent amongst LGB and Trans people than amongst the general public (as measured by the NHS); and that there are significant concerns about the level of relevant skills, knowledge and also to some extent attitudes encountered by many LGBT people who have recently approached generic mental healthcare services.

**Mental health needs linked to people's experience of life as an LGB or/and Trans person**

As part of the mental health results, we have new figures on how far people connect their experience of various mental health conditions with their experience of living life as an LGBT person. This survey has provided at least a working baseline of 19% for the incidence of some degree of feelings of internalised homophobia / transphobia / biphobia amongst LGB and Trans people within the South West.

**Adult social care**

Ratings for people's experience of adult social care services are encouragingly positive, though from a relatively small cohort of respondents.

**Crime and policing**

In respect of crime, it is very good to see that some indicators of community trust and confidence in the police have improved since 2006, and that a clear majority say that the police would be their preferred contact if they were to report a phobic incident.

However, the great majority also see at least one real barrier to reporting any incident at all. It is a matter of concern that perceptions of several of the potential barriers to reporting have changed little or not at all since 2006.

## Some key action points

1. Many of these results suggest opportunities for deeper research. Community and institutional stakeholders are invited to suggest further more detailed surveys to drill down into key points raised in this report.
2. Mental health services and some other healthcare providers need to work with community professionals and others to improve the satisfaction level of LGB and Trans service-users.
3. Police services, and the CJS as a whole, need to work with community stakeholders and representatives to address the barriers identified here to reporting phobic crimes and incidents, both the newly-identified barriers and those already known from 2006 or earlier. Over the last fifteen years or more the police have worked particularly hard amongst public agencies to ensure equality and fairness in service-delivery; these results demonstrate both that there has been a measurable and well-earned improvement in trust and confidence, and also that significant strategic action is still needed in respect of reporting phobic incidents.
4. The respondents, and the public-sector funders of the survey (see below), are all owed the warmest thanks, not only from Intercom and the wider LGB and Trans communities but also from service-providers and strategic planners in the South West, for having made this survey possible, either by supporting it financially or by investing time and skills in responding to it.


## Funding and support

We warmly thank the following for their generous grant-funding towards the costs of the survey:

Borough of Poole
Bournemouth Borough Council
Cornwall Council
Devon and Cornwall Police
Devon County Council
Devon NHS
Dorset Police

We have also received invaluable and generous support in kind from Public Health Devon, who have provided advice on data analysis and methodology. Our judgements are our own, however, and any error is also our own responsibility.

We are deeply grateful to all these, and to all who completed or promoted the survey.

# 1. Overview

## i. Background to the survey

The Big Community Survey was opened in late summer 2013, and closed in February 2014. There were 182 responses.

Most responses were received through our community consultation website Voices In Action (www.lgbt.voicesinaction.com). However, we also provided appropriate support for respondents who have learning difficulties and for others who preferred to complete the survey face-to-face, by phone, or on paper. At the time of closing the Big Community Survey there were 330 people registered on the LGBT Voices In Action site, so it could be said that the 182 responses make a response rate of around 55%, which is good.

## ii. The sample

We promoted the survey through general LGBT social and activities groups, and the wider population in the South West, but we did not promote it to our own Help Support and Advocacy service-users, or through other services (e.g. Victim Support) that are focused on people who have asked for help. The survey sample is accordingly not weighted towards those who have had problems and looked for help.

In respect of age, gender and gender-identity, the responses appear to constitute a sound sample in respect of adults aged 25 plus, and a useful indicative sample in respect of those aged 24 and below.

## iii. Confidentiality

The confidentiality of respondents to all our surveys is carefully protected, internally as well as externally. The administrator who deals direct with those registered on the Voices In Action site does not see their responses to any of the surveys, and the person who analyses the results does not have the data which would identify the author of any particular response.

## iv. Survey design

The survey was designed to produce results that could be usefully compared with those of our previous South West survey, published as *A Firmer Foundation* (2006), which we refer to throughout this report as "AFF 2006".[1] Some questions were carried down from 2006 to 2014 so as to enable us to see what might have changed over the intervening eight years. We also included many new topics which had not been touched on in AFF 2006.

We warmly thank our colleagues in Devon & Cornwall Police and Dorset Police who worked with us to finalise the community-safety questions, and our colleagues in local government and the NHS whose input on the overall approach and design was very valuable.

1 Available on our website at www.intercomtrust.org.uk/resources.

### v. This report

We have given disaggregated results by gender, gender identity and age wherever we have identified an interesting difference in responses. We are happy to respond to specific requests for disaggregated results within the limit of our capacity. We have not disaggregated by geography, since analysis has suggested there are no significant differences between responses across the region.

We have used the word "significant" here and throughout this report only where we have confirmed that a particular result is statistically significant to the 95% confidence level — that is, that there is only a 5% or smaller probability that that particular result might have arisen by chance.

Where there was a conflict between balancing page-lengths and presenting larger charts we have prioritised the accessibility and clarity of the charts.

## 2. Overview of key respondent profiles

### i. Gender

Where the questions gave respondents the option of replying as female or as male, 90 responded as male, 90 responded as female, and 2 as neither. In a separate question about gender, it was clear that 9 out of the 182 (4.9%) preferred to identify their gender as non-binary.

For comparison, out of the 130 responses in the AFF 2006 survey, 60% identified as male and 40% as female.

### ii. Gender identity

Twenty-eight respondents (15%) self-identified as Trans (including transgendered, questioning, transsexual and formerly transsexual).[2]

For comparison, the AFF 2006 survey had 7 responses from Trans people (5%)

### iii. Sexual orientation

168 respondents (92%) identified as Lesbian / Gay / Bisexual, 9 (5%) as Heterosexual, and 5 (3%) as "Other" or as not defined. It can be seen that a proportion of Trans respondents also identified as LGB.

### iv. Gender, Gender Identity and Sexual Orientation in the "About You" survey

Of the 182 who answered the Big Community Survey, 160 had also separately completed our detailed demographic survey "About You", where we offer a very wide choice of options for people to

2 Where there are more than 28 respondents in the Trans cohort this is because respondents who identified in one place as (e.g.) non-binary have chosen in the context of a particular question to respond as being Trans. See Section iv following.

record their definition of their gender, gender identity, and sexual orientation, including free text. The profiles of these results are interesting in themselves, and may be particularly useful for those planning the terms of future surveys, monitoring, or community outreach.

**Gender**. In respect of Gender 54% of these 160 defined as Male, 39% as Female, 2.5% as Gender Queer, and 4% in a variety of other, clearly very personal, terms.

**Gender Identity**. The situation is a great deal less clear when it comes to people's preference for defining their Gender Identity: the 160 respondents have chosen 20 different terms. However, 115 of the 160 (72%) clearly define as Not transgender; 23 (14%) recognisably define as being, inclusively, Trans (transgender, transsexual or formerly transsexual); and 4 (3%) define as Questioning.

Of the remaining 18 (11%), 3 defined their gender identity as "lesbian" or "woman", 3 as "female" and 3 as "male", and 2 as "gay".

Other responses included "consenting adult", "I don't know what this means", and "I don't have a gender identity".

**Sexual Orientation**. We have disaggregated people's definition of their Sexual Orientation against their self-defined Gender.

- Sixty-three males and 10 females identified as Gay (46%).
- Thirty-nine females and 2 gender queer identified as Lesbian (26%).
- Eight males and 7 females identified as Bisexual (10%).
- Five males, 2 females and 2 gender queer identified as Pansexual (7%).
- Six males and 2 females identified as Heterosexual (5%).
- Three males and 3 females identified as Queer (4%).
- One male identified as Questioning.
- The remaining 7 all identified in different, clearly very personal ways.

It appears that in the South West the term Queer, widely used in some national media and campaigning contexts, has not been widely adopted.

### v. Geographical analysis

Analysing these responses by respondents' place of residence confirms that the community profiles are pretty well homogeneous across the South West. The community issues in Cornwall, Devon, Dorset, Somerset and other places in the wider South West are closely congruent with each other. We have not identified any statistically-significant variances.

### vi. Further demographic details

Additional data about these 182 respondents, including geographical spread, disability, ethnicity, and relationship status, may be found in the Annex on page 33.

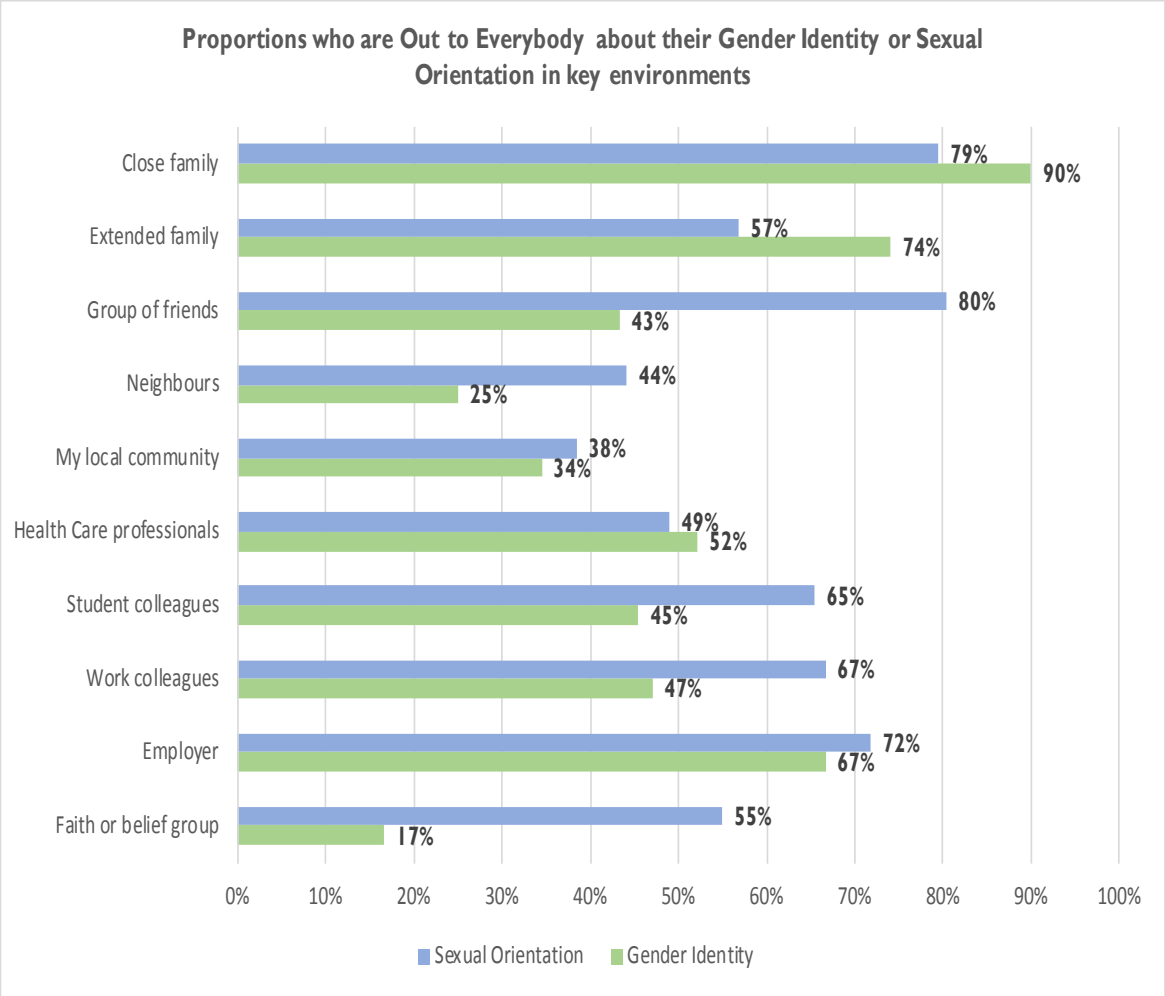
# 3. Coming Out

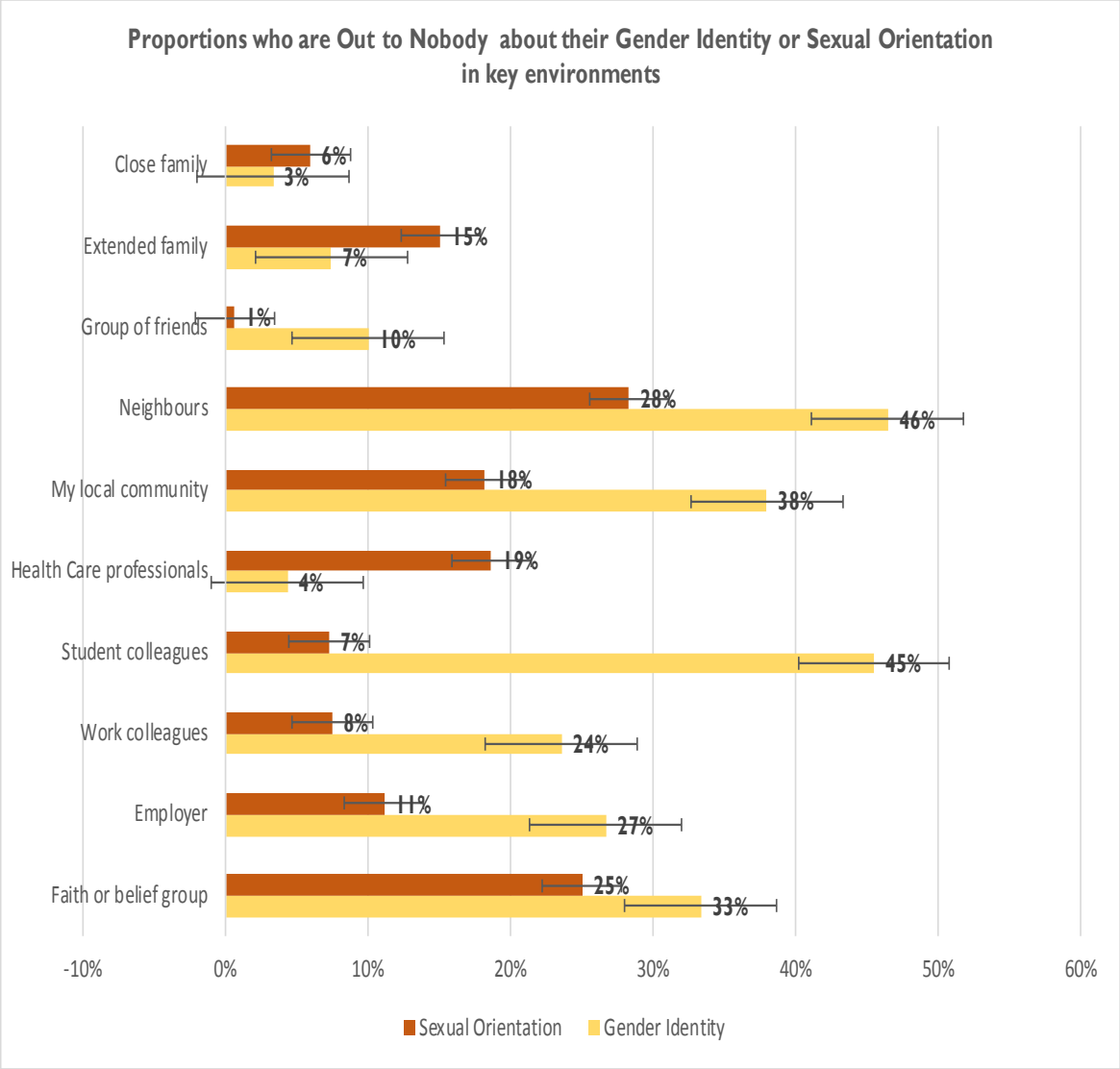
## i. Being Out in day-to-day environments

We asked respondents how far they were Out in a wide choice of possible environments: Close family, Extended family, Group of friends, Neighbours, My local community, Healthcare professionals, Student colleagues, Work colleagues, Employer, and Faith or belief group. The options we offered for each were simply All know, Some know, Nobody knows. We asked this question separately in respect of sexual orientation and of gender identity.

We analyse the results in more detail below, but in general it appears that LGB people are more widely Out as LGB than Trans people are as Trans, *except* within the family. In the Close and the Extended family, LGB people are a great deal less Out than Trans people.

The two charts following show where respondents are Out to Everyone and to Nobody in these environments.



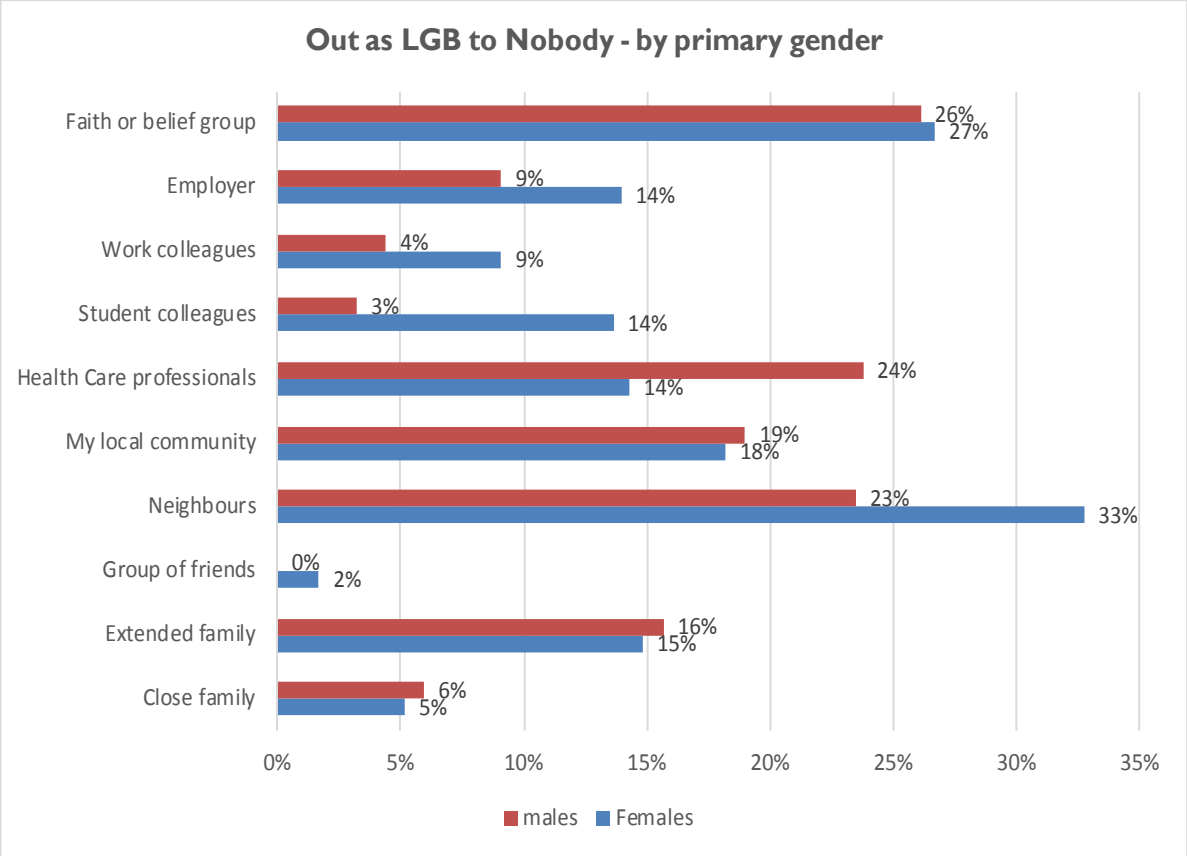



Respondents replied in respect of only those environments which were applicable to them personally, so the numbers of respondents varies according to the different environments: the responses in respect of sexual orientation range between 152 and 39, and those for gender identity between 30 and 6. The lowest number of substantive responses was in relation to "Faith or belief group", and the next lowest "Student colleagues". The highest figures were for "Group of friends" and the two Family options.

In general, it seems that nowadays Trans people are more protective of their gender identity than LGB people are of their sexual orientation. The two most important exceptions, from the point of view of public policy, are in relation to families, and to healthcare professionals. The number who said "All know" in respect of healthcare professionals was roughly equal (49% re being LGB, 52% re being Trans), but the proportions who said "Nobody knows" under that heading were very different: only 4% of these Trans respondents (1 out of 23) said they were not Out as Trans to

any health professional, whereas 19% of LGB people have told no health professional about their sexual orientation (27 respondents out of 145). However, even here we can see a definite change over the last eight years: the equivalent figure for LGB people in 2006 was 47%.

There are noticeable differences in respect of gender cohorts, though these are indicative rather than being statistically significant to the 95% confidence level. 33% of LGB women are Out to none of their neighbours, compared with 23% of GB men, while 24% of GB men are Out to no healthcare professionals, compared with 14% of LGB women.

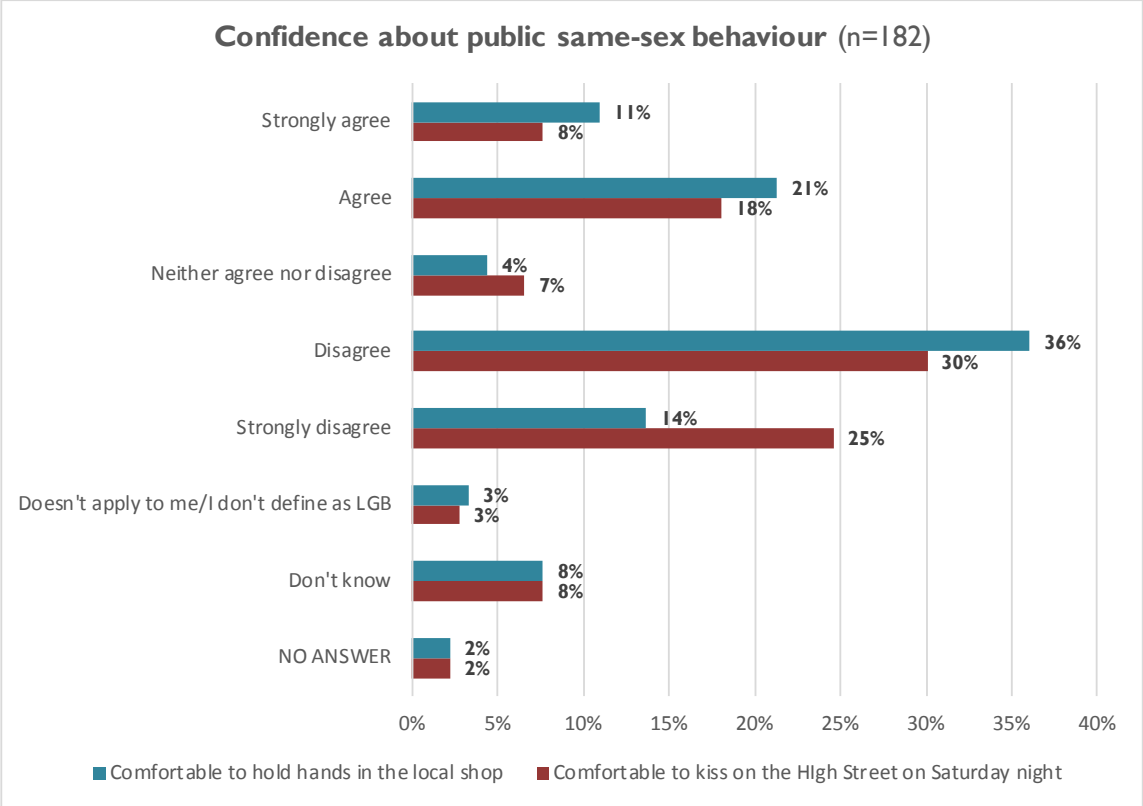



We have noted above that in two specific areas of life, these charts suggest that LGB respondents are less likely than Trans respondents to be Out as such in their families, and to healthcare professionals. This is not entirely unexpected. Many LGB people are wary, to say the least, about the potential reactions of family-members to their coming Out, while Trans people are unlikely to be able to keep their transitioning private from their own family.[3] As shown above, 19% of all LGB people are not Out to any healthcare professional; on the other hand, Trans people who have entered the transitioning pathway will have done so with medical assistance.

3 But it should always be borne in mind that there are both Trans people and LGB people who have little or no contact with their birth / nurture families.

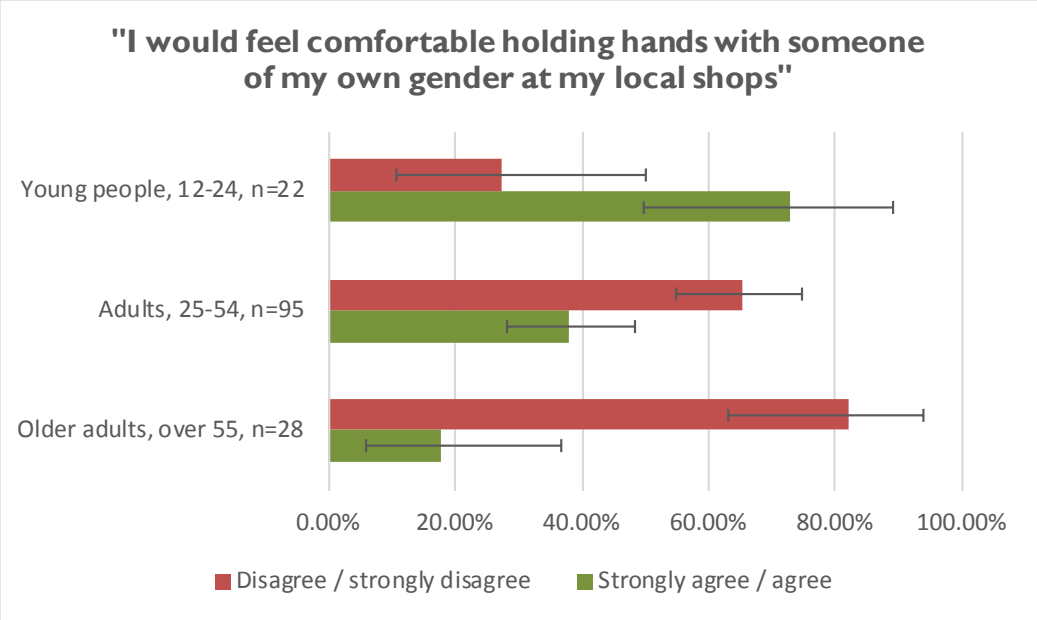
## ii. Being Out as LGB in public places

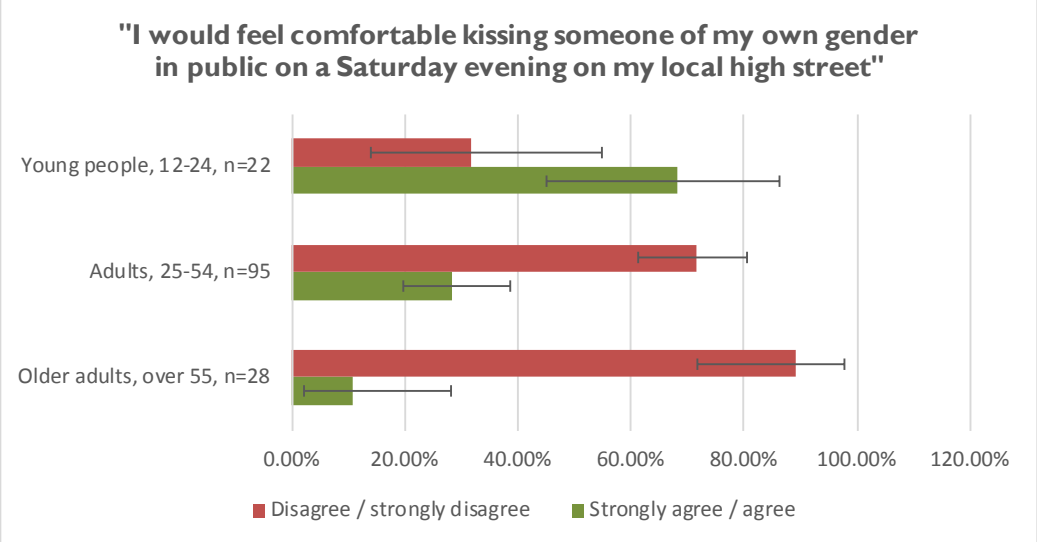
We asked how comfortable LGB respondents would be in respect of (a) holding hands with someone of their own gender at their local shop, and (b) kissing someone of their own gender in their local High Street on a Saturday night.




Taking the sample as a whole, people are more wary of being seen kissing in their local high street on a Saturday night than they are about holding hands in a local shop. This was also the case in AFF 2006.

However, disaggregating the 2014 results by age-range shows a different picture (see the charts on the following page). Young people under 25 are on balance very positive about both scenarios; middle-aged and older people are comparatively negative, or more cautious.


"I would feel comfortable holding hands with someone of my own gender at my local shops"
Young people, 12-24, n=22
Adults, 25-54, n=95
Older adults, over 55, n=28
0.00%
20.00%
40.00%
60.00%
80.00%
100.00%
Disagree / strongly disagree
Strongly agree / agree


"I would feel comfortable kissing someone of my own gender in public on a Saturday evening on my local high street"
Young people, 12-24, n=22
Adults, 25-54, n=95
Older adults, over 55, n=28
0.00%
20.00%
40.00%
60.00%
80.00%
100.00%
120.00%
Disagree / strongly disagree
Strongly agree / agree

# 4. Health

## i. Key findings

Anonymised findings from the Big Community Survey were shared at an early stage with Public Health Devon, while they were developing the new Devon LGB&T Health Needs Assessment on behalf of the two Clinical Commissioning Groups that cover Devon, Plymouth and Torbay, with the support of Stonewall and Intercom. The final version has been published, and draws widely on results from this survey.[4]

Perhaps the most striking findings from this survey are the high level of mental health problems our respondents reported having experienced in the previous two years (see Section 4.iii below), the widespread dissatisfaction amongst those who had recently approached generic mental health services (see section 5 on page 17ff below) and the fact that a high proportion of those who had had mental health problems reported that they felt these problems were associated, wholly or partly, with their experiences of living as an LGB or Trans person (see page 13 below).

## ii. Physical health

We asked two questions about physical health.

"In the past two years have you experienced a drug and/or alcohol problem?" Those who answered "Yes" were 7% of men, and 3% of women.

"In the past two years have you experienced a sexual health problem?" Those who answered "Yes" were 17% of men, and 2% of women.

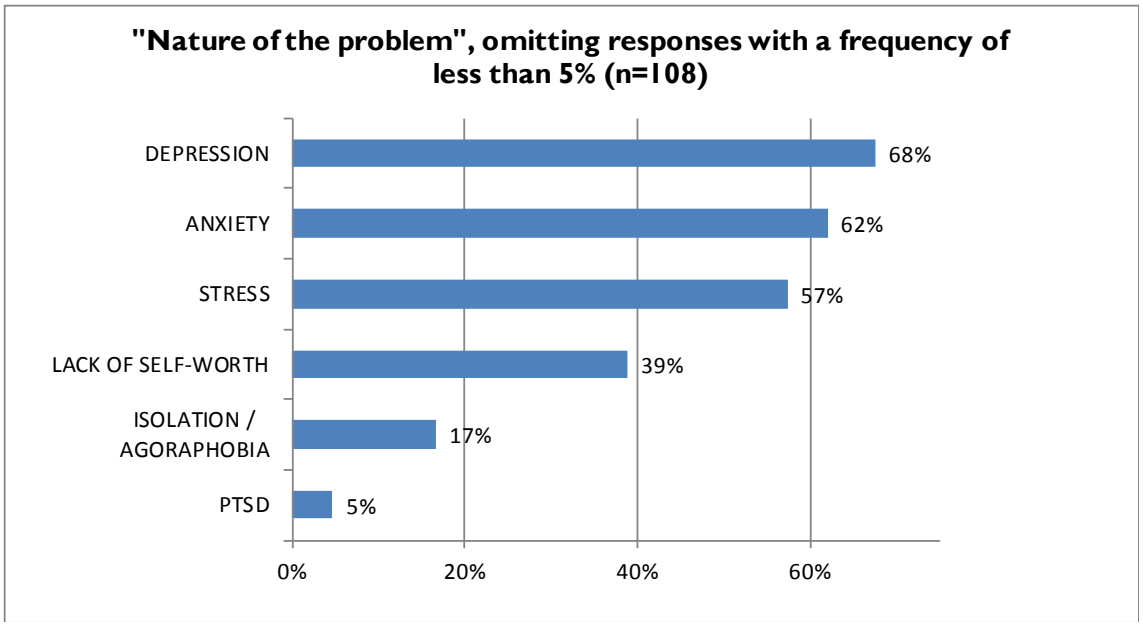
## iii. Mental health problems: prevalence

We asked, "In the past two years have you experienced any Mental Health problems?". Two survey respondents did not answer this, leaving 180 who did. All percentages in this section are percentages of the 180 who responded to this section unless otherwise indicated.

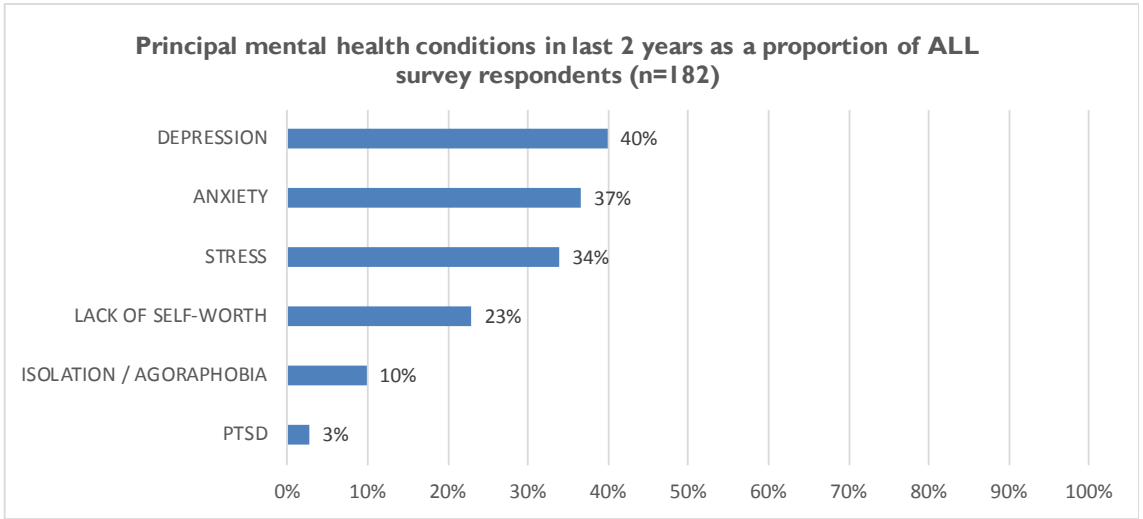
40% answered "No". Another 40% said "Yes, and received medical treatment or counselling". A further 12% said "Yes, but did not receive medical treatment or counselling". A further 8% said "Possibly". The difference between the 40% who said "No" and the 60% who said "Yes" or "Possibly" is reliable to the 95% confidence level. This is significant in the context that this survey as a whole appears to be a good representative sample of LGB and Trans adults in the South West.

4 It can be downloaded from www.devonhealthandwellbeing.org.uk/wp-content/uploads/2014/09/Devon-LGBT-Health-Needs-Assessment-2014.pdf

In total, 108 respondents (59% of the total survey respondents) said they had or possibly had had a mental health problem in the previous two years. We asked these 108 to indicate the nature of this mental health problem. We allowed multiple choices, and offered a free-text box.




In the table below we show these figures as a percentage of the entire response sample of 182, which, as said above, we have set out to make as demographically representative as possible, and not to over-represent those who are in some way in need.




These figures seem to confirm other research that finds that LGB and Trans people are disproportionately affected by mental health issues compared with the general population.[5]

As a useful comparison with the general population, the QOF Prevalence of Depression register for 2011-12 gives the incidence of depression in the general population of the South West (18+)

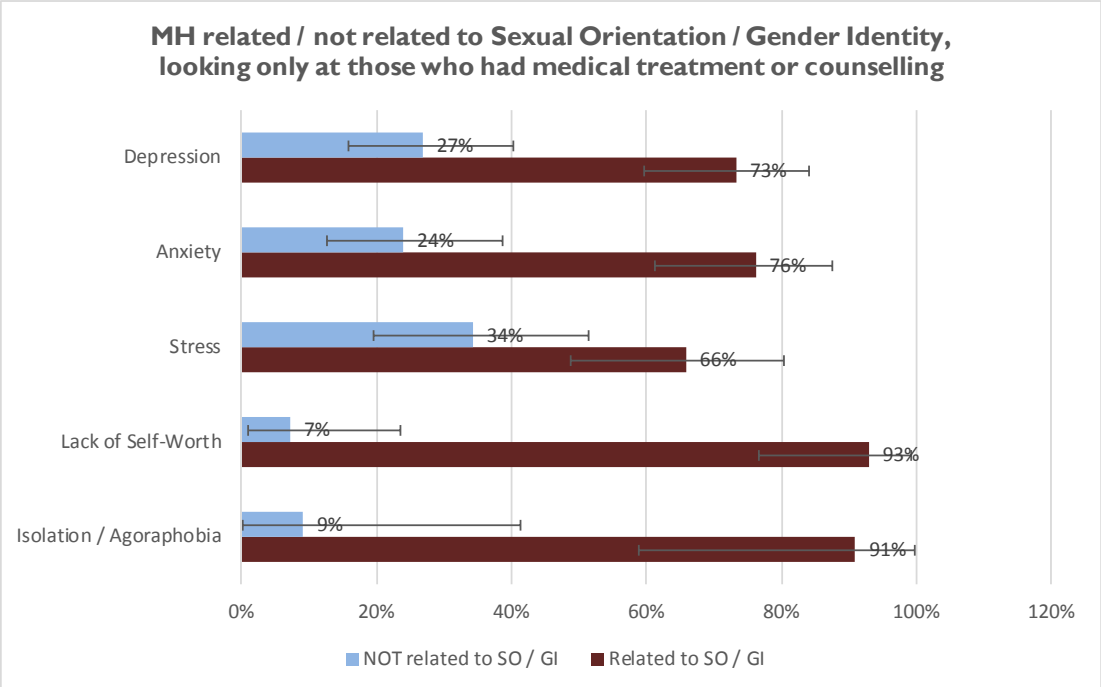
5 See Public Health Devon, *Devon LGB&T Health Needs Assessment* sections 3.4 and 3.8.

as 12.75%.[6] This can be compared with the figure of 40% of our LGB and Trans survey respondents, seen in the chart above. The comparison between 40% and 12.75% is not quite straightforward, since the Big Community Survey refers to 'the previous two years,' whereas the QOF POD register refers to a single year, but the figure seems to support larger scale studies that indicate a higher prevalence of mental health problems in LGB and Trans people. Further consideration of this may be found in Public Health Devon's *LGBT Health Needs Assessment* referred to above.

### iv. Mental health problems: association with experience of being LGB / Trans

We asked the 108 respondents who had responded that they had experienced mental health problems in the previous two years whether they associated that mental health problem with their experience of being LGB or Trans. 53% said "Yes, fully" or "Yes, partly"; a further 12% said "Not sure"; 33% said "No".

We have analysed the five highest-frequency mental health conditions by this distinction, looking at that sub-cohort of respondents who had received professional counselling or medical treatment. It will be seen that on almost every issue there is a statistically-significant difference between those who did, and those who did not, associate their Depression, Anxiety, Lack of Self-Worth, and Isolation / Agoraphobia with their experience of being LGB or Trans.




Disaggregating the results for lack of self-worth by gender identity and by gender, we find that these feelings affect a higher proportion of men than of women, and a higher proportion of Trans people than non-Trans people, but none of the differences are statistically significant. Exactly the same is true of the results for social isolation. There are no significant differences across age-ranges.

6 In the NEPHO Community Mental Health Profiles 2012-13, http://www.nepho.org.uk/cmhp/.

### v. Internalised homophobia / biphobia / transphobia

There is a noticeably high percentage of respondents who were *both* living with lack of self-worth *and* associated their mental health problem with their life-experience as an LGBT person. Internalised homophobia / transphobia / biphobia (internalised phobia, or "IP"), can express on many levels ranging from mild low self-esteem to, at worst, externalised self-hatred, and is directly related to living in, or having been brought up in, a prejudiced, hostile or uncomprehending environment. We find that IP, at one level or another, operates as a negative background lighting to a worrying proportion of LGBT lives, underlying or intensifying other LGBT-related (and non-LGBT related) issues.[7]

It has been found difficult in the past to assess what proportion of the LGB and Trans populations as a whole are living with a greater or lesser degree of IP. In this survey, we find that 19% of all who answered the mental health questions (n=180, which includes those who responded that they did not have a mental health problem) were living with low self-esteem *and also* associated their mental health condition with their experience of being LGB or Trans. This may be seen as at least a working baseline for the prevalence of IP amongst the LGBT populations in the South West.

However, it should be borne in mind that one of the difficulties in setting a baseline for IP is that many LGBT people do not recognise that they are living with IP, while some people who are living with IP experience it in such a form as impels them not to define their identity as LGB or Trans. These will not of course engage with an LGBT community survey, and are also unlikely to raise their IP experience in any other, non-LGBT, context.[8]

### vi. Mental health problems: comments

We asked respondents who felt that their mental health problems were or might be related to their experience of being LGB or Trans to give us their thoughts about this. Some took this as an opportunity to explain the general background of their mental health or wider problems. Of particular interest is the recurring theme of complexity and interrelationships between different but linked life-issues in the lives of LGB and Trans people.[9]

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7 Low self-esteem connected with internalised phobia has turned out to be an element in the lives of more than half of our most recent 741 community support cases in the South West. However, only around 6% of those service-users who are living with IP contact us specifically for help with low self-esteem or related issues. The great majority of these first approach the service looking for help or support with social isolation, depression, family or relationship problems, crime or housing issues, or a wide range of other issues. See our *Briefing Note: Internalised Phobia* (February 2015), available at www.intercomtrust.org.uk/resources.

8 Some males who do not identify as GB do behave as MSM (Men who have Sex with Men). It should be noted that where men using public sex environments become locally known as presenting a significant risk of violence against others these aggressive behaviours may be externalisations of feelings of IP.

9 This complexity is a very notable feature of Intercom's own support casework. In 2014, 92% of our service-users presented with between 4 and 45 different but LGBT-related issues in their lives. More than one-third were living with between 15 and 45 issues. (Intercom Trust, *Help Support and Advocacy Activities Report, Devon & Cornwall, 2014*, available at www.intercomtrust.org.uk/resources.)

These free-text responses are widely illuminating, as will be seen from the following selection. We have not weighted this selection: the recurring focus on internalised phobia and low self-esteem is an accurate reflection of all comments made in this section.

- I was assigned to a counsellor who immediately terminated the session when I told her that I was gay.
- Yes, but only in the sense that the actions of others that led to my PTSD (bullying, violence, sexual abuse) were in part caused by homophobia and transphobia. My condition was not caused by my gender identity or sexuality, but in part by others' response to this.
- I have always felt out of place with other people and that was definitely reinforced by the homophobia I experienced as a child.
- Childhood issues had contributed to a confidence problem.
- Accepting myself as a person, accepting my sexuality as part of me, identifying my sexuality.
- If I am around someone who doesn't know I'm a lesbian, and they begin to say things that may [*be*] unintentionally offensive, it stops you wanting to come out to them, and just makes things difficult
- I have experienced a lot of negative and nasty experiences from people due to my sexual orientation.
- Several years of bullying at school that eventually caught up with me in my twenties pushing me into a rut that I couldn't get out of by myself.
- Accessing medical support to progress towards gender reassignment was difficult at one stage because of a specific GP's approach. This, along with threats of a violent nature from a neighbour intensified my condition and pushed me to the brink.
- Isolating myself because I didn't understand fully that I'm trans. Suffered stress/anxiety at college when coming out and depression from rejection at home.
- Coming out as transgender and the body dysphoria that comes with it. Self harm, suicidal thoughts.
- Issues around personality / self; coming out / being outed and the reactions / responses of others; relationships (first steps); the expressed opinions and actions of family / friends; isolation based on not having anybody neutral to talk to…
- I'm not the same as other guys, and find this a constant source of insecurity, especially as a child. This has lead me to be a loner & not want to socialize or enjoy doing so.
- Build up of various issues over a period of time. Now moderated with medication.
- Fear
- I was worried about what my family and friends would think of me coming out.
- Related, but not caused by; sorting out my own identity in general was very delayed as a result of the long time it took me to process childhood psychological abuse so I only figured out who I am (including my orientation) in my mid 30s.

- Transphobia from my parents.
- Isolation.
- Stress of coming out led to an increase in the severity of auditory hallucinations.
- I had issues with loss and abandonment and started to use hard drugs and heavier sex to 'escape' which lead to dangerous situations.
- Social isolation relating to specifically LGB issues.
- I was isolated from the LGBT community and wondering what to do about it. Few friends at the moment. Depressed as I seem to be only one in village.
- Repeated homophobic bullying from neighbour.
- I feel my HIV status stimulates my negative traits.
- Trouble with my confidence in getting and keeping a job and a relationship.
- Never knowing how people are reading me/ forever being misgendered/ not having an identity that is generally recognised as valid... (the list goes on) this causes a lot of anxiety and does affect my mental health/ depression. I have been out of work…
- General disgust and hate at my body. Feeling really ill when my period is due because I'm really a guy. People trying to bully me to become something I'm not, ie telling me what my gender is then telling me to 'shut up' when I keep reminding them…
- Low self-confidence, esteem, self-worth, body image issues, feeling isolated and lonely.
- A total dysphoria concerning gender.
- I suffered depression and anxiety because my PCT decided to go against the standards of care they said they followed and insisted that I complete two years Real Life Experience before I could have chest surgery despite significant issues…
- Not fully understanding, and familial concerns.
- Loneliness, confusion and isolation.
- I lost my confidence in my self, my relationship and began wondering what it was all about. I work in [*the public sector*] as a manager. This was not always the most "welcoming" environment to work in as a gay man.
- My guilt over 'coming out'.
- Before coming out (almost two years ago) as trans I was suicidal, didn't think I could transition, was scared about losing family and friends, being unable to find employment (I didn't have a job at the time) and never being able to 'pass'.
- Issues due to PTSD (previous domestic violence incidences), anxiety, depression, self esteem issues, aspergers, body image issues, weight issues.
- Not feeling as good as everyone else. Particular family issues relating to emotional well-being.
- Complex really - i find there is nothing precisely normal in this world, therefore nothing can be abnormal. I get frustrated coming out to new people, explaining myself - i feel the need to explain myself, almost defensively sometimes.

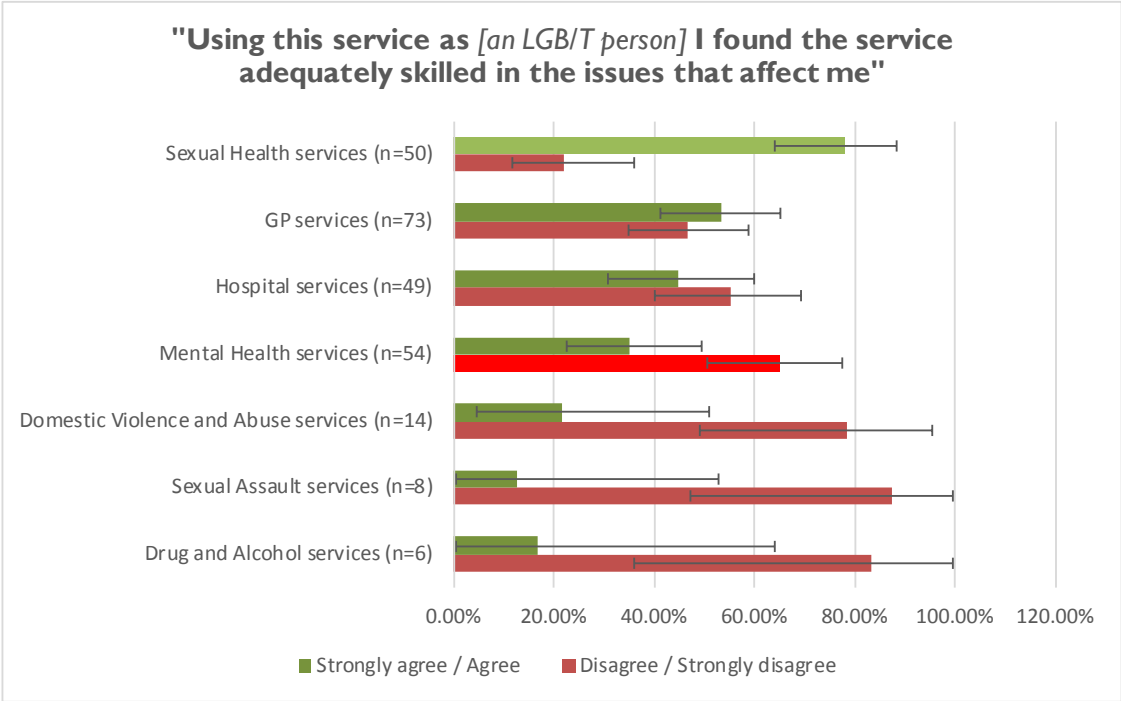
- Gender dysphoria worsens my depression and anxiety significantly
- Did not know where/how to access places to meet gay men for friendship/start a relationship. My caring commitments also impact on this issue.

## 5. Key services: Access and Satisfaction

We asked people if they had used any of seven key services over the previous two years, and if so whether they had found the services they had accessed "were adequately skilled in the issues and needs that affect me as a [Trans woman / Trans man / LGB woman / GB man]". We have disaggregated the results where useful by these four different cohorts of respondents.

### i. Overview of satisfaction with seven key services

Only two of these seven services were found satisfactory by more than 50% of respondents, consolidated across all four cohorts: Sexual Health and GP surgeries. A majority of each of the four cohorts expressed dissatisfaction with four services: Mental Health care, Domestic Violence and Abuse services, Drug and Alcohol Services, and Sexual Assault Services.




The findings for Mental Health care services are statistically significant. Responses for the other six services are indicative.

In respect of the three services where feelings were mixed:

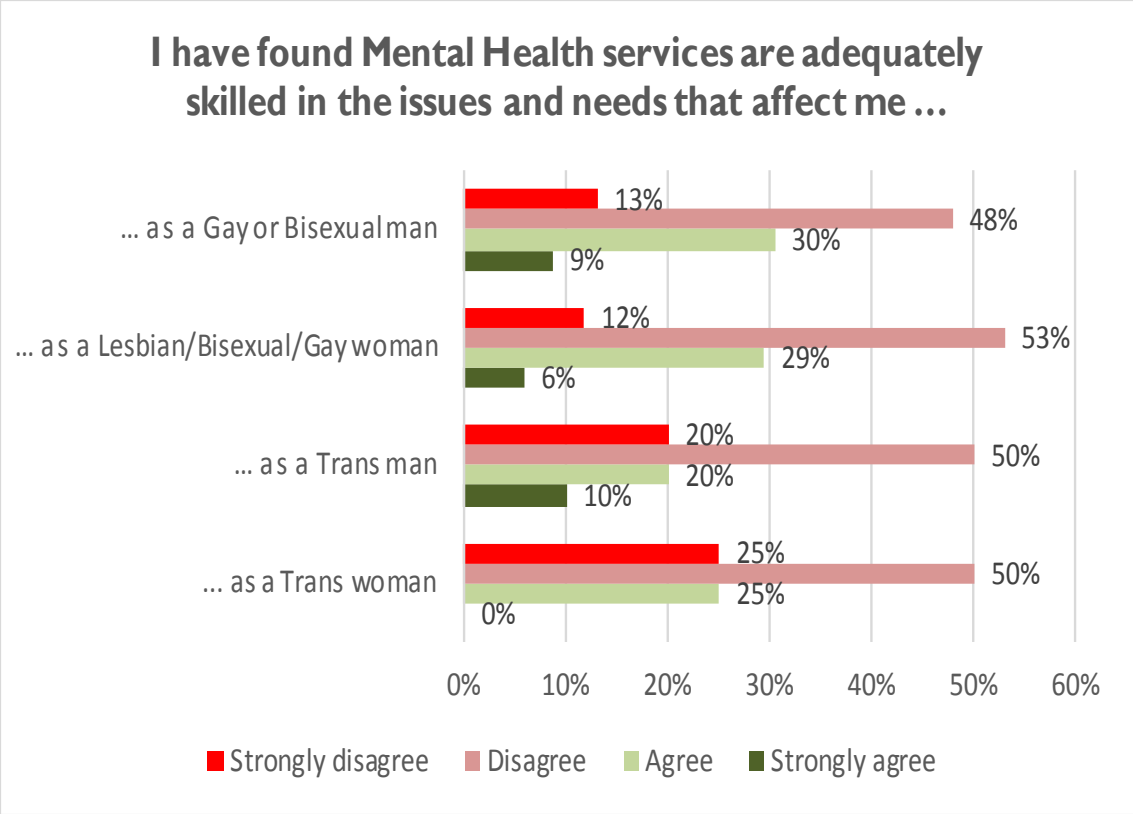
**GP Services**. Three cohorts were on balance positive about GP services (LGB women by only a small margin). Trans men were dissatisfied by a ratio of 2.75 to 1 (n=15).

**Hospital services**. Only one cohort, GB men, was on balance satisfied with Hospital services (ratio of 1.75:1, n=22). LGB women were dissatisfied by a ratio of 3.5 to 1 (n=18). Trans men's opinions were evenly balanced (n=6), and 3 Trans women were divided 2:1 against.

**Sexual Health services**. GB men were positive by a ratio of 5:1 (n=36), and LGB women by a ratio of 2.67:1 (n=11). The only Trans woman to respond to this question said "Strongly disagree". Of the 2 Trans men who responded, one said "Agree" the other "Disagree".

### ii. Mental Health services

As stated above, the overall rating of this service as unsatisfactory by all four cohorts, is statistically significant. We give below a more detailed breakdown of the responses.




Analysis shows there is no significant difference in responses from different localities: the results are pretty well homogeneous across the South West.

Considering that the question was framed in such a way that it was answered only by those who had personally used each service as an LGB or/and Trans person in the previous two years, all

these results, whether significant or indicative, need to be carefully considered by Intercom and all our partners and stakeholders across the South West.

## 6. Social care

We asked respondents if they had used care services in the last two years, or had contact with them as an unpaid carer, partner or family member. 22 respondents answered "Yes" to one or more of these.

| | I have personally received this service | I have had contact with this service as an unpaid carer, partner or family member. |
|---|---|---|
| Adult residential care services | 1 | 6 |
| Child residential care services | 0 | 2 |
| Domiciliary Care / Home help | 2 | 4 |
| Day care activities or other community-based care setting | 4 | 4 |
| Fostering and Adoption service | 2 | 0 |
| Other | 6 | 2 |

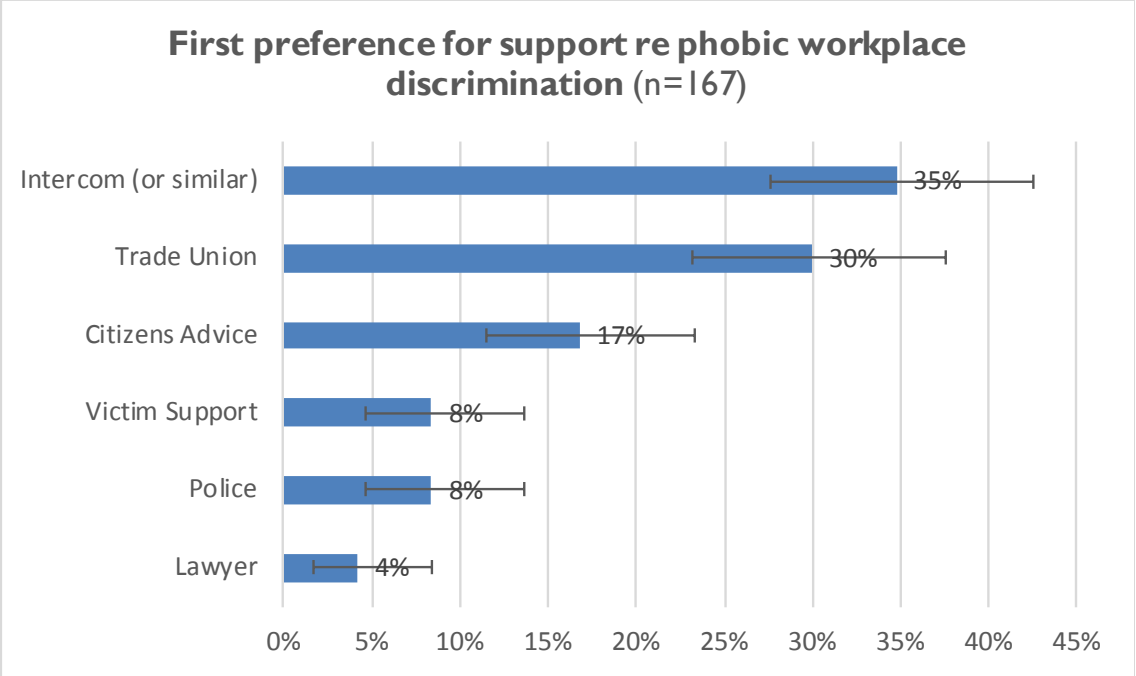
These 22 respondents comprised 12 female, 9 male and 1 non-binary. The sample is very small, but satisfaction levels both amongst those who had received and those who had had contact with any of these services were high. (We asked, "Did you feel as an LGB or Trans person that the service(s) provided were positive and non-discriminatory?".)

## 7. Advocacy and complaints

We wanted to get a sense of how people prioritise the internal complaints systems of public services compared with a range of third-sector and other services, so we asked how people would go about getting support if they had an issue (i) about workplace harassment, (ii) about the NHS, and (iii) about a phobic crime or incident. We gave people the opportunity to list the options in order of preference, but analysis has shown that the second preferences and onwards make little difference to the results based on first preference only.

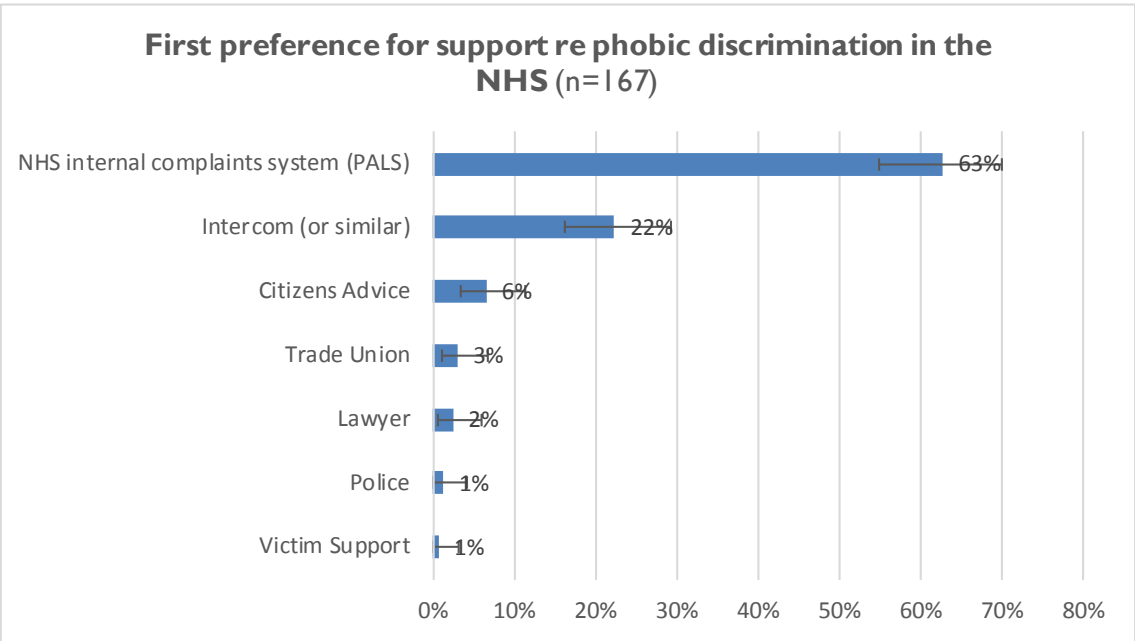
### i. The Workplace

We asked, "If you were looking for help support or advocacy about phobic discrimination in your workplace which of the following services would you prefer to contact? ". The preferences were headed by a community support service such as Intercom, and a trade union.



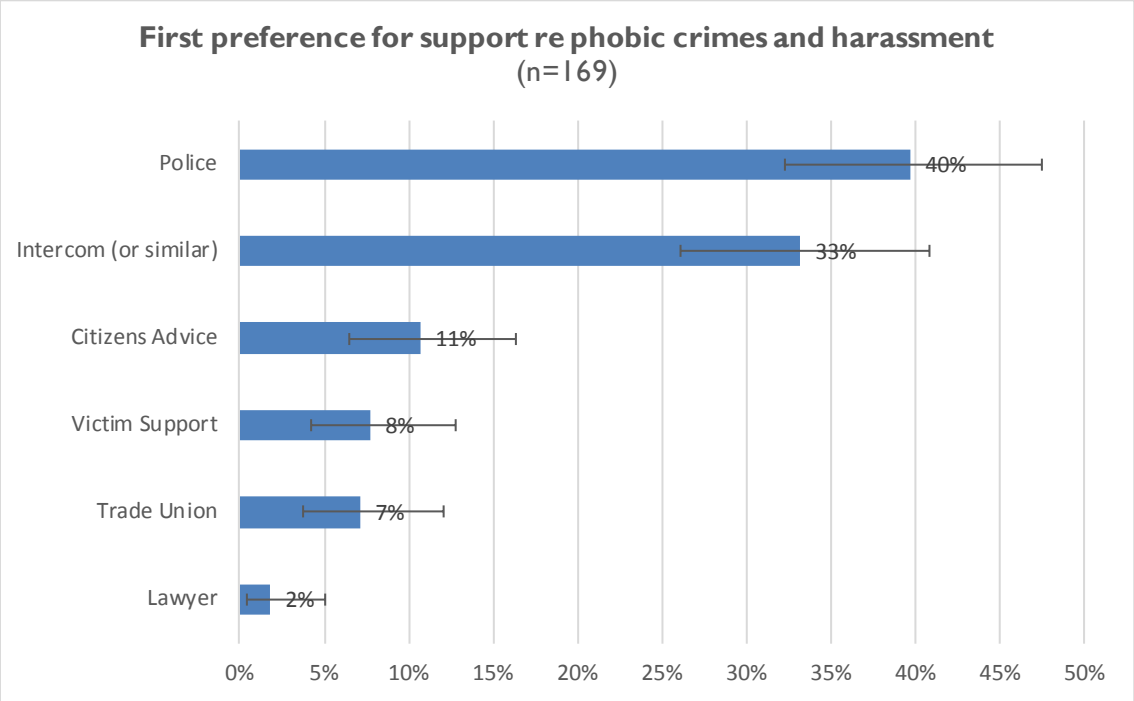

### ii. The NHS

We asked, "If you were looking for help support or advocacy about discrimination in the NHS which of the following services would you prefer to contact? " The NHS's internal system was widely preferred, followed by a community organisation such as Intercom. These two were statistically significant both as against each other and also as against the other options.



### iii. Crime and Harassment

We asked, "If you were looking for help support or advocacy about phobic crime or harassment which of the following services would you prefer to contact?" The preferences were headed by police, and a community organisation such as Intercom. The difference between these two and the remaining options, including Victim Support, was statistically significant and reflects Intercom's grassroots experience when working with victims and communities on crime issues.




## 8. Crime and policing

### i. Experience of crime

75 respondents (49% of women and 32% of men; n=182) had experienced one or more of the following in the previous two years: threats, harassment, verbal abuse, physical assault, domestic abuse or violence, sexual assault.

36% (n=182) said that they had experienced such incidents that were specifically motivated by homophobia or transphobia.

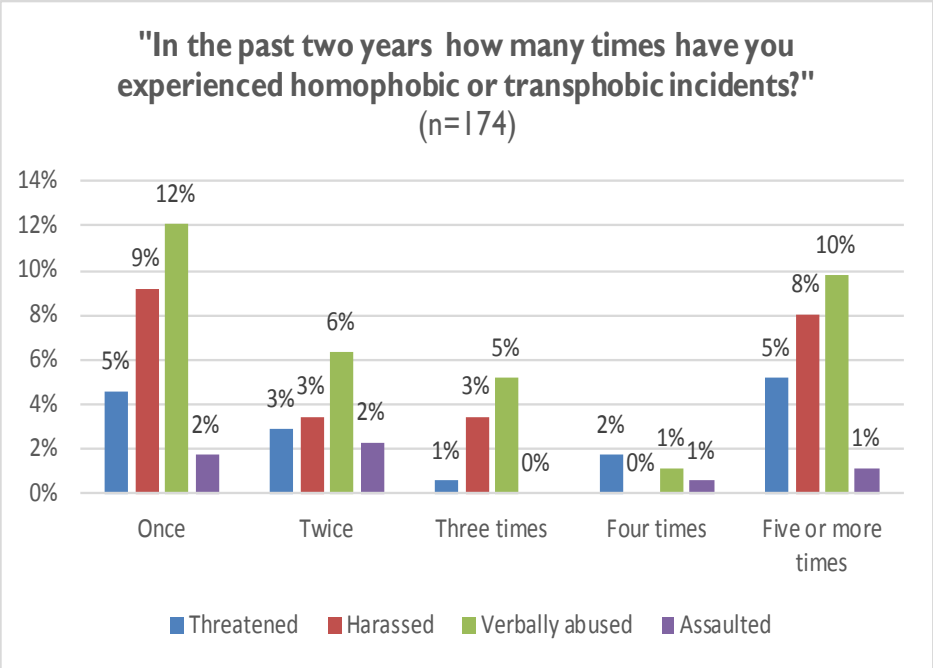
14% of women and 12% of men had experienced domestic violence or abuse in the preceding two years. 30% of women and 20% of men had experienced crime or other anti-social behaviour other than DVA. 48 respondents (26%) answered "yes" to one or the other of these two options; 25

respondents (14%) answered "yes" to both. There were no significant differences across age-ranges, genders or gender-identities.

Five respondents (3 women, 2 men) said they had been the victim of specifically sexual assault in the previous two years.

### ii. Frequency of crimes

We asked how often, in the previous two years, people had experienced any of the following: threats, harassment, verbal abuse, or physical assault. (This is the standard list that we test for: we find that the general public understanding of these terms more or less matches criminal offences as these are monitored by the police and CPS.) The results suggest that where these respondents have experienced one of these, it tended to be part of a pattern of extended repeat victimisation.




### iii. Fear of crime in the neighbourhood

70% of respondents (n=182) said they felt "very safe" or "fairly safe" walking in their area alone after dark, and the same proportion said they were "not worried at all" or "not very worried" about "becoming a victim of crime".

### iv. Reporting history

Overall, 47% of the 75 who had experienced an incident (36 respondents) had reported at least one incident. The proportion of those reporting who had experienced specifically phobic crime was noticeably lower at 36%.

These figures cannot be read as an indication of the proportion of *incidents* that were and were not reported. We asked whether people had experienced *any* phobic crimes, and if they had reported any of them; we did not ask *how many* phobic crimes people had experienced or reported. We know from our casework that a few (very few) LGBT people will report everything to the police, many will report one incident here and there, or one incident out of a series, and many will report nothing to anyone.

### v. Reasons given for not reporting

We asked those who had not reported if they would like to give some idea of why they had not reported. The responses range over a wide range of motivations, which may be borne in mind when considering the data in the sections that follow.

- Didn't think it was worth making a fuss over.
- Because I became stuck in a situation where I made myself believe I was happy.
- It was just drunk people being stupid and transphobic, and I didn't perceive it as a real threat, just very unpleasant.
- I reported this to [*social landlord*]. Through this, Intercom were involved and I was moved.
- Didn't think they would do anything about it.
- Because there's no point.
- Neighbour scary, police might make it worse.
- Don't think they have enough officers to have the time to deal with it.
- Relatively minor abuse on the street and I don't think the police would have been able to do anything about it.
- Did not have identifying details of the harassers, and not confident in being taken seriously by the police as a butch lesbian.
- DVA again. Emotional and mental abuse isn't a police matter.
- Did not think it would be taken seriously.
- I didn't know it was emotional abuse.
- Previous incident was reported to police and this made the perpetrator more abusive than before.
- I didn't because i felt it wasn't serious enough to warrant involving the police and i couldn't handle the thought of police possibly treating me badly or laughing at me.
- Feel nothing would be done.
- I felt like I didn't want to risk making things worst by bringing the police into things. Things stopped when I started passing better or I might have taken things to the police.
- It didnt seem big enough to report - it was young people shouting the word 'lesbian'.
- What is the point?

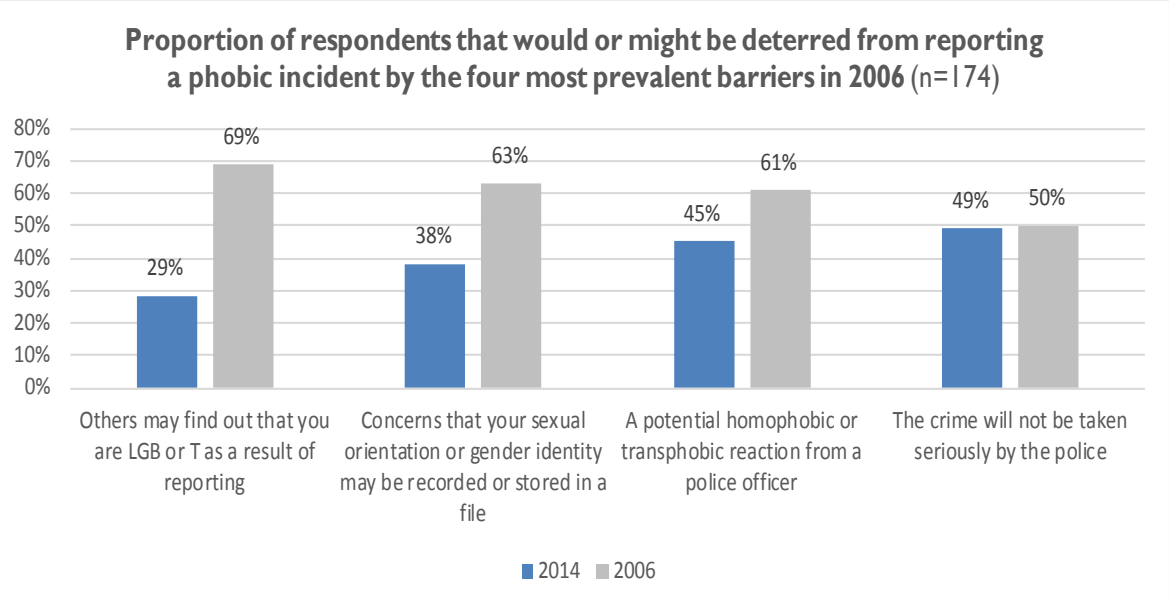
- Pointless.
- I don't think I would be listened to and taken seriously.

### vi. Attitudes to the police: barriers to reporting (comparisons with 2006)

In our 2006 community survey we asked the same questions about barriers to reporting that had scored most highly in the 1998 National Advisory Group survey, *Breaking the Chain of Hate*. In the 2014 survey we repeated the four of these that had scored as the most frequent barriers in the 2006 survey, to see how far things had changed since 2006. These four potential barriers to reporting were:

a. Others may find out you are LGB or T as a result of reporting
b. Concerns that your sexual orientation or gender identity may be recorded or stored in a file
c. A potential homophobic or transphobic reaction from a police officer
d. The crime will not be taken seriously by the police.

The results were somewhat mixed, but it is clear that in 2014 a substantial proportion of respondents would still find each of these a potential barrier.

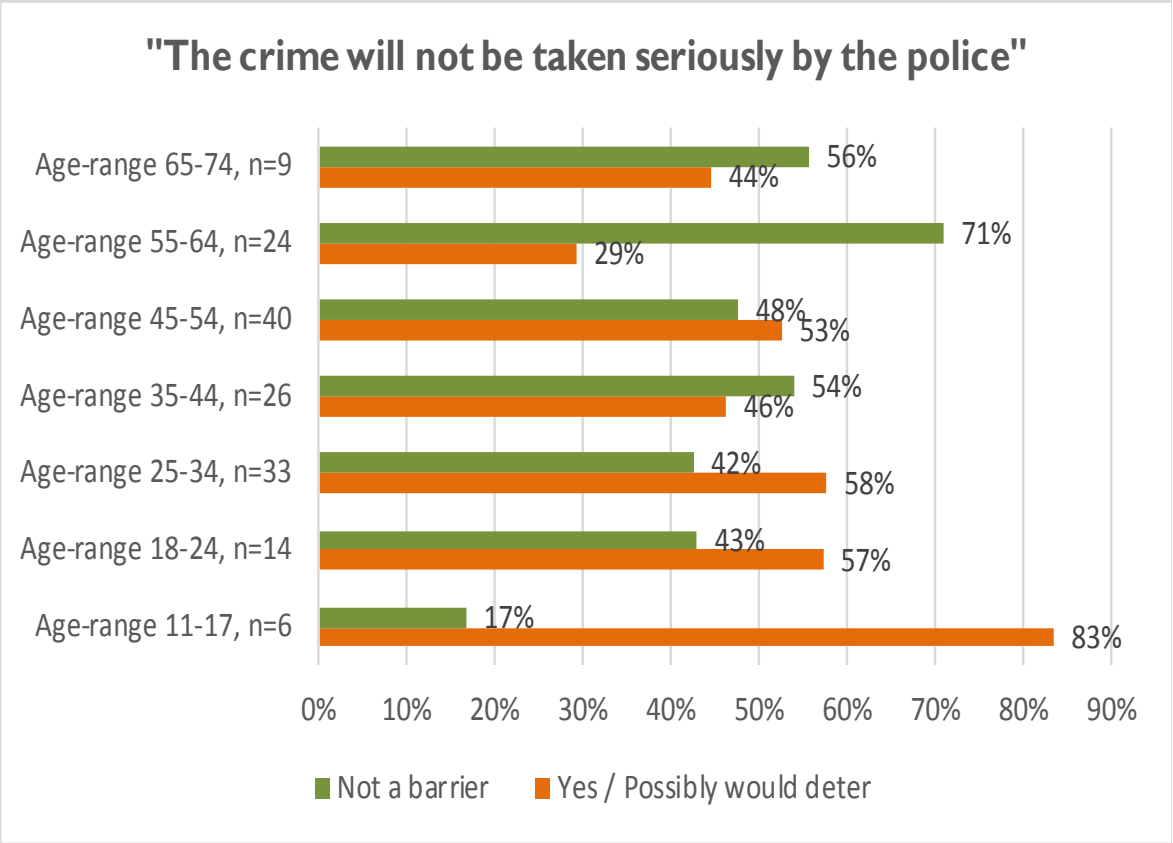



It will be seen that barrier (a) has improved greatly, from 69% of respondents in 2006 to only 29% in 2014; however, this particular measure reflects a much greater ease amongst LGBT people in coming Out rather than a clear improvement in trust and confidence in the police. The improvements in relation to barrier (b), and particularly barrier (c), are smaller, but still definitely good news.

However, it is a matter of concern that barrier (d), the fear that "the crime will not be taken seriously by the police", has not significantly changed at all in eight years, and still potentially deters half of all these LGB and Trans respondents from reporting.

### vii. Attitudes to the police: differing across the age-ranges

We have analysed the responses around these four potential barriers to reporting by age-range, and find that there is more anxiety amongst younger people than amongst the older cohorts (see the chart on the following page). This result was unexpected. The responses around the anxiety that the crime would not be taken seriously are indicative and are worth giving in the full breakdown of age-categories, below. The profiles of the responses to the other three of these barriers are similar.




The figures for the under 25s are small, but as indicators they are congruent with the findings of (e.g.) consultations with young people through our Dorset Police Consultation Group. There seems to be evidence, at least in the South West, that young people's trust and confidence in the police has diminished in parallel with the far lower frequency, compared with say ten or fifteen years ago, of routine confidence-building police visits to young people in schools, talking about community-safety, drugs and alcohol, and self-protection.

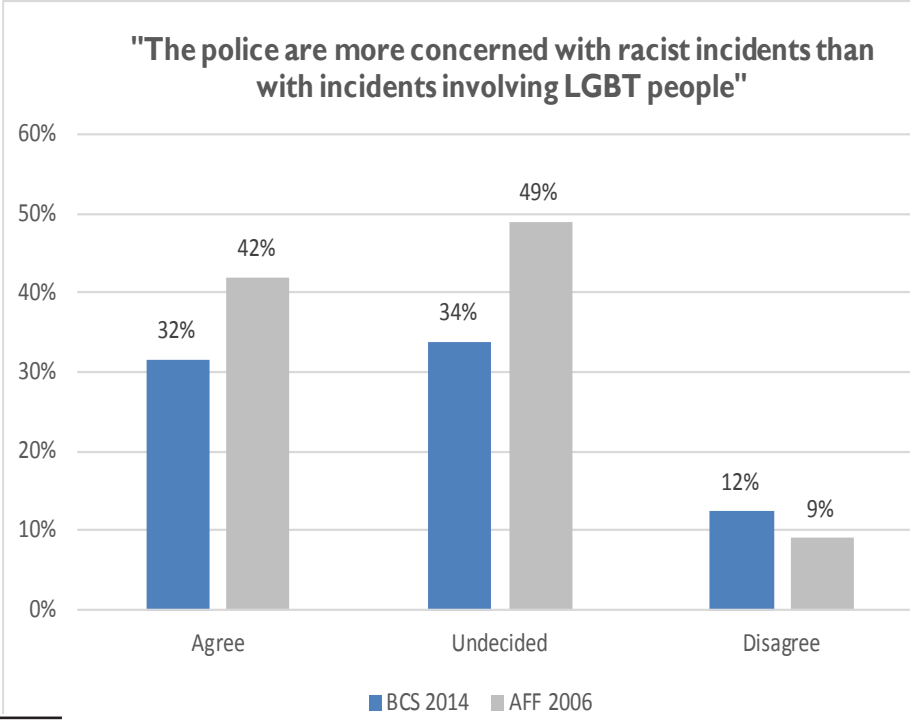
### viii. Attitudes to the police: national relative priorities

In the years leading up to 2006 there had been a great deal of community concern that the government of the day was significantly more proactive in addressing racism than in addressing homophobia, transphobia or biphobia, and that this was inevitably reflected in local police and local government priorities.[10]

Between 1997 and 2007 the Home Office opened numerous programmes targeting racist crime but none at all for addressing phobic crime. BME LGBT people were particularly unhappy and angry about a policy that seemed to be actively discriminating against one half of their identity. Many recalled with disappointment, or bittterness, how in the first few days after the Admiral Duncan bombing (April 1999) Home Office ministers had placed on record a passionate government commitment to combating homophobic crime.

By asking in 2006 what respondents thought of the statement "The police are more concerned with racist incidents than with incidents involving LGBT people" we were reflecting a live issue of community concern, equally among BME and other LGBT communities. The responses confirmed that on this issue there was great community disquiet about Home Office policy.

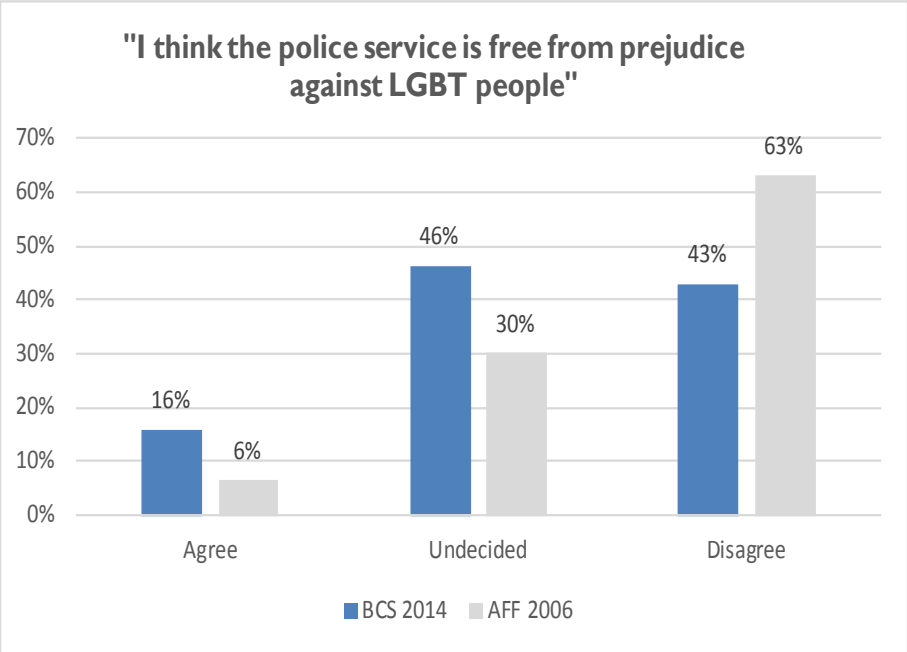
Aiming to measure change wherever we could, we asked the same question in 2014. The results suggest that there is still a real perception of a confidence gap on this particular issue.

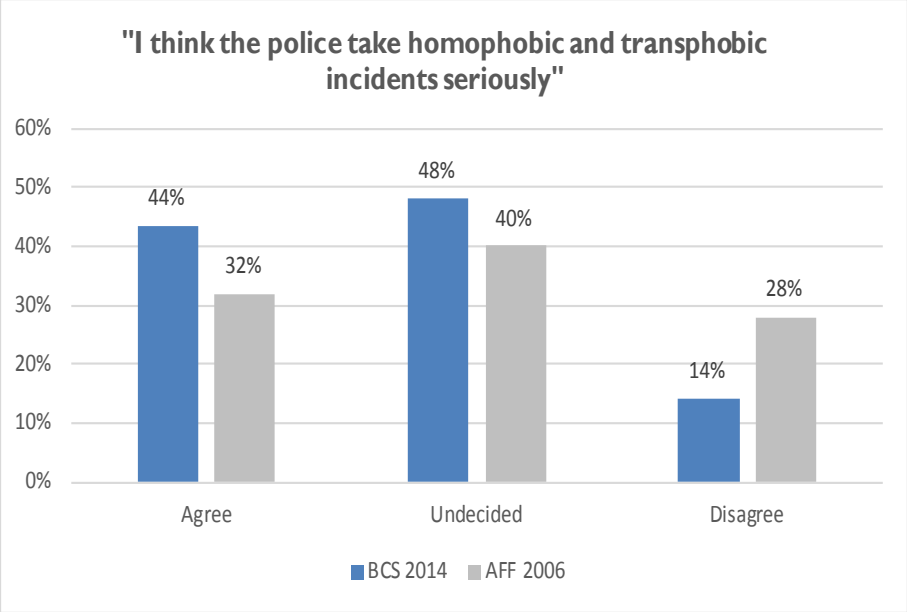



10 In these years Intercom encountered many senior officers in Devon & Cornwall and Dorset who were determined that all prejudice-related crimes should be treated equally. However, at the time the Home Office was requiring police forces to collect statistics only on racist incidents, and ACPO lead officers were marching in step with ministers who were concerned (as one minister phrased it, in this very context) "not to dilute the anti-racist message", and this was what the wider public was hearing.

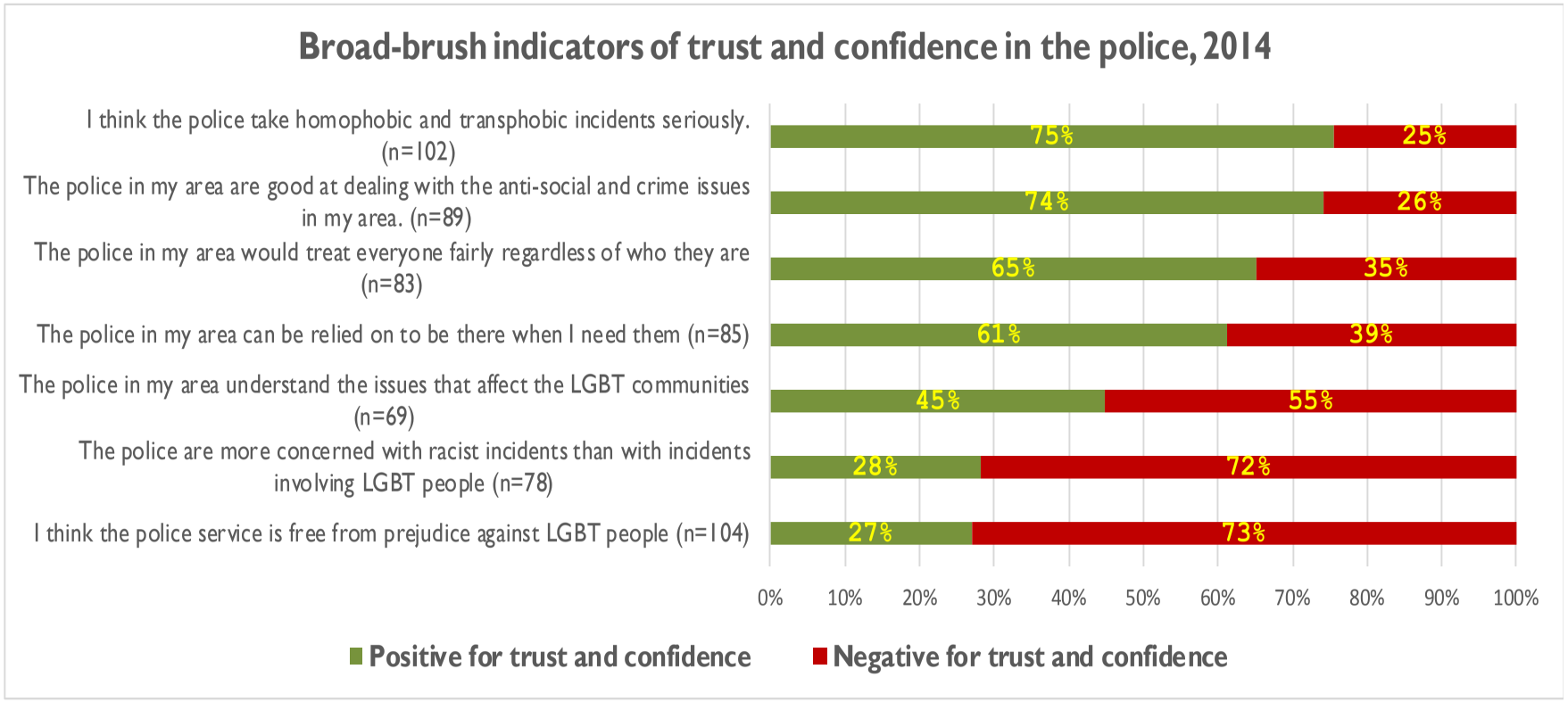
### ix. Attitudes to the police: other measures of trust and confidence

There is noticeable improvement in two other key measures between 2006 and 2014.



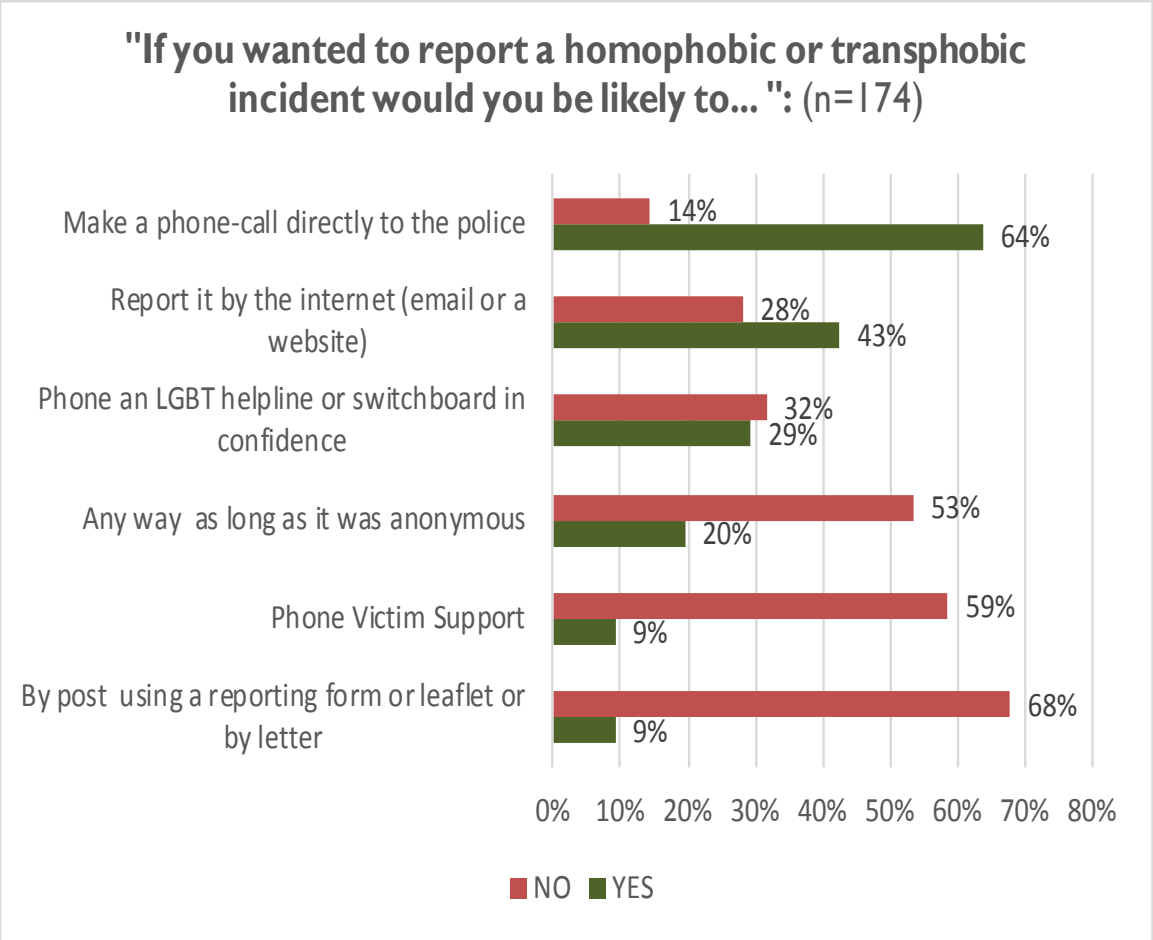

In 2014 we asked a total of seven questions around measures of trust and confidence, and the results are usefully tabulated in the following chart, simply showing the proportions of positive responses to negative responses. There are no significant differences in respect of gender or gender identity.


Broad-brush indicators of trust and confidence in the police, 2014
I think the police take homophobic and transphobic incidents seriously. (n=102)
The police in my area are good at dealing with the anti-social and crime issues in my area. (n=89)
The police in my area would treat everyone fairly regardless of who they are (n=83)
The police in my area can be relied on to be there when I need them (n=85)
The police in my area understand the issues that affect the LGBT communities (n=69)
The police are more concerned with racist incidents than with incidents involving LGBT people (n=78)
I think the police service is free from prejudice against LGBT people (n=104)
75%
25%
74%
26%
65%
35%
61%
39%
45%
55%
28%
72%
27%
73%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Positive for trust and confidence
Negative for trust and confidence

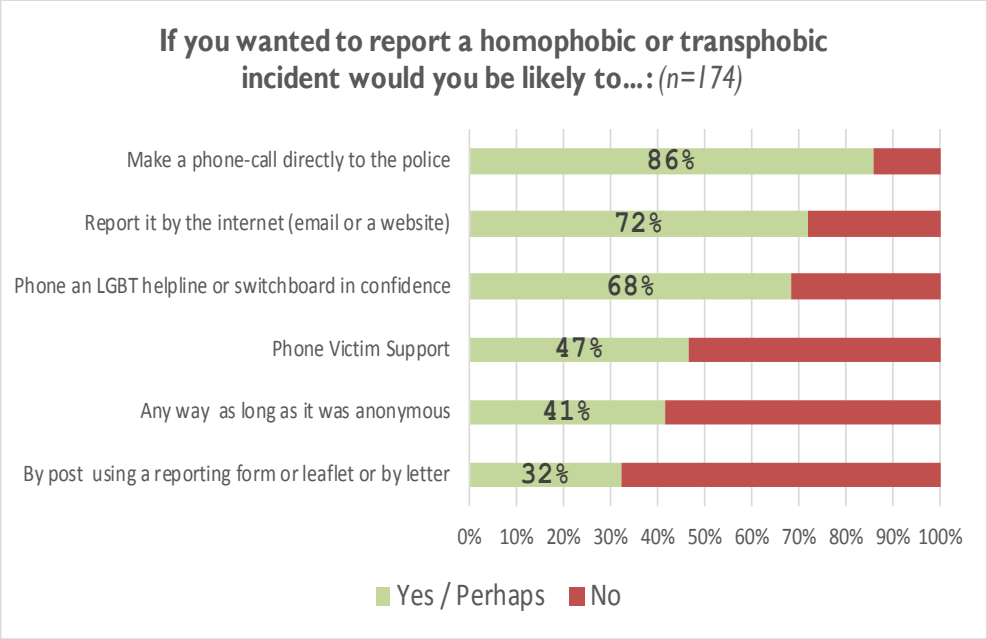
These are clearly very mixed figures. It is helpful to bear in mind at this point that as many as 40% of these 182 respondents said that when it came to reporting a phobic incident the police would be their first choice (see page 21 above), and 64% now say they would be likely to report a phobic incident directly to the police. Fifteen years ago the police service would hardly have appeared on either of these charts at all.

### x. Preferred routes for reporting phobic crimes and incidents

We asked people to express a preference for six possible ways of reporting a phobic incident, with the options of "Yes", "Perhaps" and "No". The distribution of definite responses ("Yes" and "No") was as shown below.

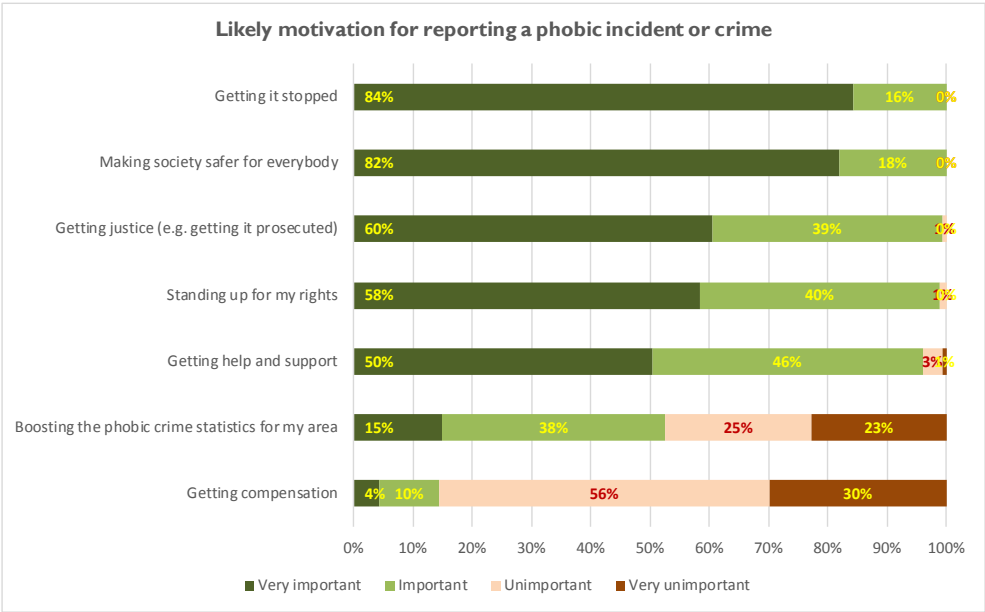


Combining the "Yes" and the "Perhaps" responses, the order of preference was slightly different:




## xi. Motivations for reporting

Based on our casework and our strategic work with the police and CJS, we offered a choice of seven possible motivations for reporting a phobic incident or crime. We allowed multiple choices; this meant, in the event, that the distribution of answers was very strongly positive for five of the seven options, and on balance negative for the remaining two.



Results are generally very uniform across genders and gender identities. Trans respondents are particularly unenthusiastic about the idea of boosting the phobic crime reporting statistics.

These are strategic responses made to a notional situation within a consultation environment. It may be noted that our casework experience is that most of those who do in fact report are doing so primarily because they are looking for direct face-to-face help and support.

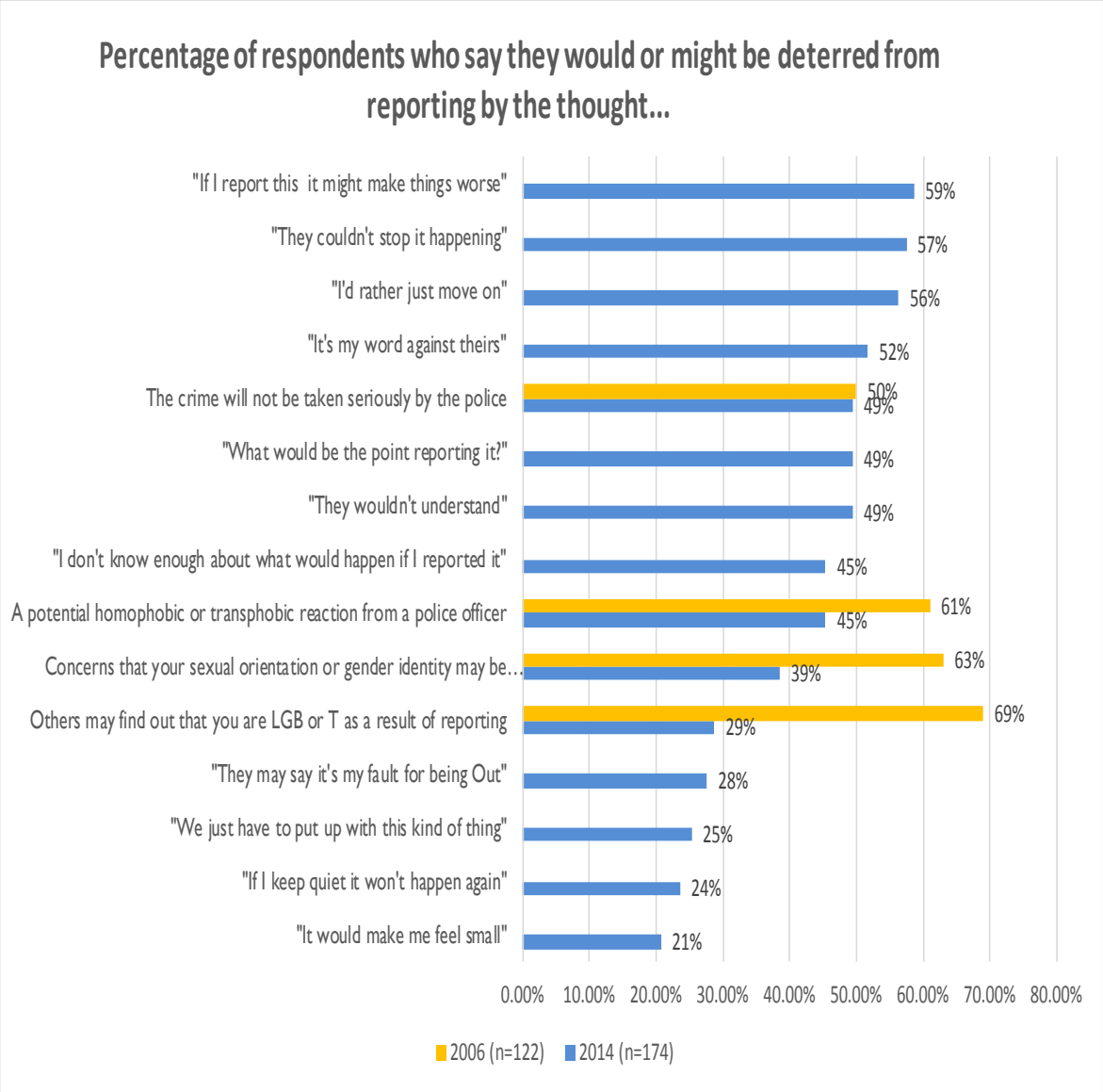
It is also very important to record that in the great majority of cases where people have experienced a phobic incident and call our own helpline, they do not call specifically to report the phobic incident. Their first approach to the helpline is frequently about something apparently quite separate, such as depression, or family or relationship problems, or housing issues, or (very often) social isolation. However, these primary concerns of the caller can often be identified during the support process as springing from the incident, or underlying it, or intensifying its effects.

### xii. Barriers to reporting: the wider list

As well as re-running the four top preferences from the 2006 survey (see above, page 24), we asked people their opinion about eleven other barriers that we and other practitioners and service-users had identified in focus groups in the intervening years.

Some of these turned out to be much stronger barriers to reporting than any of the four classic barriers derived, originally, from the 1998 NAG survey.

In the chart on the following page we have shown the 2014 results for these eleven barriers in blue, and added, in yellow, the 2006 ratings for the four original barriers, for comparison.




## xiii. Attitudes around reporting: the prevalence of barriers

Overall, we find from the 174 responses to this question that there are in practice fairly widespread community reservations about reporting incidents and crimes. Only 32 respondents (18%) saw no potential or actual barrier to reporting at all.

150 respondents (86%) identified one or more actual or potential barriers to reporting. 102 respondents (59%) saw at least one definite barrier to reporting, and another 48 (28%) saw no definite barrier but at least one potential barrier. Amongst the 102 who perceived at least one definite barrier, the average number of definite barriers was 5.29, and the median was 5. Only 13 of these 102 (7% of all 174 respondents) saw only one single definite barrier to reporting.

# 9. Annex: demographic details

## i. Age-ranges

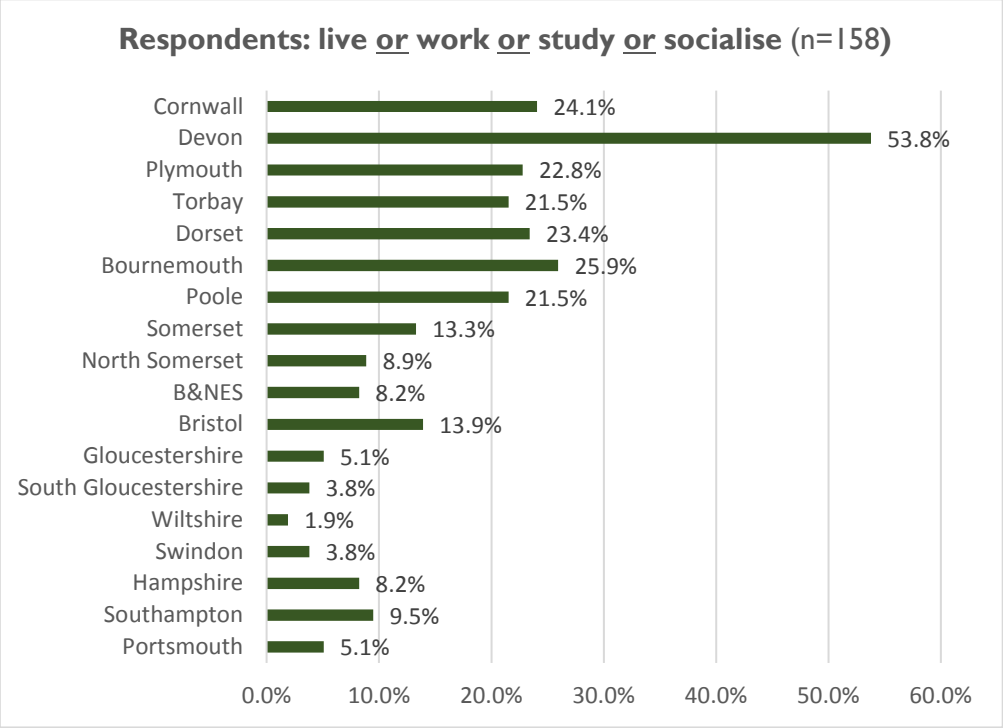
The ages of respondents ranged from 80 to 14; 65% of respondents were in the age-range 25-54.

## ii. Geographical spread

Out of the 182, we had geographical data for 158 (87%). These respondents' place of residence ranged widely from Western Cornwall to Christchurch and from Bristol to Gloucester, the New Forest and Swindon; however, 98% of the 158 lived within "the South West peninsula" — the Cornwall - pan-Devon - pan-Dorset - pan-Somerset subregion.[11]

As well as asking where they live, we also asked where people work, study and socialise. These questions provided some interesting indicators of the key places where LGB and Trans people from the wider South West are socialising. For instance, 22% of the 158 socialise (not necessarily exclusively) in London, and, perhaps surprisingly, only 7% in Brighton. 5% socialise in Manchester, and 3% in each of Cardiff and Edinburgh.

The combined profile of all responses for all districts shows something of the geographical spread of these respondents' lives and activities. The sample for each line is 158, but there is of course duplication between lines.



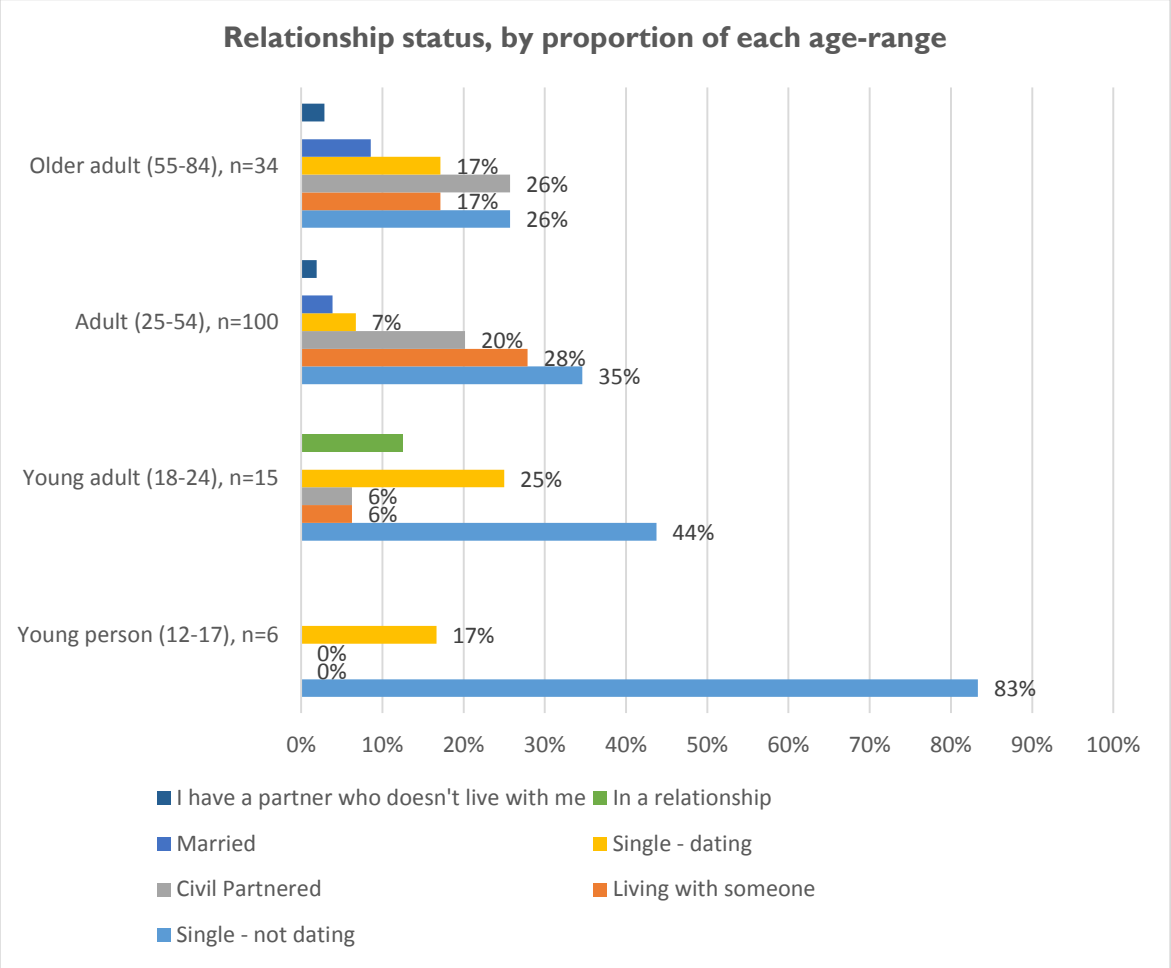

11 Note that 3 respondents gave two different places as their place of residence. This might reflect young people sharing their lives across two families, or people who regard themselves as having two homes because they have a partner who does not live with them.

### iii. Disability

Out of the 182, 32 said they had a disability (17.6%), and 149 (82%) said they did not; one did not answer. Specified disabilities included being Deaf or hearing-impaired, being blind or visually-impaired, long-term illness, having mobility needs, having a learning difficulty or disability, living with Asperger's or Autistic Spectrum Disorder, and others. One of the 32 identified their disability simply as "being homosexual".

### iv. Relationships

The results for this section reflect a wide variety of living arrangements. As one respondent said in a free-text box, "It's complicated." (Note that this survey ended before same-sex marriage provisions were implemented, so "married" should be read as "in an opposite-sex marriage".)




A large proportion are not in relationships: overall, 51% are in a relationship, 49% are not. This confirms other research that suggests that social isolation may be a significant element in LGB and Trans community profiles in the South West. Disaggregated by gender, 37% of female respondents and 55% of male respondents are living without any current partner or relationship.

### v. Ethnicity, religion and citizenship

Of the 162 respondents who gave us details, 5 (3%) defined their ethnicity as "mixed heritage", 3 as "European", 3 as "Jewish", and one each as "White African", "White Irish" and "Celtic". Five preferred not to answer, and the remaining 143 (88%) defined as "White".

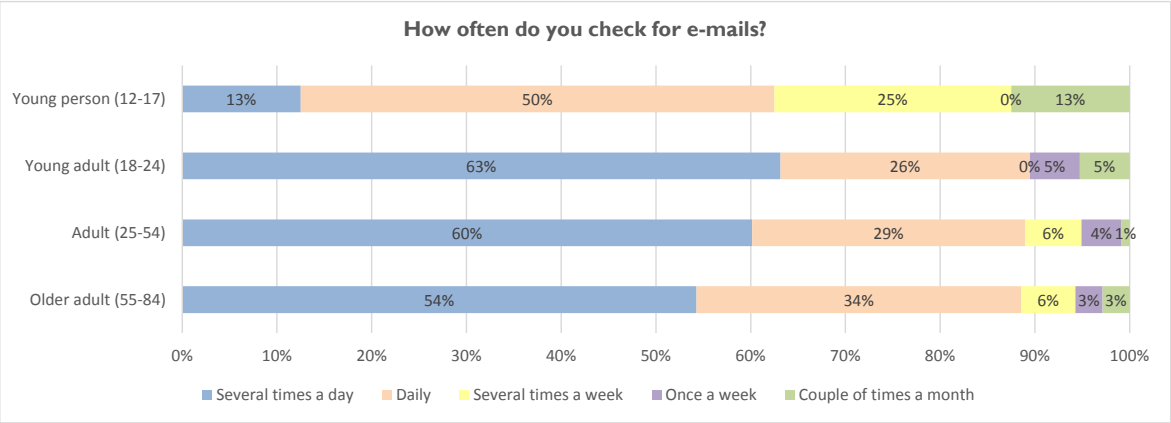
Of the 161 who gave us information about their religious beliefs or attitudes, 55 (34%) declared a religious belief, 19 (12%) may be described as generally Agnostic or Questioning, and 87 (54%) declared themselves to be Atheist, Humanist or of no religion.

Three-quarters of respondents identified their citizenship / nationality as "British". Other preferences included "English" (15%), "UK Citizen" (4%), and "Cornish", "Irish", "Scottish" and "American" (between 2% and 1% each).

### vi. Internet usage

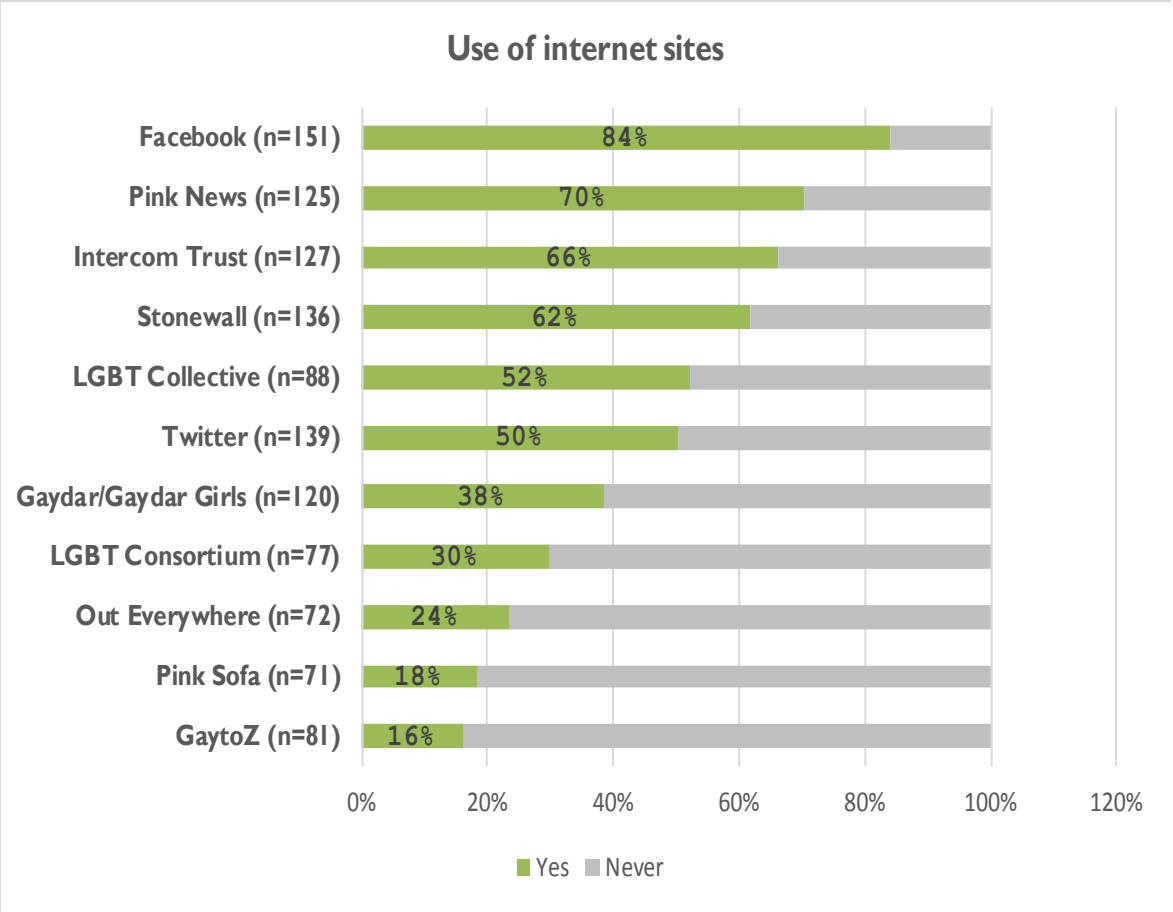
As a help towards developing Intercom's use of social media, we asked the 182 Big Community Survey respondents for information about their use of the internet. 79% of the 182 had accessed LGBT community information over the preceding two months; 21% had not. The proportions who had not varied amongst the age-groups: 31% of older adults (55+) but only 16% of young adults (18-24); the figure for 12-17 year olds was 22%, and for adults 25-54 was 19%.

All 182 respondents had e-mail addresses, but the frequency with which they used them varied.

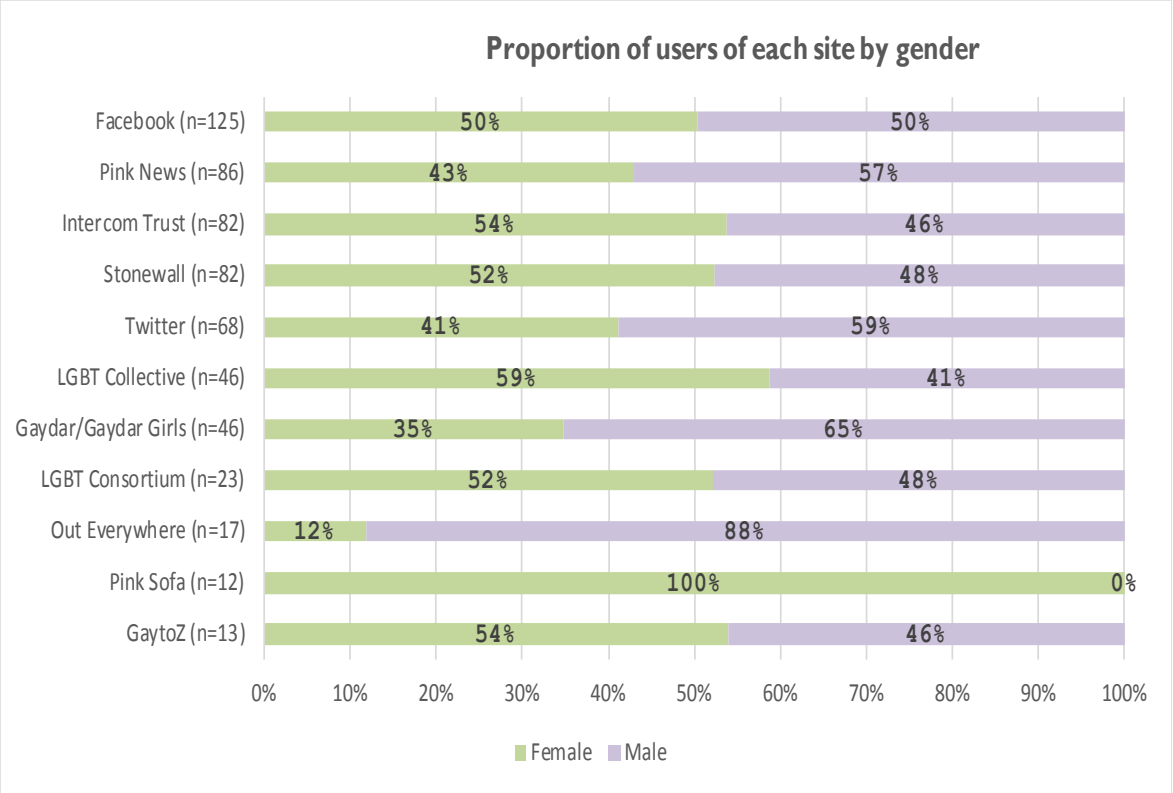



The commonest places for checking e-mails were (in descending order) Home, Mobile phone, Work, Friend's house, and Library.

Asked how often they used a selection of websites, respondents gave Facebook the prime position, followed by Pink News, Intercom, Stonewall, the LGBT Collective, and Twitter.




Disaggregating these responses broadly by gender, we found that Intercom, the LGBT Collective, the national LGBT Consortium and Stonewall all had a distinct preponderance of female users. (So, unsurprisingly, did Pink Sofa.) The majority of Twitter users are men, while equal proportions of men and women use Facebook.




# 10. References


**Intercom Trust publications**

Intercom publications may be downloaded from www.intercomtrust.org.uk/resources.

Halls, M. and Wong, W. *A Firmer Foundation: new community-based evidence from the lesbian gay bisexual and transgendered populations in the rural south west peninsula*, September 2006

Halls, M. and Hill-Art, T. *Briefing Note: Internalised Phobia. Internalised homophobia, biphobia and transphobia: client support profiles in the South West*, February 2015

*Help Support and Advocacy Service Activities Report, Devon & Cornwall, January - December 2014.*

**External publications**

Public Health Devon on behalf of Northern Eastern and Western Devon CCG and South Devon and Torbay CCG. *Lesbian, Gay, Bisexual & Transgender (LGB&T) Health Needs Assessment*, August 2014.