"Out about Town"

Survey of the Needs of Lesbian, Gay, Bisexual and Transgendered People in Luton 2003/ 2004

Produced by the Needs Assessment Subgroup of Luton LGBT Steering Group

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Executive Summary

Introduction

Luton Lesbian, Gay, Bisexual and Transgendered Steering Group (known as the 'Steering Group') is a voluntary forum for LGBT people and service providers who have an interest in developing services and facilities for LGBT people in Luton. In April 2003 the Steering Group was awarded funding through the Community Funding Initiative to undertake a small-scale survey of the needs of LGBT people living, working and socialising in the town. The survey was conducted on a voluntary basis between August 2003 and February 2004. In total 99 people took part in the survey. The key findings, in general, and for each chapter are shown below. More detailed summaries and recommendations are highlighted at the end of each chapter.

General Findings

Overall the findings from the needs assessment presented a positive view of the experiences of LGBT people dealing with services and living in Luton. However, there were a number of areas where there was room for significant improvement. In particular, key themes that re-emerged throughout were the need for improved information and a sense of a LGBT community away from, or in addition to, the commercial scene. It was clear that many LGBT people preferred to seek information and advice related to their sexuality/ gender identity from other LGBT people. While this can partly be achieved voluntary, and though informal social networks, there is a need to consider a role for a paid, or paid, LGBT Officer, or Officers.

Access to Services, Information and Advice

Respondents stated that wider information about LGBT services, rights, etc. and informal social support through social activities were the most important developments they would like to see. Access to community, primary care and sex health services were generally good. However, a quarter of respondents had been made to feel uncomfortable about their sexuality/ gender identity by a health, social services, or other type of professional. There was a need for GP practices to reassure LGBT service users that they would receive non-discriminatory services, and to clarify when and how an individual's sexuality/ gender identity should be documented. The main issue in relation to access to sexual health was the difficulty that many respondents had faced making an appointment. There were also issues about access to sexual health information for women-who-have-sex-with-women and transgendered people.

Experience and Reporting of Discrimination and Violence

Discrimination from various institutions towards our respondents and their families was generally low with the exception of 'education and schooling' and 'employment'. Over half (54.5%) of our sample had been a victim of a homophobic or transphobic incident in the last five years. One in five respondents had experienced 'five or more incidents' in this time. Around one-

third of respondents said they would 'definitely not', or were unsure about, reporting such an incident to the police. Although around half (53.9%) of respondents were aware that they could report homophobic/ transphobic incidents through Community Investigators at Luton Police Station, fewer respondents were aware of other options for reporting such crimes. Respondents were almost evenly divided about whether or not Luton was a safe place for LGBT people.

Mental Health and Social Support

Overall we found a very positive picture of mental health and social support among LGBT people in Luton. Only 3% of respondents were not 'out' to anyone. 73.5% of our sample had never thought about or attempted suicide. However, 8.2% had attempted suicide once, and 3.1% had attempted it more than once. 93.7% agreed to some extent that their sexuality/ gender identity had been a 'positive' and 'enriching' part of their lives.

The most common living arrangements among our sample were living with a same sex partner (39.8%) followed by living by oneself (30.6%). Friends were by far the most common source of support in relation to emotional problems. They remained important in terms of the provision of physical care, but their importance declined relative to parents and partners. The significance of friendship as an important source of informal social support for LGBT people was reiterated.

Sexual Health

71.4% of the male sample had taken a test for HIV; 25% of the male sample had not been tested. Of those who had tested for HIV, 24.5% (33.9% among the male sample) said they were not sure of their HIV status at the time of the survey. 60.7% of the male sample had been vaccinated against Hepatitis B; 33.9% of the male sample said they had not been vaccinated.

70% of women in our sample for whom a cervical smear test is available under the NHS cancer screening programme had had a test. This was lower than the national target of 80%.

Physical Health

LGBT respondents in the sample were found to have higher rates of smoking (especially among men), alcohol consumption (especially among women), and frequent drug use (i.e. at least once a month) compared to the general UK population, or comparable LGBT samples in a neighbouring county (i.e. Buckinghamshire and Milton Keynes). Around one-third of respondents used leisure/ sports centres or health clubs in Luton to exercise or keep fit (although many respondents preferred to exercise at home or outdoors). Of those people who did not use leisure/ sports centres or health clubs, 16.4% said the reason they chose not to was because they didn't perceive these spaces to be LGBT-friendly.

Key Recommendations

Detailed recommendations are included with the summary at the end of each chapter. These are the principal recommendations only.

- Luton LGBT Steering Group should continue to raise its profile in the local community.
- Consideration should be given to seeking funding of a paid LGBT Officer, or LGBT Officers.
- In terms of social support priority should be given to the provision of information and the development of informal social networks. Possibilities for the development of a jointly-funded regional LGBT helpline should be investigated.
- GP practices should take more of a leading role in ensuring that LGBT people know that they will receive non-discriminatory treatment or advice. Policies should be developed about when and how LGBT sexuality/ gender identity should be documented.
- Sexual health services should review information on the sexual health needs of women-who-have-sex-with-women and transgendered people as well as that for gay and bisexual men. Luton and Dunstable GUM clinic will need to investigate the difficulty that many respondents had making an appointment.
- Funding should be sought for an investigation into the needs of LGBT people and their families in relation to 'education and schooling'. Information about protection for LGBT people in employment should be made more widely available.
- Bedfordshire Police and the Diversity forum need to continue to raise the profile of ways of reporting homophobic and transphobic incidents in Luton. The police will need to find ways to re-assure a minority of LGBT people that their reports will be handled sensitively and without prejudice.
- The Steering Group should work with service providers as appropriate to help disseminate information and increase the uptake of HIV testing, Hepatitis B vaccination, and cervical smear tests as appropriate.
- The Steering Group should seek to encourage appropriate agencies to further investigate the tentative findings that LGBT people may have increased incidence of smoking, alcohol consumption and drug use. Appropriate interventions should be developed where necessary.
- Luton Borough Council Leisure Services should continue to involve LGBT people in leisure and sports activities, and find ways to reduce the perception among a minority of LGBT people that facilities in the town are not LGBT-friendly.

Chapter 1

Introduction

Luton LGBT Steering Group

Luton Lesbian, Gay, Bisexual and Transgendered (LGBT) Steering Group (referred to here as the 'Steering Group') is a voluntary forum for LGBT people living and working in the town, and for services providers who are interested in developing or improving services for the LGBT community in Luton. The Steering Group was first established in the autumn of 2001 by a group of LGBT people and service providers who had identified the relative lack of services and support for LGBT in Luton compared to other counties nearby. In April 2002 the Steering Group received a small, one-off grant from Luton Borough Council under the LGBT theme of its Voluntary Sector Grants Awards. In April 2003 the group also successfully applied for a small grant from the Community Funding Initiative (CFI), Community Chest to conduct a LGBT needs assessment survey in Luton, and to pilot a helpline or another form of social support depending on the outcome of the survey. In May 2003 a Needs Assessment Subgroup of the main Steering Group was established. This group took responsibility for the conduct of the survey and reporting regularly to the main Steering Group on progress made.

Assessment of LGBT Needs in Luton

Based on conservative figures from the National Survey of Sexual Attitudes and Lifestyles (see also Wellings et al. 1994), and figures on Luton's population from the Census 2001, there may be between 5,000 to 11,000 lesbian, gay and bisexual people in Luton (see Table 1).

Table 1. Estimate of Numbers of Lesbian, Gay and Bisexual in Luton

Definition of being LGB	NATSAL Survey 2000 %	No. of Luton LGB population
Males		
Ever had sex with a same sex partner, including genital contact	6.3%	5,803
Have you had sex with a same sex partner in the last 5 years	2.6%	2,395
Females		
Ever had sex with a same sex partner, including genital contact	5.7%	5,258
Have you had sex with a same sex partner in the last 5 years	2.6%	2,398

Figures based on the National Survey of Sexual Attitudes and Lifestyle (NATSAL) (2000) – www.avert.org/hsexu1.htm and Census 2001 figures for Luton Unitary Authority – www.statistics.gov.uk/census2001/pyramids/pages/00ka.asp

Additionally there may be a much larger regional LGB population using facilities and services in the town (e.g. there may be up to 20,000 LGB people in Bedfordshire as a whole). The figures in Table 1 are based on the percentage of people surveyed in the UK who 'ever had sex with a same sex partner' or 'who had a same sex partner in the last five years' (although this excludes people with feelings towards people of the same sex who may not have had sex and/ or a partner). These figures were then extrapolated as a percentage of Luton's population to give an estimate of the size of the LGBT population in the town. In addition to these figures there are also likely to be a small but significant number of transgendered or trans people, although numbers are notoriously difficult to predict and depend on definitions (see below). Given these figures LGBT people are likely to represent a sizeable minority in Luton whose needs are often unmet. To date the only attempts to examine the needs of LGBT people have related to small scale, adhoc surveys focusing usually on the sexual health needs of gay and bisexual men, and the Launch Event Report produced by the Steering Group in June 2002. While the Launch Event Report, in particular, produced useful information about the perceived needs of the LGBT people based on the views of people who attended the event, it was felt that a more systematic and representative approach was needed to assess the needs of LGBT people in Luton.

The Policy Context

There are a number of reasons why this survey is so timely and can help inform and develop services in the town. In recent years there has been a much greater emphasis on the involvement and consultation of local groups, including minority groups, about their health and support needs (e.g. Department of Health, 1997). The Health Act (1999) established a statutory duty for Primary Care Trusts to develop locally agreed health improvement programmes in conjunction with their partners, such as Local Authorities. Similarly, the Local Government Act (2000) imposes a duty on local authorities to prepare a 'community strategy' to promote 'community well-being' and "improve the quality of life and health for their local communities" (Local Government Association, 2001). Notably, these acts makes specific references to the duty to 'involve' and 'consult' those who use services, and to do so in ways that actively acknowledge diversity within communities, and diversity of need.

Besides the increased duty of local authorities to consult the diverse communities they serve, there are also a number of changes at the social, political and legal levels that mean the needs of LGBT are being recognised in the UK for the first time. For example, the Department of Health's (2001) *National strategy for sexual health and HIV* for explicitly acknowledged that 'homophobia' can act as a barrier to access for services for LGB people. The Employment Equality (Sexual Orientation) Regulations (2003) and the Sex Discrimination (Gender Reassignment) Regulations (1999) mean that there have been substantial changes in terms of protection for LGBT people in employment. Abolition of Section 28 of the Local Government Act (1988) means that schools and Local Education Authorities can no longer hide behind this legislation to deal with discrimination against LGBT people in

schools and homophobic/ transphobic bullying. The Criminal Justice Act (2003) allows for increased sentences for assaults involving or motivated by hostility based on sexual orientation. Additionally, the proposed Civil Partnership Bill and the ruling of Goodwin and I versus UK (2000) means that the rights of same sex couples and partnerships involving transsexual people are being taken seriously for the first time.

Similarly, while not always specifically addressing the needs of LGBT people, strategies to improve public health and National Service Frameworks provide ways of demonstrating the impact of heterosexism, homophobia and transphobia and LGBT 'lifestyles' in areas such as mental (e.g. suicide) and physical health (e.g. smoking). By beginning to demonstrate these impacts specific interventions can be devised that contribute to wider community health and well-being. In this context, supportive and affirming services for LGBT people are increasingly a sign of good practise, as well as often being a statutory necessity.

Key Aims of the Survey

It was not possible in a short survey to cover all areas of health, social policy and community development of interest to service providers and LGBT people. In this respect certain key areas were covered. These included:

- Access to services, information and advice and priorities for the development of new services.
- The experience and reporting of discrimination and violence against LGBT people.
- Issues around mental health and social support.
- Issues around sexual health.
- Issues around physical health.

Chapter 2

Methodology, Sample and Analysis

Method

The scale and nature of the research meant the most suitable method to use was a survey questionnaire. Drawing on previous local needs assessments and national surveys a survey of 53 questions was devised. This included mostly structured questions, but also allowed for open-ended questions where appropriate. The Steering Group and local service providers were asked to comment on the questionnaire before the final version was produced.

Distribution and Sample

Establishing representative samples from the LGBT community is extremely difficult because of the lack of any national or local statistical sampling frames against which samples can be examined, the 'hidden' nature of the population, and the difficulties associated with defining what is meant by an LGBT 'lifestyle' (Heaphy and Weeks, 1998). In this respect Platzer and James (1997) recommend trying to recruit as diverse a population as possible using a variety of strategies (e.g. word of mouth, advertising, Internet, local organisations working with LGBT people, commercial venues, etc.). We distributed questionnaires using a variety of means. These included:

- Personal distribution by Steering Group members
- Snowballing from initial contacts by Steering Group members (i.e. asking the first person contacted if they knew of any other person who would complete the survey)
- Local commercial venues (i.e. pubs, club, sauna).
- Local support organisations working with LGBT people in Luton (e.g. The Lodge, Body Positive, Women's Centre)
- Social/ activity groups and sports groups
- Further and higher education establishments (e.g. University of Luton Student's Union)
- Luton Central Library
- Advertising about the survey in Lutonline, the Herald & Post, the Pink Paper, DIVA, etc.
- A downloadable version of the questionnaire on the Steering Group website

Where particular social groups were found to be under-represented (e.g. minority ethnic groups) additional efforts were made to try to recruit participants through relevant organisations, publications, etc. (not always with a great deal of success). Questionnaires were returned using a FREEPOST envelope or a FREEPOST address (if downloading from the Internet). A £50 prize was offered for taking part in the survey.

Originally questionnaires were distributed between August and November 2003. However, at this stage only 78 questionnaires had been returned. A decision was taken to extent the deadline for return until at least 100 questionnaires were returned, and a second push was made to achieve this number. In total approximately 400 questionnaires were distributed. In the end 99 questionnaires were returned. The final cut of date for return of the questionnaires was the end of February 2004. This gave us a return rate of approximately 25%, and represented around 0.9% of our upper estimate of Luton's LGBT population (see Table 1 above). The difficulty recruiting large numbers of LGBT to take part in the survey presents significant problems in terms of the validity of the data. However, it also demonstrates the problems gaining access to a 'hidden' population in a town where there are no groups, services, or organisations targeted at the LGBT community as a whole. Despite the small numbers we still believe that the information contained in this report represents a useful starting point in recognising the views and needs of LGBT people in Luton and the surrounding area.

Sexuality or Gender Identity

Firstly respondents were asked to define their sexuality or gender identity (see Table 2).

Table 2 – How would you define your sexuality/ gender identity (n=99)		
Sexuality/ gender identity	**frequency**	**%**
Lesbian	19	19.2
Gay	58	58.6
Homosexual	4	4
Bisexual	8	8.1
Transgendered	1	1
Transsexual	3	3
I do not define my sexuality	2	2
Other	4	4

The majority of respondents preferred to use the positive and chosen terms 'gay' and 'lesbian' rather than the old-fashioned term 'homosexual' with its connotations of criminality and sickness. Notably, 8% of the sample were bisexual and 4% defined themselves as transpeople (either transgendered or transsexual). Of the four people who defined their sexuality/ gender identity as 'other' two people felt they fitted more than one category (e.g. gay and transsexual, gay and homosexual). Others preferred to define their sexuality/ gender identity themselves (e.g. bisexual transwoman, gay female who loves a woman). How the categories of sexuality and gender identity were broken down by sex are shown in Table 3. A simple break down of respondents by sex is shown in Table 4.

Table 3 – How would you define your sexuality/ gender identity, by SEX (n=98)				
SEXUALITY/ GENDER IDENTITY	**SEX**			
	Female	Male	Trans (m to f)	Trans (f to m)
Lesbian	19 51.4%	-	-	-
Gay	9 24.3%	49 87.5%	-	-
Homosexual	-	4 7.1%	-	-
Bisexual	6 16.2%	2 3.6%	-	-
Transgendered	-	-	1 25%	-
Transsexual	-	-	2 50%	-
I do not define my sexuality	2 5.4%	-	-	-
Other	1 2.7%	1 1.8%	1 25%	1 100%

Table 3 shows, for example, that approximately one-quarter of women surveyed defined themselves as 'gay' rather than lesbian, although 'lesbian' was the most used term among women. It also shows that 87.5% of men prefer to define themselves as 'gay'. Only a small minority of men define their sexuality as 'homosexual', with no women or transpeople using the term. There were more bisexual women than men in the sample. Those defining their sexuality/ gender identity as 'other' were found across all sexes.

Sex

Table 4 shows responses to the survey by sex. It is difficult to know whether different sexual groups are under or over-represented because of the lack of national or local statistical information on the LGBT population in the UK. It may be the case that women are under-represented in our sample. Previous research suggested that same sex experience and relationships among women were less common than among men (Wellings et al. 1994). More recent research, however, conducted as part of the National Survey of Sexual Attitudes and Lifestyles between 1999-2001, suggests that lesbian relationships have become as common as those among gay men over the last decade.

Table 4 – What is your sex? (n=99)		
Sex	**frequency**	**%**
Female	37	37.8
Male	56	57.1
Transsexual (male to female)	4	4.1
Transsexual (female to male)	1	1

The number of transsexual people has also been notoriously difficult to calculate (partly because of a concentration on people who are post-operative only). For example, the Interdepartmental Working Group on Transsexual People estimated that there were 1,300-2,000 male-to-female and 250-400 female-to-male transsexuals in the UK. However, Press for Change estimates the number of post-operative transsexuals in this country to be closer to 5,000 (Batty, 2004). This suggests that we would probably be correct to expect smaller numbers of transpeople than lesbian, gay and bisexual people in our sample, and there would be more male-to-female transsexuals than female-to-male. However, we do not know the number of transpeople who may be excluded because they have not undertaken surgery, or have no wish to. There is also the issue of whether other groups of people such as those born as 'intersex' are excluded from such counts.

Age

Table 5 shows the distribution of our respondent by age groups. With the exception of the oldest age groups, the age distribution of our respondents is similar to the Census 2001 profile for Luton Unitary Authority with greatest numbers in the 20s, 30s and 40s age groups. The lack of older LGBT people may reflect the greater difficulties that this group faced in terms of 'coming out' in the past. It may also reflect that many older people feel uncomfortable using the gay scene where many of our questionnaires were distributed. People under 16 were not targeted as part of the survey.

Table 5 – What is your age? (n=99)		
Age group	**frequency**	**%**
Under 16 years	1	1
16 to 20 years	9	9.1
21 to 30 years	24	24.2
31 to 40 years	41	41.4
41 to 50 years	21	21.2
51 to 60 years	1	1
61 to 70 years	2	2
71 to 80 years	-	-
Over 80 years	-	-

Ethnicity

Table 6 shows the respondents by ethnic group. According to Census 2001 data 71.9% of people in Luton are White, of which 64.9% are White British, 4.6% are White Irish, and 2.3% are White – any other background. This suggests that overall White ethnic groups are substantially over-represented in our sample. All other ethnic groups are *under-represented* (with the only exception being Black – any other background).

Table 6 – How would you define your ethnicity? (n=99)		
Ethnic group	**frequency**	**%**
White British	82	83.7%
White Irish	8	8.2%
White – any other background	1	1
Asian - Indian	1	1
Black - Caribbean	1	1
Black - African	1	1
Black – any other background	1	1
Other (e.g. British/ Irish, European, Internationalist)	3	3.1

Most notable of all is the absence of people from Asian backgrounds despite our attempts to include people from these communities. While we had 1 Indian respondent (1% of our sample), Indian people make up 4.1% of Luton's population. We had no respondents from the Bangladeshi community (4.1% of Luton's population), or the Pakistani community, which is the largest minority ethnic group in the town representing 9.2% of Luton's population. Mixed Ethnicity and Chinese people were also absent in the sample.

There are various reasons why minority ethnic groups were probably under-represented. Some individuals may prioritise their ethnic identity over their sexuality or gender identity in a wider community or scene that is perceived to be hostile or racist. Others may perceive their own community to be intolerant of LGBT people, preferring instead to keep their sexuality secret or to mix with other LGBT people away from their hometown. Sigma Research (2003) found a similar pattern of under-representation of minority ethnic groups in Luton in their annual study of the sexual behaviour and attitudes of gay and bisexual men. Only 2.8% of their sample from Luton were from 'Black' ethnic groups. They were not able to recruit any respondents from 'Asian' groups. Given these types of experiences more labour-intensive and culturally sensitive research methods are needed. Unfortunately they were not possible given the scale of the research and the experiences of the research team in this case.

Long-Term Illness and Disability

Table 7 shows that 12.1% (n=12) of the respondents had a permanent, long-term illness, health problem or disability, which is slightly less than the 15.3% of the wider Luton Unitary Authority figure for people with limiting long-term illness in the Census 2001.

Table 7 – Do you have any long-term illness, health problem or disability? (n=99)		
Health status	**frequency**	**%**
No	78	78.8
Yes, temporarily	7	7.1
Yes, permenantly	12	12.1
Missing data	2	2

Only 4 of the 10 people who said that they were HIV-positive regarded living with HIV as a long-term illness, health problem or disability.

Connection to Luton

Table 8 shows the connections that respondents had with Luton. Just over 71% of our sample lived in Luton; 33% worked in the town; 12% were studying in the town. Of the 51 people socialising in Luton, over two-thirds (68.6%) of this sample also lived in Luton. This suggests that about one-third of the LGBT we sampled who were socialising in the town came from outside of Luton.

Table 8 – How have you been connected to Luton to date?		
Connection to Luton	**frequency**	**%**
Live in Luton (n=97)	69	71.1
Work in Luton (n=97)	32	33
Study in Luton (n=97)	12	12.4
Socialise in Luton (n=97)	51	52.6
Other connection (e.g. born in, unemployed in) (n=96)	8	8.3

Analysis

Analysis of the data employed SPSS (Statistical Package for the Social Sciences) version 10. The majority of members of the Needs Assessment Subgroup were given in-house training on how to input data into SPSS and to understand basic information. Most members of the subgroup were involved in data input. However, consolidation of the data and analysis was left to a more qualified member of the group. The data has primarily been analysed in terms of simple frequencies, percentages and cross-tabulations where appropriate. However, SPSS also allows for short comments from respondents to be included in the analyses, and these have been included where relevant.

Chapter 3

Access to Services, Information and Advice

Awareness of Luton LGBT Steering Group

During 2003 a great deal of the work of the Steering Group was taken up with trying to raise the profile of the group and attracting new members. Significantly, the survey itself acted as an important way of making people aware of the Steering Group, with a number of respondents making comments to this effect and deciding to volunteer for the group as a result. However, other activities were also undertaken to try to raise the profile of the group. These included:

- A launch event and posters to advertise the event
- Production and distribution of a local LGBT information leaflet
- Launch of the Steering Groups website – www.geocities.com/lutonlgbt
- An article in *Lutonline*, a free local newssheet distributed by Luton Borough Council
- Listings in LGBT publications such as Gay Times and Diva

Consequently, the Steering Group wanted to know to what extent they had been successful in raising awareness of the group.

Extent of Awareness of Luton LGBT Steering Group

Respondents were asked: 'Before today, had you heard of Luton LGBT Steering Group' (Table 9)? At first sight it seems positive that almost 40% of respondents (39.8%) have heard of the group. However, 11 of the 39 people who said that they had heard of Luton LGBT Steering Group were already members of the group, and a further 15 knew members of the Steering Group personally. This means, that before the survey, only 14 people (14.1% of the sample) had heard of the Steering Group via wider attempts at advertising. This may account for why some respondents were confused over the name of the group. For example, one respondent stated, "Why do you think you need to steer us"? In this respect, the Steering Group may need to clarify and explain what it sees as its purpose to the wider LGBT community in the town.

Table 9 – Before today, had you heard of Luton LGBT Steering Group? (n=98)

Heard of Luton LGBT Steering Group?	frequency	%
Yes	39	39.8
No	56	57.1
Not sure	3	3.1

Ways in which Respondents had Heard of the Steering Group

After direct contact with Steering Group members, most respondents had heard of the Steering Group through word of mouth. Leaflets and the Steering Group website had also begun to play a part in raising awareness of the group. Importantly, since the time of the survey a new table-top card with details about the Steering Group has been produced for distribution in local LGBT venues and the Steering Group has entered into discussions with other regional LGBT groups about the possibility of a jointly funded 'Three Counties' LGBT information leaflet. This leaflet would cover services and commercial venues for LGBT people in Bedfordshire, Buckinghamshire and Hertfordshire.

Table 10 – How respondents had heard, or thought they had heard, about Luton LGBT Steering Group (n=97)
Ranked from most to least effective at raising awareness

Ways in which respondents had heard about the Steering Group	**frequency**	**%**
Know a member of the group	14	14.4
I am a member of the group	11	11.3
Word of mouth	9	9.3
Leaflet/ pamphlet	8	8.2
Steering Group website	6	6.2
Launch event	4	4.1
Poster	3	3.1
Other website	3	3.1
Lutonline article	3	3.1
Listings in magazine	2	2.1
Not sure	2	2.1

The survey may also be a significant under-estimation of the extent to which the Steering Group website has raised awareness of the group. As a result of the preliminary findings from the survey the Steering Group tried a number of approaches to increase hits on the site. Firstly, a link was established with the successful *www.gay-luton.co.uk* site run by commercial venues in the town and to the newly established *gay-bedfordshire.co.uk* site supported by Luton Primary Care Trust. Secondly, a more appropriate domain name was purchased, *www.lutonlgbt.co.uk*, that would direct people to the Steering Group site. At the time of writing there have been 663 hits on the site. However, there is still the need to continually raise the profile of the Steering Group. We recommend that the Steering Group should consider appointing a group member or subgroup whose responsibility it will be to maintain the profile of the Steering Group and to ensure that the website, publicity, listings, etc. are up to date.

Access to Existing Services in Luton

It is important not to assume that all LGBT people have miserable lives and that they will require extensive use of services. Indeed, a number of our respondents specifically made comments in this respect:

"Why do you consider being gay is a problem and need to make a such a big deal of it"?

"Don't make the mistake that all mental health problems are related to sexual/ gender identity"?

Yet, there will be times when LGBT individuals need support or advice about their sexuality or gender identity (e.g. while coming out or coming to terms with ones gender identity), or when sexuality/ gender identity may influence how society and various services respond to LGBT people (e.g. hate crime, housing or education policies, etc.). Importantly, to date there have been very few services or social groups targeted directly at LGBT people within Luton (exceptions include the now defunct Queer Company/ Alternative Ways of Living, and the recently established Men4Men Project). What services that there are have mostly been associated with gay men, HIV/AIDS and sexual health or the reporting of hate crime. As part of the questionnaire a list of local LGBT groups, services and organisations, or groups, services and organisations perceived to be LGBT-friendly, were compiled. Respondents were then asked which groups/ services/ organisations they had 'heard of', whether they had 'used' them, and, if they had used them, how useful they had found them.

Awareness of Groups, Services and Organisations

Table 11 – Groups, services and organisations that respondents had heard of. Ranked from most to least known (n=99)
*** = group, service or organisation no longer exists**

Group, service or organisation.	frequency	%
Samaritans	72	72.7
The Lodge	67	67.7
Victim Support	60	60.6
Relate	54	54.5
Bedfordshire Body Positive	52	52.5
Police LGBT Liaison Officers	47	47.5
Rape Crisis Centre	32	32.3
gay-bedfordshire.co.uk website	30	30.3
Women's Aid	30	30.3
Bedfordshire Friend Helpline *	26	26.3
Friends Together	26	26.3
Women's Centre	25	25.3
Men4Men Project	24	24.2
Queer Company/ AWOL *	20	20.2

The groups, services and organisations that the survey sample had 'heard of' are shown in Table 11. Of the top five three are mainstream support organisations (Samaritans, Victim Support, Relate), while two are organisations relating to HIV/AIDS and sexual health (The Lodge, Bedfordshire Body Positive). The high profile of organisations such as the Samaritans and Victim Support demonstrates their importance as potential first points of contact when LGBT people need support, as well as the importance of those organisations being able to respond appropriately to the needs of their LGBT clients. Table 11 also shows, that while 47.5% of our sample were aware of Bedfordshire Police's LGBT Liaison Officers or Community Investigators, more than half were not. The relatively poor awareness of the gay-bedfordshire website and the Men4Men Project reflects that these were both quite new projects at the time of the survey.

Use of Groups, Services and Organisations

Reflecting the fact that most LGBT people do not need support all of the time, the numbers of people surveyed who had 'used' the groups, services or organisations listed were small. The Lodge emerged as the most used service, although this may partly reflect its involvement as a place of distribution for the questionnaire. Notably, both the gay-bedfordshire website and the Men4Men Project were relatively well used despite the fact that they were not widely known about.

Table 12 – Groups, services and organisations that respondents had used (n=99). Ranked from most used to least used.
*** = group, service or organisation no longer exists**

Group, service or organisation.	frequency	%
The Lodge	15	15.2
gay-bedfordshire.co.uk website	11	11.1
Men4Men Project	10	10.1
Samaritans	9	9.1
Bedfordshire Friend Helpline *	5	5.1
Victim Support	5	5.1
Bedfordshire Body Positive	4	4
Police LGBT Liaison Officers	4	4
Relate	4	4
Rape Crisis Centre	3	3
Women's Centre	2	2
Women's Aid	1	1
Friends Together	0	0
Queer Company/ AWOL *	0	0

Perceived Usefulness of Groups, Services and Organisations

Those people who had 'used' groups, services or organisations were asked how 'useful' they had found them. However, there was evidence that a number of respondents misinterpreted this question, commenting on the

perceived usefulness of groups, services and organisations whether they had used them or not. For example, while 15 respondents said they had used The Lodge, 22 respondents commented on its perceived usefulness as a service. Table 13 below must therefore be interpreted with great care. Additionally the numbers involved are small, and those included in our survey sample are not necessarily a representative sample of people using a group, service or organisation. Nonetheless even the perceived 'usefulness' of groups, services and organisations among our sample may be helpful to know.

Table 13 – Perceived usefulness of groups, services and organisations

Group, service or organisation	Very useful	Quite useful	Not useful
Bedfordshire Body Positive	3 37.5%	5 62.5%	-
Bedfordshire Friend Helpline	-	2 33.3%	4 66.7%
Friends Together	-	1 33.3%	2 66.7%
gay-bedfordshire.co.uk website	7 70%	2 20%	1 10%
The Lodge	16 72.7%	5 22.7%	1 4.5%
Men4Men Project	9 75%	2 16.7%	1 8.3%
Police LGBT Liaison Officers	2 25%	4 50%	2 25%
Queer Company/ AWOL	-	-	-
Rape Crisis Centre	3 50%	1 16.7%	2 33.3%
Relate	3 60%	1 20%	1 20%
Samaritans	7 63.6%	3 27.3%	1 9.1%
Women's Aid	1 50%	-	1 50%
Women's Centre	1 100%	-	-
Victim Support	2 28.6%	3 42.9%	2 28.6%

From Table 13 it is possible to see that the Men4Men Project, The Lodge, gay-bedfordshire website, Samaritans and Relate were all highly regarded by the small number of people who had used the service or who felt they wanted to comment. Only Bedfordshire Friend Helpline and the Friends Together social group were felt to be 'not useful', although in the latter case the number commenting were very small.

Support Needs and the Development of New Services

In addition to information about existing services and their use it was also important to find out if there were any perceived gaps in support for LGBT people in Luton. With this in mind the survey provided a list of types of services that might possibly be developed, and asked respondents to tick all the options that they thought they would find 'most useful' or would have 'found most useful in the past'. In addition respondents were invited to write, in their own words, whether 'there are any particular types of service or information' that they thought 'should be provided to LGBT people in Luton'. The services that respondents felt they would find most useful are shown in order of priority in Table 14. The top five services that female, male and transsexual respondents would find most useful are shown respectively in Tables 15-17.

Table 14 – Options for the development of LGBT services that respondents would find most useful, or would have found useful in the past. Ranked from most to least useful.

Possible developments thought to be most useful	**frequency**	**%**
Information about local LGBT services (n=96)	57	59.4
Social group/ social activities (n=96)	54	56.3
LGBT sports/ leisure facilities or groups (n=96)	46	47.9
LGBT community centre/ social space (n=96)	44	45.8
Social support group/s (adults) (n=96)	41	42.7
Telephone helpline (n=96)	33	34.4
Social support group/s (young people) (n=96)	24	25
Befriending service (n=96)	23	24
Drop-in (n=96)	21	21.9
Other (e.g. socialising, café, parenting, etc.) (n=94)	9	9.6

The main finding was that, after the desire for more information, there was an emphasis on the need for *social activities* and *informal social support* rather than more formal support such as drop-ins, befriending and helplines. To some extent this may reflect the recruitment strategy for the survey since many questionnaires were distributed in social venues among people who are likely to be socially confident. It is important, therefore, that more formal types of support should not be dismissed. However, there was a clear demand for social groups and activities, with this being particularly evident among women. Comments were also made about the need for social spaces for young LGBT people, older people, and transpeople.

Information Needs

Information about local LGBT services was thought to be the most useful potential development among all respondents as well as among the male respondents. This issue has at least partly been resolved by the Steering Group's production of a local information leaflet about LGBT services and commercial venues. However, other types of information that were thought to

be useful included legal information, financial information, and health information (especially for lesbians). For example, in relation to legal information one respondent stated:

"Would appreciate free legal advice on such things as partnership rights, wills, insurance, declarations of trust, etc.".

Table 15 – Options for the development of LGBT services that respondents would find most useful, or would have found useful in the past (n=95). By SEX and ranked for the top 5 priorities among MEN.			
Options that were thought to be most useful	**female n=37**	**male n=53**	**trans n=5**
Information about local LGBT services	58.6%	58.5%	80%
Social group/ social activities	64.9%	50.9%	60%
Social support group/s (adults)	35.1%	45.3%	80%
LGBT community centre/ social space	48.6%	37.7%	100%
LGBT sports/ leisure facilities or groups	67.6%	35.8%	20%

More "specific details" about GUM clinics were also requested such as "opening times, how to get there", etc. But the existence of this information in itself was not enough. Respondents also commented that the availability of any information needed to be publicised because "people don't know it's about". It was felt that it was also necessary to "raise the profile of existing services" and to ensure that the information available is "accurate and up to date". We have already suggested that the Steering Group should appoint a person or subgroup with this specific role.

Social Groups and Social Activities

The development of social groups and activities was thought to be a useful development among 56.3% of the overall sample. The desire for socialising and social spaces was also widely reflected in the comments made by respondents. While some people felt that Luton had a good commercial LGBT scene for the size of the town, others believed that there are "not enough pubs and clubs to go to" and there is a need for "more clubs and pubs". Another respondent stated that Luton "needs a good nightclub that isn't over-priced".

While the Steering Group has no influence over the development of the commercial scene in Luton, it may be able to play a role for those respondents who felt there was a need for social groups and activities away from the scene. For some people there was the need for social spaces where people could meet in an environment less intimidating than the scene:

"Casual meeting centre or night, whether it be in a local pub or hall. Difficulty meeting other gay people if not confident enough to go to pubs on your own".

Significantly, some people felt more excluded from the scene than others. One respondent felt there should be "social groups for older gay men". A number of respondents emphasised the "lack of places for lesbians to meet in Luton".

Table 16 – Options for the development of LGBT services that respondents would find most useful, or would have found useful in the past (n=95).
By SEX and ranked for the top 5 priorities among WOMEN.

Options that were thought to be most useful	female n=37	male n=53	trans n=5
LGBT sports/ leisure facilities or groups	67.6%	35.8%	20%
Social group/ social activities	64.9%	50.9%	60%
Information about local LGBT services	58.6%	58.5%	80%
LGBT community centre/ social space	48.6%	37.7%	100%
Telephone helpline	35.1%	32.1%	40%

Another respondent felt that social activities should not always be held in venues associated with drinking alcohol: "social groups/ clubs/ venues not related to pubs/ drinking". The theme of a café where people could meet casually was raised several times reflecting similar desires raised in previous LGB needs assessments (Mitchell et al. 2001). Such a café was variously referred to as a "night café" or a "Friends" type "café/ bar". For others there was a need for a wider-purpose "venue/ social group or non commercial centre". The desire for a community centre/ social space was thought to be the most useful potential development among transsexual respondents.

Table 17 – Options for the development of LGBT services that respondents would find most useful, or would have found useful in the past (n=95).
By SEX and ranked for the top 5 priorities among TRANSPEOPLE.

Options that were thought to be most useful	female n=37	male n=53	trans n=5
LGBT community centre/ social space	48.6%	37.7%	100%
Information about local LGBT services	58.6%	58.5%	80%
Social support group/s (adults)	35.1%	45.3%	80%
Social group/ social activities	64.9%	50.9%	60%
Telephone helpline	35.1%	32.1%	40%

LGBT Sports/ Leisure Facilities or Groups

Among the female respondents, sports/ leisure facilities or groups were thought to be the most useful potential future developments (see Table 16). To this extent sport and leisure was prioritised to a much greater extent than among men or transsexuals (the latter of whom had concerns about appropriate changing facilities – see chapter 7), although it was still thought to be the third most useful development overall. For example, one respondent stated:

"Perhaps a sports club, say badminton or walking. Not everyone goes to pubs/ clubs".

Once again, the theme of social groups and activities instead of, or as a compliment to, the scene is reiterated.

Helpline

Importantly, the CFI funding that enabled the survey was also partly given on the basis that a helpline or other form of social support activity would be piloted depending on the outcome of the survey. It should be noted that a number of respondents stated that they felt a helpline or support group *was* necessary. For example, one respondent simply stated that "a local helpline or support group" would be the most useful development for LGBT people in Luton. Another respondent referred more specifically to a "coming out helpline" or a "prejudice helpline" where people could gain legal advice and social support. However, it was clear that generally speaking a helpline or formal social support was not the priority of the majority of respondents. In this context a helpline should not be the priority of the Steering Group at this stage. Rather Luton LGBT Steering Group may wish to explore the possibility of a shared helpline with other regional LGBT organisations.

Building Social Networks

Instead of formal support it was thought to be more important that "there is a network available to support LGBT people wherever they live". Such a network can be built through informal social activities and the provision of supportive information. In these circumstances we recommend that the Steering Group *prioritise* the *provision of up-to-date and accurate information* and the *development of informal social groups and activities that affirm LGBT culture and identity*. The Steering Group will need to review its existing hard copy and website information to see if it can be expanded in line with the needs expressed above. The Steering Group may also wish to investigate the possibility of an events subgroup or person responsible for arranging periodic social activities or groups.

Access to Informal Social Support

Given that the provision of information to the LGBT community was regarded as the most useful development that the Steering Group could be involved with, it is important to know where LGBT people feel most happy seeking information so that it can be appropriately distributed. With these issues in mind two key questions were asked. Firstly, respondents were asked to consider who they would have felt happy seeking information from when they were 'coming out' or discovering their gender identity. This is likely to be a time when many individuals are feeling confused and vulnerable and an appropriate response is vital for his or her mental health. Secondly, respondents were asked where they would seek information if they were

looking for it 'today'? Responses to the first question are shown in Table 18, and responses to the second in Table 19.

The Importance of Friends for Support

There is now a large and growing body of research indicating the importance of friendship and a sense of a wider LGBT community for effective social support and positive mental health among LGBT people (Nardi 1992; Weeks, Heaphy and Donovan, 2001; Weston 1991), and this was reflected in the responses of our sample to the survey (see Tables 18 and 19). Notably, 'family' are much less likely to be seen as an important source information when an individual is discovering his or her sexuality/ gender identity compared to friends (including 'straight' friends). The relatively low level of information sought from partners reflects the fact that fewer people are likely to have partners in the early days of discovering their sexuality/ gender identity. The significance of partners as sources of informal support doubles in Table 19. However, the fact that LGBT seek most of their information through informal relationships tells us little about where information should be targeted in the public domain.

Table 18 – When you were 'coming out' (discovering your sexuality/ gender identity) where were you most happy seeking information about your sexuality/ gender identity.
Ranked from most to least popular source of information.

Source of information	frequency	%
LGBT friends (n=97)	43	44.3
LGBT pub/ club (n=97)	34	35.1
Straight friends (n=97)	27	27.8
Partner (n=97)	22	22.7
LGBT press (n=97)	22	22.7
Media (e.g. TV or radio) (n=97)	21	21.6
LGBT social group (n=97)	21	21.6
Family (n=97)	20	20.6
Self-help books (n=97)	20	20.6
LGBT Internet site (n=97)	16	16.5
LGBT helpline (n=97)	14	14.4
Mainstream press (n=97)	13	13.4
Counsellor/ therapist (n=97)	13	13.4
Other (n=97) (e.g. gay brother, lgbt books, myself)	12	12.4
GP/ Doctor (n=97)	11	11.3
Library (n=97)	11	11.3
Mainstream Internet site (n=97)	7	7.2
GUM clinic (n=97)	6	6.2
Practise nurse (n=97)	6	6.2
Leisure centre (n=97)	5	5.2
Mainstream helpline (n=97)	2	2.1
Religious leader (n=97)	2	2.1

Self-Help and the Media

Even when coming out, most information is sought by LGBT people from other LGBT people (e.g. through LGBT pubs and clubs, the LGBT press, LGBT social groups, LGBT Internet sites, and LGBT helplines), and this appears to increase as a person's identity becomes more consolidated and affirmed. Once again, this reaffirms the importance of a sense of an LGBT community, and community networks, within a town. In this context Local Authorities and other agencies have a vital role supporting these structures. However, for those with no contact with the LGBT community the findings suggest that the most important sources of information (beyond straight friends) are the media, self-help books, and the mainstream press. In this respect, the Steering Group should continue to work with Luton Central Library to ensure that appropriate and up-to-date self-help books about coming to terms with/ celebrating ones sexuality, sex/ gender identity are available for people seeking them. The Steering Group may also want to discuss whether it should challenge any homophobic/ transphobic and misleading articles in the local press and media and how it can react quickly to such developments.

Table 19 – Where would you feel most happy seeking information about your sexuality/ gender identity today?
Ranked from most to least popular source of information.

Source of information	frequency	%
LGBT friends (n=96)	60	62.5
Partner (n=96)	41	42.7
LGBT Internet site (n=96)	41	42.7
LGBT press (n=96)	34	35.4
LGBT pub/ club (n=96)	34	35.4
LGBT social group (n=96)	29	30.2
Straight friends (n=96)	26	27.1
LGBT helpline (n=96)	26	27.1
Family (n=96)	25	26
Self-help books (n=97)	21	21.6
Media (e.g. TV or radio) (n=96)	20	20.8
Counsellor/ therapist (n=97)	19	19.6
Mainstream Internet site (n=96)	17	17.7
Library (n=96)	15	15.6
GP/ Doctor (n=96)	11	11.5
GUM clinic (n=96)	10	10.4
Mainstream press (n=96)	7	7.3
Practise nurse (n=96)	7	7.3
Mainstream helpline (n=96)	6	6.3
Other (n=96) (e.g. LGBT books, school)	6	6.3
Leisure centre (n=94)	5	5.3
Religious leader (n=96)	3	3.1

Low Priority Given to Health Professionals as Sources of Information

One interesting point is the consistently low priority given to seeking information from health professionals, whether at the stage of discovering one's sexuality/ gender identity, or today. For example, only 11% of respondents said they would feel happy about seeking information about their sexuality/ gender identity when they were coming out from a GP/ doctor, with this figure remaining unchanged in terms of how respondents felt today. Notably, people were more likely to seek information from counsellors and GUM clinics once they had established their identity, but these were still regarded as relatively unlikely sources of information compared to informal relationships and LGBT sources. It is possible that this simply reflects the way that the issues involved are not regarded as sufficiently health-related or technical to need information from a health professional. But the low priority given to health professionals as a source of information can also be regarded as an issue of access to information and healthcare.

Access to Health and Community Services

Previous research suggests that health and social care professionals have not always been good at responding to the needs and concerns of LGBT people (Albarran and Salmon, 2000). Many LGB people are fearful that revelation of their sexuality will lead to worse treatment at a time when they are already feeling unwell or vulnerable. The issues for transsexual people are even more difficult because of the way that revelation of their identity is necessary in order to receive appropriate counselling or treatment. In this context whether or not transgendered people receive a well informed and sympathetic response is all the more important. During the survey we explored several areas of access to health services and community services. This included: primary care (including GP) services; community services more generally; sexual health services; and whether individuals preferred advice about their sexuality/ gender identity to be offered by someone of the same sex/ gender identity as themselves. Overall we found a positive experience of access to health services and services in the community. Experience of discrimination tended to be limited to a minority, although there were still a number of issues that needed to be addressed. In particular, GP services needed to make it easier for LGBT people to come out and to offer clearer reassurances that non-discriminatory practices would also cover LGBT people. In relation to sexual health services there were also issues around sexual health information for women.

Primary Care Services and Coming Out to Your GP

Previous research suggests, that while the majority of LGB people come out to their GP, there are still a are large minority that feel unable to do so. For example, Mitchell et al. (2001) that 40.8% of their LGB sample were not out to their GP or family doctor. Similarly, Carr et al. (1999) found that 40% of their lesbian sample felt unable to disclose their sexuality to their GP. Information

about the number of transgendered people who are open about their identity to their GP is not available to the same extent, and is complicated in terms of whether a person has undergone, is under going, or has yet to decide whether to under go sex change surgery.

Table 20 – Are you "out" (open) about your sexuality/ gender identity to your GP/ family doctor or local health practice? (n=99)		
Whether out	**frequency**	**%**
Yes	56	56.6
No	36	36.4
Not sure	5	5.1
Not registered with GP	2	2

Table 20 shows that over half of our respondents were 'out' to their GP or family doctor, although 36.4% of the sample (36 respondents) were not. Women were far more likely as a percentage of their sex to be out to their GP than men (see Table 21). However, transsexuals were most likely to be 'out', with all five transsexuals included in our sample having told their GP about their identity.

Table 21 – Are you "out" (open) about your sexuality/ gender identity to your GP/ family doctor or local health practice? By SEX (n=98).				
Sex	**Out about sexuality/ gender identity**			
	Yes	**No**	**Not sure**	**Not reg'd**
Female	24 64.9%	10 27%	2 5.4%	1 2.7%
Male	26 46.4%	26 46.4%	3 5.4%	1 1.8%
Transsexual	5 100%	-	-	-

Table 22 – Are you "out" (open) about your sexuality/ gender identity to your GP/ family doctor or local health practice? By AGE (n=99).				
Age group	**Out about sexuality/ gender identity**			
	Yes	**No**	**Not sure**	**Not reg'd**
Under 16 years	-	1 100%	-	-
16 to 20 years	2 22.2%	6 66.7%	1 11.1%	-
21 to 30 years	14 58.3%	9 37.5%	1 4.2%	-
31 to 40 years	26 63.4%	11 26.8%	2 4.9%	2 4.9%
41 to 50 years	13 61.9%	7 33.3%	1 4.8%	-
51 to 60 years	1 100%	-	-	-
61 to 70 years	-	2 100%	-	-

It was also the case, that with the exception of the two respondents in the oldest age group (61-70 years), the older respondents were, the more likely they were to be out to their GP (Table 22). This may reflect the way in which LGBT people feel more confident about their identity as they grow older. However, it also suggests that the youngest and oldest members of the community may be least likely to seek help from GPs with health or emotional problems associated with their sexuality/ gender identity.

In terms of ethnicity care has to be taken in interpreting data because of the small numbers of minority ethnic groups involved in the sample. However, overall White British people were the ethnic group least likely to be out to their GP, followed by the White Irish. All of the Black (n=3) and Asian (n=1) participants in the survey were out to the GP. Respondents with long-term illnesses, health problems or disabilities were more likely to be out to their GP than those with no health problems. For example, 75% of people with permanent health problems were out to their GP compared to 52.6% of people with no health problems. However, there were a small number (n=5) of people with health problems who were not out to their GP. Of course, it may be the case that the health problem is not perceived to be pertinent to the person's sexuality.

How Well Did GPs Respond to LGBT People Coming Out

For those people who had come out to their GP, we also asked how well they felt their GP, family doctor or local practice had responded to that person's sexuality or gender identity. Table 23 shows that the vast majority of respondents felt that their GP had responded 'very well' or 'quite well'. However, 14% of those sampled who had come out had a poor experience, and it is often the unpredictability of this outcome that is the problem for many LGBT people (Mitchell et al., 2001).

Table 23 – How well would you say that your GP, family doctor or local practice responded to your sexuality or gender identity? (n=55)

How GP responded	frequency	%
Very well	23	41.8
Quite well	20	36.4
Quite poorly	6	10.9
Very poorly	2	3.6
Unsure	4	7.3

Interestingly, although women were more likely to come out to their GP or local practice, they were also more likely to report a poor experience when having done so compared to men or transsexuals. In fact, of the 8 people reporting a poor response to the disclosure of their sexuality 7 were women. None of the transsexual respondents reported a negative reaction from their GP/ local practice.

Why LGBT People Came Out to their GP

In addition to the percentage of people who had come out to their GP, we also explored the reasons why they decided to tell their GP about their identity or not. Firstly, we explored the reasons why people *had* come out to their GP. Respondents were provided with the list of statements shown in Table 24 and asked to tick as many of the statements that they felt applied to them. When these statements were listed in order from most to least common reason for telling GPs about the sexuality/ gender identity of respondents it was clear that service users rather than the service providers themselves took the lead in raising the issue. Importantly, 17.9% (n=10) of those people who had disclosed their sexuality/ gender identity stated that they knew that the GP/ practice would be accepting. How they knew this, however, is unclear. It is significant that only 3 people (3% of the whole survey sample) had seen leaflets or posters indicating acceptance of their sexuality/ gender identity at their surgery. Only 5 people (8.9% of those who had disclosed their sexuality/ gender identity to their GP) thought they would receive better treatment if they were honest about their sexuality.

Table 24 – What factors contributed to your decision to come out to your GP or local practice?
Ranked from most to least common reason given.

Reason for coming out to GP/ practice	frequency	%
I raised my sexuality/ gender identity in relation to a particular health issue I needed to discuss (n=43)	24	42.9
I felt I should be honest about my sexuality/ gender identity from the start (n=43)	17	30.4
I knew the GP/ practice was accepting of my sexuality/ gender identity (n=43)	10	17.9
Other (e.g. had to in order to seek treatment for gender dysphoria, feed up of questions about contraception) (n=43)	10	17.9
It slipped out while discussing a health problem related to my sexuality/ gender identity (n=42)	7	12.3
My GP asked me about my sexuality/ gender identity and I told him/ her (n=43)	6	10.7
I thought that I would receive better treatment if I was honest about my sexuality/ gender identity (n=43)	5	8.9
There were visible leaflets/ posters indicating the acceptance of my sexuality/ gender identity at the practice (n=43)	3	5.4
My sexuality/ gender identity was documented on my notes from a previous GP/ Practice (n=43)	2	3.6
I heard from other people that the GP/ practice would be accepting of my sexuality/ gender identity (n=43)	1	1.8

Interestingly, 'other' reasons given for disclosing one's sexuality or gender identity also reflected the necessity of doing so in order to receive treatment, or to receive appropriate treatment. For example, a number of transsexual respondents stated that they had to disclose their identity in order to seek advice and treatment:

"I needed to tell my GP in order to seek treatment for my gender dysphoria".

"I required help about my gender identity to find out what course of action to take".

However, disclosing one's sexuality/ gender identity didn't only occur in relation to treatment for oneself. As one respondent put it, the "birth of twins necessitated it". It is here also that the relevance of sexuality/ gender identity to certain forms of treatment or care can be revealed, even when many LGBT people and health professionals think that sexuality/ gender identity should be irrelevant to treatment (Harrison, 1996). For example, our findings confirmed previous research (Platzer and James, 2000) that lesbians are often forced to disclose their sexuality because of persistent questions about contraceptive needs and the assumption they are heterosexual:

"She kept asking me if I was taking any contraceptive".

"Fed up with questions about my contraceptive needs".

However, sexuality was also sometimes disclosed in relation to mental health issues. One respondent stated:

"I was going through a difficult period and decided to raise it with my GP for advice and direction".

Sexuality/ gender identity could also be revealed in terms of something as simple as talking about one's partner: "Talked about my partner". Feeling able to talk freely and openly about same sex partners or LGBT families is vitally important in terms of ensuring support for individuals when they are hospitalised or need long-term treatment. Consequently, while many LGBT people prefer not to disclose their sexuality/ gender identity, or do not see it as relevant to their treatment or support, there are likely to be many situations where disclosure is important and cannot be avoided.

Why LGBT People Chose Not to Come Out to their GP

Of the people who had *not* chosen to disclose their sexuality/ gender identity to their GP or local practice, the most common reason given was that sexuality or gender identity was not relevant to the health problems that the individual needed to discuss. Similarly, the third most common reason given for non-disclosure was that respondents didn't see why his or her GP or practice needed to know his or her sexuality/ gender. Of course, as we discussed above, there will be many circumstances where sexuality and gender are irrelevant to treatment. But it is equally important that service users and providers feel comfortable enough to discuss these issues when they are (Wilton, 2000).

Very few people gave examples of overt or perceived discrimination as the reason why they had chosen not to disclose their sexuality/ gender identity. Instead there was a concern that information about the person's sexuality/ gender identity would not remain confidential within the practice, or that

documentation of the person's sexuality/ gender identity on their notes would have prejudicial consequences.

Table 25 – What factors contributed to your decision not to disclose your sexuality/ gender identity to your GP or local practice? Ranked from most to least common reason given.		
Reason for not disclosing sexuality/ gender identity	**frequency**	**%**
My sexuality/ gender identity has never been relevant to the health problems I needed to discuss (n=36)	25	69.4
My GP has never asked me (n=38)	18	47.4
I do not see why my GP/ practice needs to know my sexuality/ gender identity (n=38)	17	44.7
I do not trust that information about my sexuality/ gender identity will remain confidential (n=37)	13	35.1
There were no posters/ leaflets in the surgery that indicated the practice/ GP would be accepting of my sexuality/ gender identity (n=36)	8	21.6
I believe I will receive worse treatment if I am open about my sexuality/ gender identity (n=35)	5	14.3
Other (e.g. financial implications for mortgages, insurance, pensions, uncertainty how GP will respond, not been to GP in five years) (n=36)	5	13.9
I had heard that the GP/ practice would not be accepting of my sexuality/ gender identity (n=36)	3	8.3
The GP had made comments previously that made me think he she would not accept my sexuality/ gender identity (n=37)	1	2.7

At one level there was a fear that people who the individual didn't want to know about their sexuality/ lifestyle might find out they were LGBT from their notes:

"She then wrote LESBIAN across my notes when my relation worked at the [same organisation]".

However, most comments made involved the possible prejudicial consequences when applying for mortgages, life insurance, etc., particularly for gay and bisexual men. As one man put it: "I do not wish there to be a written record of my sexuality in my medical notes". The reasoning given for this reflected comments such as:

"Financial implications vis-à-vis pensions and life insurance"

"I've heard it can affect future applications for loans, etc."

Consequently, it is important that GP practices create an environment in which LGBT people feel that they are able to disclose their sexuality/ gender identity when it is relevant. Where LGBT service users disclose their sexuality there should be a clear policy on how sexuality/ gender identity will be documented in patient notes and in what circumstances such information is likely to be used. LGBT service users must also be reassured that practice

staff will uphold the highest standards of confidentiality in relation to this information. The Steering Group can raise these issues with Luton Primary Care Trust to ensure a more consistent approach in this respect. An appropriate way forward may be to write to the Trust Board's Diversity sub committee raising these points.

Access to Services in the Community in General

Table 26 shows that the relatively positive experience found in relation to GPs was also repeated in relation to access to services in the community more generally. Among our sample 71.1% of respondents said they had *not* been made to feel uncomfortable about their sexuality/ gender identity during an interaction with a professional in the community. However, it would be wrong to be complacent because about one-quarter (25.8%) of respondents had been made to feel uncomfortable in such an interaction.

Table 26 – Have you ever been made to feel uncomfortable about your sexuality/ gender identity during an interaction with a health or social services professional or any other service provider? (n=97)

Whether made to feel uncomfortable	frequency	%
Yes	25	25.8
No	69	71.1
Not sure	3	3.1

For those individuals who had been made to feel uncomfortable, respondents were also asked which type of professionals they were referring to. The fact that doctors and nurses are at the top of the list is probably because they are the professionals that most people have contact with in the community. Nonetheless there is still some room for concern that 16.2% of the overall sample had been made to feel uncomfortable during an interaction with a doctor.

Table 27 – Number and % of whole sample who had been made to feel uncomfortable about their sexuality/ gender identity during an interaction with a health or social services professional or other service provider (n=99)

Professionals	frequency	% whole sample
Doctor	16	16.2
Nurse	7	7.1
Therapist/ counsellor	5	5.1
Dentist	3	3
Social worker	3	3
Other (e.g. GUM clinic, previous doctor)	3	3
Sports/ leisure centre worker	2	2
Youth worker	1	1
Voluntary/ charity worker	1	1

Previous research has suggested that as a result of the discomfort described above LGBT people may delay seeking treatment or be denied access to the services that they are entitled to (Greco and Glusman, 1998). The generally low level of discomfort when dealing with professionals in the local community is encouraging. This trend was also reflected in the small percentage of people who delayed seeking treatment or advice because they were afraid it might raise questions about their sexuality/ gender identity. As can be seen in Table 28, only a small minority (12.5%) had delayed seeking treatment or advice, although we do not know the consequences of the decisions to delay.

Table 28 – Have you ever delayed seeking treatment or advice from a health/ social care professional because you were afraid it might raise questions about your sexuality/ gender identity (n=96)

Whether delayed	frequency	%
Yes	12	12.5
No	80	83.3
Not sure	4	4

The vast majority had not delayed seeking advice or treatment. But for those who had done so doctors (11.1% of the whole sample), dentists (3%), nurses (2%) and therapists (2%) were the professionals respondents were most likely to try to avoid (see Table 29).

Table 29 – Number and % of whole sample who had delayed seeking treatment or advice from a health/ social care professional because they were afraid it might raise questions about their sexuality/ gender identity (n=99)

Professionals	frequency	% of whole sample
Doctor	11	11.1
Dentist	3	3
Nurse	2	2
Therapist/ counsellor	2	2
Voluntary/ charity worker	1	1
Social worker	-	-
Youth worker	-	-
Other	-	-

Access to Sexual Health Services and Information

In addition to primary care services and general services in the community we also asked LGBT people about their access to local sexual health services and information. Firstly, we asked if respondents were able to find sexual health information when they needed it in the local area. Table 30 shows that overall the picture was positive, with 47.3% of the sample saying they could

'always' find the information they needed, and a further 36.6% saying they could find it 'some of the time'. However, there was still a minority who were not happy with the level of sexual health information available to them.

Table 30 – Are you able to find information about sexual health when you need it in the local area? (n=93)		
Ability to find sexual health information	**frequency**	**%**
Yes, always	44	47.3
Yes, some of the time	34	36.6
No, rarely	13	14
No, never	2	2.2

No significant patterns were found when the data was cross-tabulated for age and ethnicity. However, it was clear that men were happier with the level of sexual health information available compared to women and transsexuals. Table 31 shows that, while 50.9% of men felt they could 'always' find the sexual information they needed, only 40.6% of women and 40% of transsexuals (n=2) felt this way. Those who thought that they could 'rarely' or 'never' find the sexual health information they needed locally were also concentrated among women and transsexuals (as a percentage of their sex). Historically this has been encouraged by the association between same sex male sexual activity, HIV/ AIDS, and other sexually transmitted infections (see Chapter 6). However, it may now be the case that the sexual health information needs of other sections of the LGBT community also need to be addressed. Indeed, one respondent wrote in the additional comments section at the end of the questionnaire that there is a need for "specific health advice for lesbian needs".

Table 31 - Are you able to find information about sexual health when you need it in the local area? By SEX (n=92).				
Sex	**Yes, always**	**Yes, some of the time**	**No, rarely**	**No, never**
Female	13 40.6%	12 37.5%	6 18.8%	1 3.1%
Male	28 50.9%	21 38.2%	5 9.1%	1 1.8%
Transsexual	3 40%	1 20%	2 40%	-

Access to GUM Clinics

In terms of access to GUM clinics in Luton and Bedfordshire a very high proportion of our respondents had 'heard of' the GUM clinics at Luton and Dunstable and Bedford hospitals. Although only 30.3% (n=30) of our sample had used Luton and Dunstable GUM, 75% (n=72) of our sample had 'heard of' the clinic. This means that at least three-quarters of the LGBT community are aware of the L&D GUM if they should need it. Additionally n=36 of our respondents had also heard of Bedford GUM.

Table 32 – Have you ever heard of any of the following GUM (Genito Urinary Medicine)/ sexual health services in Bedfordshire?		
Luton and Dunstable GUM (n=96)	**frequency**	**%**
Yes	72	75
No	22	22.9
Not sure	2	2.1

Table 33 – Have you ever heard of any of the following GUM (Genito Urinary Medicine)/ sexual health services in Bedfordshire?		
Bedford GUM (n=82)	**frequency**	**%**
Yes	36	43.9
No	42	51.2
Not sure	4	4.9

Importantly, whether our respondents had used a GUM clinic is likely to be a sensitive subject for many of our respondents. This may account for the high proportion of missing data in Tables 34 and 35 (and missing data is shown for this reason). Nonetheless, 30.3% of our sample had used Luton GUM clinic and a further 7.1% had used the Bedford clinic.

Table 34 – Have you ever used any of the following GUM (Genito Urinary Medicine)/ sexual health services in Bedfordshire?		
Luton and Dunstable GUM (n=99)	**frequency**	**%**
Yes	30	30.3
No	53	53.5
Not sure	2	2
Missing data	14	14.1

Table 35 – Have you ever used any of the following GUM (Genito Urinary Medicine)/ sexual health services in Bedfordshire?		
Bedford GUM (n=99)	**frequency**	**%**
Yes	7	7.1
No	63	63.6
Not sure	70	70.7
Missing data	29	29.3

Men were far more likely to have used Luton and Dunstable GUM clinic than women. Overall 23 of the men in our sample (46.9% of men) said they had used the L&D GUM clinic compared to 4 women (12.5% of women). While only 3 transsexuals had used this GUM this accounted for 75% of the transsexual sample. Far fewer respondents had used Bedford GUM. In this case there were 6 men and 1 woman.

A small number of respondents had used Bedford and Luton and Dunstable GUM. In this case, when individuals who had used GUM services were asked to comment on the quality of services, they were asked to comment only on the service they had used the *most*. In this case 29 people said they had used

Luton and Dunstable GUM 'the most' (although slightly fewer people than this commented on the quality of services at the clinic – see Table 36). Only 4 people in our sample used Bedford GUM 'the most' (consequently, the numbers were not sufficient to make a table on the perceived quality of GUM services in Bedford viable).

In terms of the perceived quality of services at Luton and Dunstable GUM most aspects of the service were rated as 'excellent', 'good' or 'satisfactory'. The only real exception to this trend was the 'ease of making an appointment', where 37% of the sample (n=10) rated this part of the service as either 'poor' or 'terrible'. In all other cases where the service was rated 'terrible' (e.g. welcoming/ relaxing environment) the responses were given by men.

Table 36 – Rating of services at Luton and Dunstable GUM clinic for those respondents who had used them.
Percentage and number of respondents.

Rating criteria	Excellent	Good	Satis-factory	Poor	Terrible
Ease of making an appointment (n=27)	4 14.8%	7 25.9%	6 22.2%	7 25.9%	3 11.1%
Helpfulness of staff (n=27)	8 29.6%	9 33.3%	10 37%	-	-
Welcoming/ relaxing environment (n=27)	7 25.9%	8 29.6%	10 37%	-	2 7.4%
Understanding sexuality/ gender identity (n=26)	9 34.6%	12 46.2%	3 11.5%	1 3.8%	1 3.8%
Understanding my sexual health problem (n=26)	10 38.5%	12 46.2%	2 7.7%	1 3.8%	1 3.8%

In the past LGBT people have sometimes been found to prefer to use services away from their local community, or to use services in London because they are perceived to be more LGBT-friendly. Consequently, we also asked if respondents had 'ever' used GUM services 'outside' of Luton and Bedfordshire, and subsequently, if they had done so, to give their reasons.

Table 37 – Main reason for using GUM services outside Luton and Bedfordshire (n=25).
Ranked from most to least frequently given reason.

Reason	frequency	%
Other (e.g. lived in different area when used GUM)	14	56
Better services available	6	24
Difficulty getting an appointment	6	24
More convenient	4	16
Away from people I know	2	8
Better understanding of my sexuality/ gender identity	2	8
Better confidentiality	1	4
More helpful staff	1	4
More welcoming environment	0	4

Almost exactly one-quarter (n=25 or 25.3%) of the overall sample had used GUM services outside the county at some time. The main reason for having used a GUM clinic outside of Bedfordshire was simply that the individual had lived in a different area at the time. There was some limited evidence that LGBT people felt they would receive better services elsewhere. Notably, the theme of not finding it easy to make an appointment locally also re-emerged.

Sex/ Gender Identity of Service Provider

One final area we addressed in terms of access to services was whether respondents would prefer advice and information about issues relating to the person's sexuality or gender identity to be offered by someone of the same sex/ gender identity.

Table 38 – In general, if you were seeking advice or information about your sexuality/ gender identity, would you prefer that advice to be offered by someone who is of the SAME sex or gender identity as yourself? (n=96)

Preference	frequency	%
Yes, always	24	25
Yes, sometimes	53	55.2
No	14	14.6
Not sure	5	5.1

In terms of whether women, men or transsexuals were more likely to prefer to seek advice and information from a person of the same sex or gender identity, there was very little difference between the sexes. Men were most likely to 'always' want advice and information about their sexuality/ gender identity from a person of the same sex, although the difference was marginal. For example, 25.9% of men felt this way, but this was not substantially different from the 22.2% of women, or 20% of transsexuals who felt similarly. The majority did not feel it was always necessary to seek advice and information from a person of the same sex or gender. However, over half the sample (55.2%) felt that it was 'sometimes' appropriate to be offered advice and information by someone of the same sex/ gender identity when it was *sexuality/ gender identity* that was being discussed. This has significant implications for the provision of services and support for LGBT people in Luton, and may require the funding of an LGBT Officer or Officers. Numbers were not sufficient to examine whether there were any discernable patterns in this respect in relation to age or ethnicity.

Access to Services, Information and Advice: Summary and Recommendations

Awareness of Luton LGBT Steering Group

At the time of the survey only 14.1% of the sample had heard of the Steering Group (who were not already members, or who did not already know a member of the group). The Steering Group should continue to raise its profile in the local community. A person or subgroup should be appointed to take responsibility for ensuring that the profile of the group is maintained.

Access to Existing Services in Luton

Non-LGBT organisations (e.g. Samaritans, Victim Support, Relate) were best known among our sample, but groups, services or organisations that were directed at LGBT people, or perceived to be LGBT-friendly, were most used (e.g. The Lodge, gay-bedfordshire.co.uk website, Men4Men Project).

Support Needs and the Development of New Services

The developments that respondents said they would find most useful were, information about local LGBT services and legal rights, and informal social support through social activities. There was a specific need to build informal social networks and social spaces in addition to those offered through the LGBT commercial scene (e.g. café, sports activities, walking group, etc.). Formal social support such as a helpline was not a priority but was still thought to be important.

The Steering Group should appoint a person or subgroup whose role it will be to provide information about local services, legal advice, etc. for LGBT people. This group should have responsibility for ensuring that information provided by the Steering Group is up to date, distributed regularly, posted on the Steering Group website, etc.

The Steering Group should consider holding regular social events and develop adhoc subgroups as necessary to take responsibility for these events. A proportion of these events should be held away from the scene.

The Steering Group should not prioritise a helpline as its main development. Instead, the Steering Group should explore the possibility of working with other local LGBT organisations to develop a joint-funded regional LGBT helpline.

Access to Informal Support

The majority of LGBT people in our sample felt most happy seeking advice and information about their sexuality/ gender identity from other LGBT people. Where this was not possible, self-help books and the media were the next most used sources of information and advice.

The Steering Group should continue to work with Luton Library Services to ensure that appropriate self-help books (e.g. on coming to terms with one's sexuality/ gender identity, affirming LGBT culture/ identity) are available.

The Steering Group should monitor the local media (e.g. newspapers, radio, etc.) for homophobic, transphobic or misleading features. The group may want to consider developing a way of responding to such features.

Access to Health and Community Services

Overall LGBT people in our sample had a positive experience of health and community services, but a minority had experienced discrimination in ways that need to be addressed. One-quarter of respondents had been made to feel uncomfortable about their sexuality/ gender identity during an interaction with a health, social services, or other type of professional.

The majority (56.6%) of respondents were 'out' to their GP/ practice, but 36.4% were not out. Where individuals had 'come out' the majority felt that their GP/ practice had responded well. However, GP practices need to take more of a lead in reassuring LGBT service users that they will receive a non-discriminatory service.

Policies need to be developed about when it is relevant to document a person's sexuality/ gender identity and how this can be done in a consistent way that preserves patient confidentiality. The Steering Group should raise the concerns expressed by respondents in this respect with the Diversity Sub Committee of Luton Primary Care Trust's Trust Board.

Access to Sexual Health Services and Information

Overall 47.3% of respondents said that they could 'always' find information about sexual health when they needed it in the local area. A further 36.6% said they could find the information they needed 'some of the time'. However, men were happier about the level of access to sexual health information than women or trans people. The Steering Group should ask local sexual health service providers to review the levels of information available locally to women who have sex with women and trans people.

75% of respondents had heard of Luton and Dunstable GUM services. Men were much more likely to have used GUM services. Services were generally rated as 'excellent', 'good' or 'satisfactory', with the exception of 'ease of making an appointment'. 24% (n=6) of those who had used Luton and Dunstable GUM had used another GUM outside Bedfordshire because of difficulty obtaining an appointment. The Steering Group should raise this issue with local sexual health service providers and the GUM clinic at Luton and Dunstable hospital.

Sex/ Gender Identity of Service Provider

Over half of the sample (55.2%) felt that they would 'sometimes' prefer advice or information about their sexuality/ gender identity to come from a person of the same sex/ gender identity. 25% felt they would always prefer advice and information of this nature to be given in this way.

Where appropriate the Steering Group should raise this issue with the commissioners of local support services. It is clear that there is a role for a local LGBT Officer, or Officers, to provide information about sexuality and gender identity issues.

Chapter 4

The Experience and Reporting of Discrimination and Violence

Despite substantial changes in the attitudes of British society to sexuality and gender, there is still considerable evidence of continuing institutionalised discrimination against LGBT people, with a large minority of people still harbouring strong feelings of hatred. During the survey we concentrated on three main areas of the experience of prejudice, violence and discrimination. Firstly, on the general level of discrimination experienced in relation to a variety of services. Secondly, on the specific level of experience of homophobic/ transphobic incidents and whether individuals felt able to report them. And finally on whether Luton was generally perceived to be a safe place for LGBT people to live. A key issue to emerge throughout was, that while levels of discrimination and homophobic/ transphobic incidents were quite low, where discrimination and homophobia/ transphobia existed, awareness needed to be raised, and reassurances offered, about the ways these issues could be addressed. The fact that discrimination and homophobic/ transphobic incidents continued to exist alongside positive legislative changes and hate crime reporting policies meant that there was no overwhelming view one way or the other among our sample about whether Luton was 'safe' for LGBT people.

Experience of Discrimination from Services

Table 39 – Have you or your family (e.g. partner, children) experienced discrimination in relation to any of the following services because of your sexuality/ gender identity.

n= is the number of respondents who had experience of a particular type of service. The % of people who had experienced discrimination in relation to each service is derived from this figure.
n/a= the number of people who had no experience of a particular service or who said the question was 'not applicable' to them. The remaining number of respondents needed to make n=99 is missing data/ question not completed.

Service where discrimination was experienced	frequency	%
Education and Schooling (n=64, n/a=27)	15	23.4
Employment (n=82, n/a=10)	13	15.9
The Police (n=64, n/a=27)	5	7.8
Sports/ Leisure Services (n=68, n/a=20)	4	5.9
General Health Services (n=78, n/a=13)	4	5.1
Voluntary/ Charity Services (n=61, n/a=28)	3	4.9
Social Services (n=53, n/a=37)	2	3.8
Housing (n=58, n/a=31)	2	3.4
Youth Services (n=51, n/a=39)	1	2
Mental Health Services (n=48, n/a=41)	0	0

Table 39 shows that, with the exception of *education* and *employment* the level of discrimination towards LGBT people from services in Luton tended to be low. In relation to 'education and schooling' it is not possible to work out the exact nature of the discrimination because respondents were asked to refer to themselves or their family. Consequently, respondents may be referring to their own experiences while they were at school or the experiences of their child/ren. Additionally it was also possible that respondents were referring to working in education as an LGBT person, or dealing with the schools as an LGBT parent. Nonetheless, information published on Stonewall's website (www.stonewall.org.uk) suggests that homophobic bullying in schools is a significant problem, and that of 300 secondary schools they surveyed only 6% had anti-homophobic bullying policies (see also Rivers, 1996).

In the past work tackling homophobia in schools was often held back because of 'Section 28' (Local Government Association, 2001). However, Section 28 was repealed in late-2003 and can no longer be used as a reason not to deal with issues such as the bullying of LGBT children or children who have LGBT parents. Clearly further exploration is needed in relation to discrimination faced in education and schooling by LGBT people and the families in Luton. The Steering Group may wish to investigate the possibility of seeking funding for research in this respect, or of facilitating spaces where LGBT parents and LGBT young people can come together to talk about the issues that affect them.

After education and schooling, employment was the area in which most people had experienced discrimination. Again, we do not know the exact nature of this discrimination, but LGBT have increasingly been offered legal protection in this respect. Discrimination in employment against trans people was made illegal in most respects by the passing of the Sex Discrimination (Gender Reassignment) Regulations (1999) following the case of P v S and Cornwall County Council. This made it illegal to treat someone less favourably in employment or vocational training on the grounds that he/ she 'intends to undergo, is undergoing or has undergone gender reassignment'. However, the legislation is not completely non-discriminatory and still bans trans people from working in certain areas (McMullan, 2000).

Since December 2003 LGB people have also received protection from discrimination in employment and vocational training under the Employment Equality (Sexual Orientation) Regulations (2003). This legislation bans direct and indirect discrimination, as well as harassment and victimisation, on the grounds of sexual orientation, although there are also exemptions (e.g. in religious organisations). Given that LGBT people still face discrimination the Steering Group may want to explore ways of disseminating information about legislative changes affecting LGBT people more widely (e.g. creating specific, highlighted links or posting information about the legislation on the Steering Group website, running a local awareness-raising campaign).

Experience and Reporting of Homophobic/ Transphobic Incidents

In addition to discrimination from various services LGBT people face continued hostility from various sections of society. The experience, or perceived threat, of violence and harassment can have major implications for the physical and mental health of LGBT people (Eliason, 1996; Mason and Palmer, 1995; Meyer, 1995). Stonewall (1995) found that one in three gay men and one in four lesbians had experienced at least one violent attack in the past five years. Although an offence of 'homophobic' or 'transphobic' assault does not exist as such, the Criminal Justice Act (2003) allows for increased sentences for assaults involving or motivated by hostility based on sexual orientation. Most police forces, including Bedfordshire, now record hate crimes that are motivated by homophobia, and in many cases this is extended to transphobia as well. However, the level of reported crime often vastly underestimates the level of actual violence. For example, the Metropolitan Police estimate that only one in five homophobic incidents are reported.

During the survey we asked if respondents had been a victim of a homophobic/ transphobic incident in the last five years. Table 40 shows that almost a half of our respondents (44.9%) had not been the victim of an incident in the past five years. However, this meant that 54.5% had been a victim of an incident at least once in the last five years, and almost one in five (17.3%) had been a victim of an 'incident' 'five times or more'. When the figures above were broken down by sex it was clear that the transsexuals in our sample had the worst experience. Although care has to be taken because of the small numbers involved, 80% (n=4) transsexual respondents had experienced an 'incident' five times or more', compared, for example, to only 9.1% (n=5) of men. There were no transsexual respondents who had no experience of transphobic incidents.

Table 40 – In the last 5 years, have you been a victim of a homophobic/ transphobic incident (including threats, blackmail, graffiti, vandalism or hate mail)? (n=98)

Whether a victim of homo/ transphobic crime	frequency	%
No	44	44.9
Yes, once	16	16.3
Yes, twice	11	11.2
Yes, three times	9	9.2
Yes, four times	1	1
Yes, five times or more	17	17.3

By contrast the picture for women and men was unusual (see Table 41). Not only were women more likely than men to have experienced 'no' incidents, but they were also more likely than men to have experienced 'five or more incidents'. No major trends were found in terms of age or ethnicity. However,

it is worth mentioning that the only respondent in the under-16 age group had experienced five or more homophobic incidents.

Table 41 – In the last 5 years, have you been a victim of a homophobic/ transphobic incident (including threats, blackmail, graffiti, vandalism or hate mail)? By SEX (n=97)			
Whether a victim of homo/ transphobic crime	**female (n=37)**	**male (n=55)**	**trans (n=5)**
No	19 51.4%	25 45.5%	-
Yes, once	3 8.1%	13 23.6%	
Yes, twice	5 13.5%	6 10.9%	
Yes, three times	2 5.4%	6 10.9%	1 20%
Yes, four times	1 2.7%	-	-
Yes, five times or more	7 18.9%	5 9.1%	4 80%

Reporting of Homophobic/ Transphobic Incidents

Generally speaking there has been a very good working relationship between Bedfordshire Police and the LGBT community in Luton. This has been reflected in a number of initiatives:

- establishment of specialist officers called Community Investigators.
- establishment of 'Diversity' as a forum for LGBT people to raise concerns with Bedfordshire Police.
- joint funding with Luton LGBT Steering Group and Luton Borough Council Community Safety Partnership of a hate crime reporting form.

A good deal of work has already been done in terms of building relationships between the police and the LGBT community and to encourage LGBT people to report hate crimes. However, we wanted to see how well existing initiatives and forums were perceived to be working and the extent of awareness of ways to speak to the police and to report hate crime.

Firstly we asked, 'If you experienced 'homophobic' or 'transphobic' violence, harassment or verbal abuse would you feel able to report it to Luton or Bedfordshire police'? On the positive side almost one-third of our respondents said they would 'definitely' report such an incident to the police, with the same proportion saying they would 'probably' do so. Only 9.7% (n=9) respondents said they would not feel able to report an incident to the police. However, there were just over a quarter (28%) of our sample who still felt unsure about whether they would feel able to report an incident to Luton or Bedfordshire police. In this respect the Steering Group will need to work with Bedfordshire Police and Diversity to explore ways of creating greater reassurance among sections of the LGBT community that they will receive unprejudiced treatment,

and that their report will be taken seriously, if they report a 'homophobic' or 'transphobic' crime.

Table 42 – If you experienced 'homophobic' or 'transphobic' violence, harassment or verbal abuse would you feel able to report it to Luton or Bedfordshire Police? (n=93)		
Able to report	**frequency**	**%**
Yes, definitely	29	31.2
Yes, probably	29	31.2
Not sure	26	28
Definitely not	9	9.7

When analysed by sex, men generally felt more able to report crimes while our female and transsexual respondents were less sure, or more sceptical, about doing so (see Table 43). All four respondents from the Black or Asian minority ethnic groups said they would 'definitely' or 'probably' feel able to report a 'homophobic' or 'transphobic' crime. No significant patterns emerged in relation to age.

Table 43 – If you experienced 'homophobic' or 'transphobic' violence, harassment or verbal abuse would you feel able to report it to Luton or Bedfordshire Police? By SEX (n=92)			
Able to report	**female** (n=33)	**male** (n=52)	**transsexual** (n=5)
Yes, definitely	10 28.6%	18 34.6%	1 20%
Yes, probably	10 28.6%	19 36.5%	-
Not sure	10 28.6%	12 23.1%	3 60%
Definitely not	5 14.3%	3 5.8%	1 20%

Awareness of Ways of Reporting Hate Crime

It is vitally important that people feel able to report 'homophobic' or 'transphobic' incidents. However, it is equally important that they are aware of the ways of doing so, and how they can communicate their concerns to the police more generally. In the first instance, we listed five ways of reporting homophobic/ transphobic hate-crime in Luton and asked respondents if they were aware of them. Table 44 shows that the option of which respondents were most aware was the 'Community Investigators' based at Luton police station. However, only around half of those who answered the question were aware of this option. Similarly, while it was good that 41.9% of those who responded to the question were aware of hate crime report forms in pubs and clubs, this still meant that the majority of LGBT people surveyed were not aware of this option.

Overall, Table 44 demonstrates that considerable work still needs to be done in raising the profile of different options for reporting homophobic/ transphobic

hate crime in Luton. Making LGBT people aware that they can report crimes in ways other than walking into the police station may help increase the level of reporting. The Steering Group should work with Bedfordshire Police, Diversity and Luton Borough Council to address ways in which awareness of the different options for reporting homophobic/ transphobic can be raised. This may involve joint advertising in the local press and/ or a poster campaign around the town, etc.

Table 44 – Awareness of options for reporting homophobic or transphobic incidents to the police.		
Option for reporting incidents	**frequency**	**%**
Community Relations Officers (Community Investigators) at Luton Police Station (n=89)	48	53.9
Hate crime report forms in local LGBT pubs and clubs (n=86)	36	41.9
Homophobic crime reporting via Beds. Police website (n=82)	19	22.9
Homophobic crime reporting via Luton LGBT Steering Group website (n=83)	17	20.7
Homophobic crime reporting via gay-bedfordshire website (n=84)	16	19

Awareness of 'Diversity' (Bedfordshire LGBT Policing Forum)

One other way in which the LGBT community can raise issues of concern is through the Bedfordshire LGBT Policing Forum, more commonly known as *Diversity*. But this can only be done if the local LGBT community are aware of the forum.

Table 45 – Are you aware of 'Diversity' or the Bedfordshire LGBT Policing Forum? (n=98)		
Aware of Diversity?	**frequency**	**%**
Yes	34	34.7
No	55	56.1
Not sure	9	9.1

On the positive side approximately one-third of our respondents had heard of Diversity. However, if the 11 people who are members of the LGBT Steering Group are taken out of this number, the percentage who were aware of Diversity at the time of the survey is reduced to 23%. On the negative side, therefore, more people had not heard of Diversity than those who had. This suggests that the profile of Diversity needs to be raised if it is to act as an effective forum. It is possible that this could be done as part of the advertising and/ or poster campaign suggested above to raise the profile of 'reporting' options.

Is Luton a Safe Place for LGBT People?

A mixed view was expressed by our sample in terms of whether they thought Luton was a safe place for LGBT people. Respondents were presented with the statement that, 'Overall I would say that Luton is a safe place for people of my sexuality/ gender identity', and asked to say whether they agreed or disagreed.

Table 46 – Overall I would say that Luton is a safe place for people of my sexuality/ gender identity (n=94)		
Agree or disagree	**frequency**	**%**
Strongly agree	8	8.5
Agree	47	50
Disagree	34	36.2
Strongly disagree	5	5.3

Table 46 shows that, while over half (58.5%) agreed to some extent that Luton is 'safe' for LGBT people, this left a large minority (41.5%) who disagreed at some level with the statement. Significantly, there were no major differences in attitudes about the safety of Luton for LGBT people when responses to the statement were cross-tabulated with sex, age or ethnicity.

This even split in attitudes towards whether Luton is a 'safe' place may indicate, on the one hand, the relative success that Bedfordshire Police have had building a working relationship with the LGBT community, and the fairly low levels of discrimination and homophobic/ transphobic incidents. On the other hand, however, there is still experience of continued discrimination and multiple homophobic/ transphobic incidents among a minority of LGBT people. This may be compounded by the fact that many LGBT people in Luton are unaware of information about the work that the police and groups like Diversity are doing on the reporting of hate crime. The Steering Group should therefore continue to work with Bedfordshire Police, Diversity and Luton Borough Council to ensure that LGBT people are aware of ways of reporting crime and discrimination. Luton Borough Council's *Corporate Hate Crime Policy and Procedure* is a positive start in this respect. However, it is important that this policy is publicised and that appropriate support is provided for individuals wishing to report discrimination. The Steering Group should work with Luton Borough Council to pursue funding opportunities for a paid advocate or advocates who can support LGBT wishing to report discrimination or hate crime in Luton.

The Experience and Reporting of Violence and Discrimination: Summary and Recommendations

Experience of Discrimination from Services

With the exception of 'education and schooling' and 'employment', the experience of discrimination in relation to different services among our

respondents and their families was low. Overall, 23.4% (n=15) of our sample said they, or their family, had experienced discrimination in relation to 'education and schooling'; 15.9% (n=13) had experienced discrimination in employment.

The Steering group should investigate the possibility of seeking funding to research the nature of discrimination in 'education and schooling' among LGBT people in Luton, and/ or of facilitating spaces where LGBT people, the children of LGBT people, and LGBT young people can come together to talk about the issues that affect them.

The Steering Group should investigate ways of locally disseminating information about legislative changes (e.g. the repeal of Section 28, employment protection for LGBT people) that promote the rights of LGBT people in education and employment.

Experience and Reporting of Homophobic/ Transphobic Incidents

54.5% of the LGBT people sampled had been a victim of a homophobic or transphobic incident in the last five years. In this time 17.3% had experienced a homophobic/ transphobic incident 'five times or more'.

About one-third (31.2%) of respondents said they would 'definitely' report homophobic/ transphobic violence, harassment or verbal abuse to the police. A further 31.2% said they would 'probably' do so. But this left around one-third of respondents who said they would 'definitely not' (28%) report such an incident to the police, or who were 'not sure' (9.7%) about doing so. Women and trans people were least certain about reporting incidents.

Overall 53.9% of our sample were aware that they could report hate crimes against LGBT people through the Community Investigators at Luton Police Station. However, respondents were not as aware of other options for reporting hate crimes (e.g. hate crime report forms in pubs and clubs, Bedfordshire Police and Steering Group websites, etc.). Only 23% of our sample were aware of the Diversity forum.

The Steering Group will need to continue to work with Bedfordshire Police, Diversity and Luton Borough Council to address ways in which awareness can be raised about the different ways in which LGBT people can report homophobic/ transphobic incidents to the police. Bedfordshire Police will also need to find ways to re-assure sections of the LGBT that, if they report hate crimes or incidents, their report will be handled sensitively and without prejudice.

Is Luton a Safe Place for LGBT People?

Overall 58.5% of our sample agreed that Luton was a 'safe' place for LGBT to live to some extent. However, 41.5% disagreed that this is the case.

Chapter 5

Mental Health and Social Support

Mental Health

There is now a large body of work linking sexuality to mental health problems and higher rates of suicide, although similar work in relation to trans people is more limited. The vast majority of discussion and/ or research attributes these problems to homophobia, transphobia and heterosexism rather than to simply being lesbian, gay, bisexual or transgendered (Erwin, 1993; Meyer, 1995; Robertson, 1998; Royal College of Psychiatrists, 2003; Wilton 2000). However, despite the fact that the government's National Service Framework for mental health suggests that Primary Care Trusts should 'develop the resources to work with diverse groups in the population' (Department of Health, 1999), the impact that heterosexism, homophobia and transphobia can have on mental health is rarely recognised.

During the survey we looked at mental health in a number of ways. Firstly, in terms of whether individuals felt sufficiently confident and secure about their sexuality/ gender identity to come out to other people. Secondly, in terms of whether individuals felt that their general mental health had suffered as a result of society's attitudes and response to their sexuality/ gender identity. Thirdly, in terms of levels of contemplated and attempted suicide among our sample. And, finally, by presenting positive and negative statements to the respondents that allowed us to compare how they felt about their sexuality and gender identity today. Overall, we found a very positive picture of mental health among respondents, but with a significant minority appearing to have had problems coming to terms with their identity.

Being 'Out'

Importantly, the ability to be 'out' about one's sexuality or gender identity, and to participate in a strong LGBT community or subculture has an important impact on LGBT mental health (Harrison, 1996; Mugglestone, 1999; Taylor and Robertson, 1994). With this in mind, one of the first questions we asked was to do with the extent to which people were out to others. Table 47 shows that the vast majority (79.8%) of our sample were 'out' to 'everyone' or 'to most people'. Only 3% (n=3) of our sample were not 'out'.

Table 47 – Would you say that you are 'out' (open) about your sexuality/ gender identity? (n=99)

Extent of being 'out'	frequency	%
Yes, to everyone	33	33.3
Yes, to most people	46	46.5
Yes, only to people who totally accept me	17	17.2
No	3	3

Transsexuals were most likely to be out to everyone, followed by men then women; although women were most likely to be 'out' to 'most people'. All of the three people who were not out were men, one of whom belonged to a minority ethnic group. In terms of age, two of those who were not 'out' were in the 21 to 30 age group; the other one was in 61-70 age group.

The Impact of Issues Related to Sexuality/ Gender Identity on Mental Health

The Department of Health (1998) estimates that 1 in 6 (or approximately 17%) of the UK population will have 'a mental health problem such as anxiety or depression' through their lifetime. We did not ask about mental health problems in general, because in most cases it will be more appropriate for these issues to be addressed within mainstream mental health services. Instead, we focused on whether respondents felt that their mental health had been 'affected or suffered' because of issues 'relating to' their sexuality/ gender identity (e.g. the impact of heterosexism, homophobia/ transphobia, discrimination, difficulties coming out, etc.). Again, this does not suggest that a person's sexuality or gender identity is itself the problem, but rather that dealing with the issues raised by continuing prejudice against LGBT people can have significant impacts on the mental health of some people.

Table 48 – Do you feel that your mental health has ever been affected or suffered because of issues relating to your sexuality/ gender identity? (n=99)

Whether mental health has been affected	**frequency**	**%**
No, I've never had any problems	50	50.5
Yes, I've had a few problems but did not seek professional help	19	19.2
Yes, I've had a few problems and did seek professional help	23	23.2
Yes, I've had a lot of problems but did not seek professional help	-	-
Yes, I've had a lot of problems and have sought professional help	7	7.1

Importantly, half our sample felt that their mental health had not been affected or suffered at all because of issues relating to their sexuality or gender identity. However, almost one-quarter (23.2%) had had a 'few problems' which had required some kind of professional help, with a further 7.1% (n=7) having had a lot of problems requiring professional help. Of those with 'a lot of problems', five of the seven people were men (there was also one woman and one transsexual), and they were concentrated in the thirties and forties age groups. Numbers of respondents were not sufficiently large to establish patterns among different ethnic groups. This suggests that for a significant minority of LGBT people they will need some professional help to deal with issues relating to their sexuality and/ or gender identity. There was also some tentative evidence that problems were not only related to coming out when people are younger.

Suicide

There is now a substantial amount of research linking heterosexism and homophobia to higher rates of suicide and attempted suicide among LGB people than among heterosexuals (Erwin, 1993; Nicholas and Howard, 1998; Wilton, 2000), with these issues being particularly acute for younger people (Hershberger et al., 1997; Walpin 1997). The differences in rates of suicide, or attempted suicide, between LGB people and heterosexuals can vary considerably depending on the quality of the research and the nature of the sample. But a recent review suggested that the difference could be anywhere between two (e.g. Vinke and Van Heerigen, 1998) and 14 times (e.g. Bagley and Tremblay, 1997) the rate for heterosexual people. The same extent of information is not available for trans people, but one study found five times more premature deaths in male-to-female persons than would be expected (Asscheman, Gooren and Eklund, 1989). Another public health website states that studies 'generally report a pre-transion suicide rate of 20% or more, with male-to-female transsexuals more likely to attempt suicide than female-to-males (www.metrokc.gov/health/glbt/transgender.htm). Given these findings it seems remarkable that LGBT people are not mentioned in the government's strategies for 'preventing suicide' at a local level (Department of Health, 1999). However, Bedfordshire is one of the areas being targeted by the *Campaign Against Living Miserably (CALM)* in order to attempt to tackle depression and suicide among young men.

We found that 8.2% (n=8) respondents had attempted suicide at least once, while a further 3.1% (n=3) had attempted it more than once (see Table 49). As a percentage of their sex male-to-female transsexuals were most likely to have attempted suicide (50% of this group, n=4), but men were more likely than women to have attempted suicide once, or more than once. In fact, this followed an almost identical pattern found by Mitchell et al. (2001), and reflects the fact that men are more likely than women to commit suicide in the general population (Summerfield and Bapp, 2004). Numbers were not sufficient to support patterns by age or ethnicity.

Table 49 – Have you ever thought about or attempted suicide because of your sexuality/ gender identity? (n=98)

Thought about/ attempted?	**frequency**	**%**
No, never thought about or attempted	72	73.5
Yes, attempted once	8	8.2
Yes, thought about it once	6	6.1
Yes, attempted more than once	3	3.1
Yes, thought about more than once	9	9.2

Positive Mental Health among LGBT People in Luton

Yet, despite legitimate concern for a minority of LGBT people who had attempted or thought about suicide, the majority (73.5%) of our sample had never attempted or thought about it (see Table 49). This positive outlook was also reflected in the fact that the majority of our respondents did not 'find the

stress of being lesbian/ gay/ bisexual/ transgendered too much to cope with' (Table 50), while also believing that their sexuality/ gender identity was a 'positive and enriching part of their life' (Table 51). Overall, 93.7% of our sample agreed to some degree that they found their sexuality/ gender identity 'to be a positive and enriching part of my life'. In fact, 100% of transsexuals felt this way; 94.5% of men; and 91.1% women. However, despite this positive self-identification, there was still around one-quarter (25.3%) of our sample who agreed to some extent that they 'sometimes' found 'the stress of being lesbian/ gay/ bisexual/ transgendered to much to cope with'. This indicates reinforces the importance of supporting LGBT social networks that can sustain a positive sense of self-identification in the face of continuing discrimination from sections of society.

Table 50 – Sometimes I find the stress of being lesbian/ gay/ bisexual/ transgendered too much to cope with (n=99).

Agree or disagree	frequency	%
Strongly agree	6	6.1
Agree	19	19.2
Disagree	35	35.4
Strongly disagree	39	39.4

Table 51 – I consider my sexuality/ gender identity to be a positive and enriching part of my life (n=95).

Agree or disagree	frequency	%
Strongly agree	43	45.3
Agree	46	48.4
Disagree	5	5.3
Strongly disagree	1	1.1

Social Support

In addition to the research on mental health there is also now a vast literature on the importance of community and 'familial' social support for LGBT people if good mental health and a sense of positive well-being is to be maintained. A great deal of this support would traditionally have come from within the family. Yet many LGBT people cannot rely unconditionally on family members for their support because of family rejection or attempts to protect family sensibilities through 'distancing' (Cant, 1997; Donovan et al. 1999; Hart et al., 1990; Weeks et al., 1999). This doesn't mean that LGBT people should be viewed as isolated individuals living outside the family. Instead, research suggests that LGBT people are building new types of families and commitments based on partnership, friendship and a sense of community (Giddens, 1992; Julien et al. 1999; Weeks et al. 2001). It is only when these networks fail to develop that there is a danger of social isolation and a lack of support.

Who Do You Live With?

Who a person lives with can have important consequences in terms of emotional support and practical care (Hall et al. 1999; Hart et al. 1990). Table 52 shows that for our overall sample living with a same sex partner was the most common form of living arrangement (39.8%), followed by living by oneself (30.6%), then with 'others' (e.g. landlords, student halls, etc.), 'parents', and 'children'. However, there were often marked differences between the sexes. For example, while living with a 'same sex partner' was the most common living arrangement among women and men, it was more common among women (see Tables 53 and 54). Significantly, while our transsexual sample was small, none were living with a partner (see Table 55).

Table 52 – Who do you live with?
Ranked from most to least common form of living arrangement (n=98)

Living arrangements	frequency	%
Same sex partner	39	39.8
I live by myself	30	30.6
Other (e.g. landlord, student halls, cat, dog)	10	10.2
With my parents	9	9.2
With my child/ren	6	6.1
With tenants or lodgers	5	5.1
With other family	4	4.1
With straight friends	4	4.1
With gay male friends	3	3.1
Opposite sex partner	1	1
With transgendered friends	1	1
With my ex-partner	1	1
With acquaintances or strangers	1	1
With lesbian friends	0	0
With bisexual friends	0	0

Table 53 – Who do you live with, by SEX. Top five living arrangements for WOMEN (n=97)

Living arrangements	female (n=37)	male (n=55)	trans (n=5)
Same sex partner	48.6% 18	38.2% 21	-
I live by myself	16.2% 6	34.4% 20	60% 3
With my parents	16.2% 6	5.5% 3	-
With my children	13.5% 5	1.8% 1	-
Other (e.g. landlord, student halls, cat, dog)	8.1% 3	10.9% 6	20% 1

Table 54 –Who do you live with, by SEX. Top five living arrangements for MEN (n=97)			
Living arrangements	**female (n=37)**	**male (n=55)**	**trans (n=5)**
Same sex partner	48.6% 18	38.2% 21	-
I live by myself	16.2% 6	34.4% 20	60% 3
Other (e.g. landlord, student halls, cat, dog)	8.1% 3	10.9% 6	20% 1
With my parents	16.2% 6	5.5% 3	-
With straight friends	2.7% 1	5.5% 3	-

Table 55 –Who do you live with. By SEX (n=97). Top living arrangements for TRANS PEOPLE.			
Living arrangements	**female (n=37)**	**male (n=55)**	**trans (n=5)**
I live by myself	16.2% 6	34.4% 20	60% 3
Other (e.g. landlord, student halls, cat, dog)	8.1% 3	10.9% 6	20% 1
With transgendered friends	-	-	20% 1

Overall, living by oneself was the second most common living arrangement (Table 52). However, living by oneself was the most common living arrangement among our transsexual sample (Table 55), and was more than twice as common among men than among women. By contrast women were approximately three times as likely to live with their 'parents' than men, and approximately six times more likely to live with their 'children'. Given the frequently found emphasis on friends as an important source of support among LGBT people, it was surprising how few people chose to live with them.

There was some evidence that LGBT among our sample might be more likely to live in one-person households than the general population of Luton. Among our sample 30.6% of respondents said that they lived by themselves compared to 28.8% of Luton residents in general at the time of the 2001 census (Luton Primary Care Trust, 2003). However, the definition of one-person households also includes people who live with unrelated people in shared households (Hall et al., 1999). In addition to the 30.6% of our sample who lived by themselves, 5.1% of respondents said that they lived 'with tenants or lodgers', 9.2%, in total, lived with various types of 'friends', and 1% lived with 'acquaintances or strangers'. We also found tentative evidence that, despite living with a same-sex partner increasing with age, living alone also increased with age, and was particularly common for those in the oldest age groups. The trend towards living alone in old age is not unique to LGBT people (e.g. Phillipson, 1998), but given that most social support comes from within the household, LGBT people have been found to express concerns

about the level and appropriateness of support they will receive in older age (Heaphy, Yip and Thompson, 2003; Mitchell, 2004). It is important the service providers dealing with elderly people in Luton are aware of these issues.

Support in Relation to Emotional Problems

In the absence of unconditional emotional support from family, friends often take on a much greater support role among LGBT people (Julien et al., 1999; Nardi 1992; Sarantakos, 1996). In some cases this occurs to such an extent that descriptions have been made of 'friends as family' or 'families of choice' (Weston, 1991; Weeks, Heaphy and Donovan, 2001). Our research confirmed these previous findings with 80.6% of our sample saying they would be 'most likely' to turn to 'friends' for emotional support This placed friends way ahead of any other potential source of support. One reason for this is that friends are regarded as having 'shared understandings' and as being less judgemental than family members (Mitchell, 2004).

Table 56 – Who would you be most likely to turn to if you were experiencing emotional problems such as breakdown of a relationship, or difficulties with a partner? (n=98)
Ranked from most popular to least popular source of emotional support.

Source of emotional support	frequency	%
Friends	79	80.6
Parents	34	34.7
Siblings (brothers/ sisters)	23	23.5
Counsellor/ therapist	22	22.4
Partner	21	21.4
Work colleagues	15	15.3
Health care professional	13	13.3
Other relatives	3	3.1
Neighbours	3	3.1
No one	3	3.1
Other (e.g. ex-partner, myself)	3	3.1
Religious leader	1	1
Children	1	1

The fact that partners do not appear to be prominent sources of emotional support is probably accounted for by the fact that not all people surveyed will have a partner, and that the examples of emotional crisis given in the question both involved partners (see Table 56). However, the fact that LGBT people turn to family members should not be seen as surprising. While many LGBT people experience rejection from family members, many also find that coming out to their parents or siblings brings them closer together. The high proportion (22.4%) of respondents who would seek support from a 'counsellor/ therapist' reflects the fact that therapy is often perceived as being non-judgemental. Notably, only 3.1% (n=3) respondents felt they would have 'no one' to turn to if they were experiencing emotional problems.

When analysed by sex, 100% (n=5) of transsexuals, and 89.2% (n=33) of women said they would turn to friends for emotional support compared to 74.5% (n=41) men. Transsexual respondents were also more likely to turn to family members, such as parents and siblings, compared to women or men (who did so about equally). Transsexuals and men were more likely than women to turn to counsellors/ therapists. But it was men who were most likely to turn to their partners for emotional support; 27.3% of men (n=15) said they would prefer to draw emotional support from their partners compared to 16.2% (n=6) women. Among the three people who said they had 'no one' to turn to, one was female and two were male.

Loneliness versus Support

In addition to who respondents felt they would turn to for emotional support, we also explored the extent to which LGBT people felt lonely and isolated or surrounded by people who affirmed and supported them.

Table 57 – I often experience feelings of loneliness and isolation when I think about my sexuality/ gender identity (n=98).

Agree or disagree	frequency	%
Strongly agree	8	8.2
Agree	21	21.4
Disagree	38	38.8
Strongly disagree	31	31.6

Table 57 shows that the majority of people disagreed with the statement that that they felt lonely and isolated when they thought about their sexuality/ gender identity. This is very important, but still left one in five (21.4%, n=21) who 'agreed' that they felt lonely and isolated to some extent, and 8.2% (n=8) respondents who 'strongly agreed' with the statement. There was virtually no difference between the percentage of women and men who felt lonely or about isolated when they thought of their sexuality/ gender identity, but 60% of transsexuals sampled (n=3) felt this way.

Table 58 – In most cases I am surrounded by people who affirm and support my sexuality/ gender identity (n=98).

Agree or disagree	frequency	%
Strongly agree	33	33.7
Agree	52	53.1
Disagree	12	12.1
Strongly disagree	1	1

On a positive note 33.7% (n=33) of the sample 'strongly agreed' with the statement that, in most cases, they felt surrounded by people who affirmed and supported their sexuality/ gender identity (Table 58). A further 53.1% (n=52) 'agreed' with the statement. Of the 13 people who *didn't* agree with the statement, they were slightly more likely to be male; slightly more likely to be in the middle-aged to older age groups; more likely to have a long-term

illness/ disability; and to include people from a variety of ethnic backgrounds. In other words, these were the groups of people who didn't always feel affirmed and supported (although care must be taken in drawing conclusions because of the small numbers involved in calculating the cross-tabulations).

Support During Ill-Health and Incapacity

While some research suggests that friends remain on a par with partners and family in relation to the provision of care during illness or incapacity (Heaphy, Yip and Thompson, 2003; Nardi, 1992), others suggest that the support of friends is mainly of an emotional type, and that their importance as a source of support declines relative to partners and family when physical care is involved (Hart et al., 1990; Mitchell, 2004). To a large extent our findings reiterated this pattern. During the survey we asked, who would be 'most likely to provide care and support' for the individual if he or she 'became seriously ill' or was 'involved in a major accident'? Such a question can reveal a great deal about perceived levels of social support.

Table 59 – Who would be most likely to provide care and support for you if you became seriously ill or were involved in a major accident? (n=98)
Ranked from most to least likely sources of care and support.

Source of care and support	frequency	%
Parents	62	63.3
Friends	51	52
Partner	49	50
Siblings (brothers/ sisters)	27	27.6
Health care professional	21	21.4
Other relatives	8	8.2
No one	5	5.1
Children	4	4.1
Neighbours	4	4.1
Other (e.g. ex-partner, hope it doesn't happen)	2	2

Table 59 shows that when it comes to physical care and support 63.3% of respondents said that 'parents' would be their most likely source of help compared to only 34.7% who said they would draw on them for emotional support (see Table 56). Friends by comparison had fallen from the first most likely source of emotional support (80.6%) to the second most likely source of physical care and support (52%). Interestingly, 50% of our sample said they would draw on their partner for physical care and support compared to only 21.4% who saw them as the most likely source of emotional support. Mitchell (2004) found that caring relationships between partners were often prioritised above all others, with people only resorting to family and friends when partners were unavailable. This may also partly explain why 'siblings' remain an important source of physical care and support in addition to parents. Notably, only a very small number of respondents had children. For those who did, only a small number (n=4) expected them to provide care and support. This reflects trends in the wider society (Finch and Mason, 1993) as well as

concerns about who will look after many childless LGBT people in old age (Heaphy, Yip and Thompson, 2003). Only a very small number of respondents said they had 'no one' to provide care and support, although 21.4% expected to be reliant on 'health care professionals' for their care.

When analysed by sex female respondents were marginally more likely to say they would draw care and support from parents than males. Transsexual respondents were least likely to expect care and support from parents, and more likely to expect to receive it from friends. There was virtually no difference between the percentage of men (52.7%) and women (54.1%) who expected to receive care and support from partners. Among the five people who felt 'no one' would provide care and support, there were equal proportions of men and women; three were in the 31-40 age group; one had a long-term illness/ disability; no people from minority ethnic groups were included among them.

Mental Health and Social Support: Summary and Recommendations

Mental Health

Overall we found a positive picture of mental health among LGBT people in Luton. 79.8% of our sample were 'out' about their sexuality/ gender identity to 'everyone' or to 'most people'. Only 3% (n=3) were not out to anyone.

50.5% of our sample felt that their mental health had *not* been affected or suffered because of issues relating to their sexuality or gender identity. However, 23.2% had had a 'few problems' and had sought professional help; 7.1% had had 'a lot of problems' and had sought professional help.

73.5% of our sample had never thought about or attempted suicide. 8.2% of the sample had attempted suicide at least once. A further 3.1% had attempted suicide more than once. As a percentage of their sex male-to-female transsexuals and men were more likely to have attempted suicide.

93.7% of the sample agreed to some extent that their sexuality is a 'positive' and 'enriching' part of their life, despite the fact that 25.3% also said they 'sometimes' found the 'stress of being lesbian/ gay/ bisexual/ transgendered' too much to cope with.

Where applicable the Steering Group should work with local mental health services providers and charities to reduce attempted suicide among LGBT people. The helpline discussed in the summary and recommendations for chapter 3 should include an emphasis on helping those people who felt that their mental health had suffered or been affected by issues relating to their sexuality or gender identity.

Social Support

The top three living arrangements among our LGBT sample were: living with a 'same sex partner' (39.8%); living by oneself (30.6%); and 'other' arrangements (10.2%), including living with a landlord or in student halls.

'Friends' were by far the most important source of emotional support among our sample. 80.6% of respondents said they would turn to 'friends' if they were experiencing emotional problems, compared to 34.7% who would turn to 'parents', and 23.5% who would turn to 'siblings'.

70.4% of the sample disagreed that they felt lonely when they thought about their sexuality/ gender identity. 86.8% agreed to some extent that, in most cases, they felt surrounded by people who affirmed and supported their sexuality/ gender identity.

In terms of physical care and support, 'friends' remained an important source of support, but their importance declined relative to 'parents' and 'partners'. 63.3% of the sample said they would look to 'parents' to provide care and support if they became ill or were involved in an accident; 52% said they would look to 'friends'; and 50% would look to a 'partner'.

Service providers should recognise the important role played by friends and partners in addition to 'family' in providing care and support. Providing this type of social support should be included as a key part of the attempt to build local LGBT social networks described in the summary and recommendations for chapter 3.

Chapter 6

Sexual Health

Sexual health covers a particularly wide number of issues and it was not possible to cover all of these in the survey. Importantly, research to date has tended to focus on the increased risk for men-who-have-sex-with-men of HIV/AIDS and other sexually transmitted infections, and we also wanted to address these issues. However, we also thought that it was important to include issues related to women's sexual health. The fact that we did not include issues pertinent to the sexual health of trans people was an omission but also reflected the lack of research in this area. With hindsight the small number of trans people in our sample would have made much of the data meaningless, and the type of research necessary would probably be more suitable at a national and/ or qualitative level. Consequently, in terms of sexual health, we focused on three main areas. These were HIV prevention, vaccination against Hepatitis B, and issues of women's health.

HIV Prevention

In recent years the focus and purpose of HIV prevention strategies have changed a great deal. Firstly, the success of combination therapies has improved the lifespan and quality of life for many people living with HIV (Medical Foundation for AIDS and Sexual Health, 2002). In this context, the British government's sexual health strategy has emphasised increasing HIV testing and reducing the number of undiagnosed and untreated infections as a priority (Department of Health, 2001). Secondly, the patterns of newly diagnosed infections among different social groups have changed. Since 1999 sex between men and women has been the most common route of HIV infection in the UK (Summerfield and Bapp, 2004). However, the number of people newly diagnosed each year whose only risk of acquiring HIV was heterosexual sex within the UK is small, making up around 10% of new heterosexual diagnoses. Around three-quarters of new heterosexual diagnoses each year relate to people from, or who became infected in sub-Saharan Africa (Medical Foundation for AIDS and Sexual Health, 2002).

Patterns of HIV diagnosis in Luton are very similar to those described above. By the end of 2002 the number of people diagnosed with HIV living in the Luton PCT area was 328. Of these 140 were male, and 188 were female. The main route of infection was sex between men and women, with the majority of new HIV infections diagnosed in Luton being acquired abroad (Luton Primary Care Trust, 2003). John (2003) states that between 1998 and 2000 the number of cases of HIV being diagnosed in Bedfordshire quadrupled, but around two-thirds of the county's cases were among Black Africans. While recognising that these changes are important, there is growing debate about whether focus on particular groups affected locally can lead to a neglect of HIV, and other STI, prevention among gay and bisexual men (Cairns, 2003). Although gay and bisexual men are not the only members of the LGBT community for whom the HIV-testing is important (e.g. women who have sex with men, pregnant women), a number of authorities (e.g. Health Protection

Agency) point out that sex between men remains the most likely source of infection for people acquiring HIV in the UK (Department of Health, 2001).

HIV Testing

In this context it is important to know what proportion of LGBT people have been tested for HIV. Table 60 shows that almost half of our sample had been tested for HIV. This figure rose to 71.4% for the men, and 60% (n=3) for our trans people (Table 61). Four of those who described an HIV test as 'not applicable to me' were women. However, one of these women also described herself as 'bisexual'.

Table 60 – Have you ever been tested for HIV? (n=99)
'Missing data' are shown in this table because of the high number of people who sometimes do not respond to questions related to/ perceived to be related to sexual activity.

Whether tested	frequency	%
Yes	46	46.5
No	42	42.4
Not applicable to me	5	5.1
Missing data	6	6.1

Table 61 – Have you ever been tested for HIV? By SEX (n=98).
'Missing data' are shown in this table because of the high number of people who sometimes do not respond to questions related to/ perceived to be related to sexual activity.

Whether tested	female (n=37)	male (n=56)	trans (n=5)
Yes	3 8.1%	40 71.4%	3 60%
No	27 73%	14 25%	1 20%
Not applicable to me	4 10.8%	-	-
Missing data	3 8.1%	2 3.6%	1 20%

The risk of HIV infection overwhelmingly affects sex between men when compared to the risk of HIV to women who only or mostly have sex with other women. These trends were reflected in patterns of HIV testing. It was also the case that male-to-female transsexuals were more likely to have tested, while the only female-to-male transsexual in our sample had not. When male respondents were broken down by age, older respondents were just as likely not to have taken an HIV test as younger ones.

Certainty of HIV Status

Whether or not a person has been tested for HIV does not necessarily tell us how sure they are of their current HIV status (e.g. their test may have been a long time ago and/ or they may have had an unsafe sexual encounter since). Consequently, we also asked respondents, 'How sure are you of your current

HIV status'? Table 62 shows that 56.6% (n=56) of our sample were sure that they were HIV negative, while 24.5% (n=23) were not sure of their status. Overall, 5.1% (n=5) of our sample had been diagnosed as HIV positive. Notably, 10.1% (n=10) of the sample felt that this question was not applicable to them.

Table 62 – How sure are you of your current HIV status (whether negative or positive)? (n=99)
'Missing data' are shown in this table because of the high number of people who sometimes do not respond to questions related to/ perceived to be related to sexual activity.

How sure of HIV status	frequency	%
Sure I'm HIV negative	56	56.6
Sure I'm HIV positive	5	5.1
Not sure of my HIV status	23	24.5
Rather not say	-	-
Not applicable to me	10	10.1
Missing data	5	5.1

Given that gay and bisexual men are more at risk of acquiring HIV than women who only have sex with women, Table 63 also shows current HIV status belief by sex. As might be expected, the percentage of women who are sure they were HIV negative is higher than for men. However, over half (53.6%) the male sample were sure that they were HIV negative. The vast majority of respondents who felt the question was not applicable to them were women, accounting for 21.6% (n=8) women compared to 1.8% (n=1) of men. Most importantly, 33.9% (n=19) of our male respondents were not sure of their HIV status. Additionally 5.4% (n=2) of women and 40% (n=2) of transsexual respondents were also unsure of their HIV status. All of those who stated they were HIV positive were men.

Table 63 – How sure are you of your current HIV status (whether negative or positive)? By SEX (n=98).
'Missing data' are shown in this table because of the high number of people who sometimes do not respond to questions related to/ perceived to be related to sexual activity.

Whether tested	female (n=37)	male (n=56)	trans (n=5)
Sure I'm HIV negative	24 64.9%	30 53.6%	2 40%
Sure I'm HIV positive	-	5 8.9%	-
Not sure of my HIV status	2 5.4%	19 33.9%	2 40%
Rather not say	-	-	-
Not applicable to me	8 21.6%	1 1.8%	-
Missing data	3 8.1%	1 1.8%	1 20%

Access to Condoms

One key strategy for reducing HIV infection is to make sure that condoms and safer sex information are readily available to people who need them. During the survey, therefore, we also asked how easy it was for respondents to 'get hold of condoms for safer sex' if and when they needed them. Table 64 shows that 50.2% of our sample said they could 'always' get hold of condoms if and when they needed them. A further 18.2% felt they could 'sometimes' get hold of condoms when they needed them. Only 1% (n=1) respondent was not satisfied with the level of access to condoms at all. When those people who felt the question was not relevant to them were excluded, 93.1% of respondents were happy with their access to condoms to some degree. All of the 26 people who felt this question was not relevant to them were either female or transsexual (see Table 65).

Table 64 – Are you able to get hold of condoms for safer sex if and when you need them? (n=99)
'Missing data' are shown in this table because of the high number of people who sometimes do not respond to questions related to/ perceived to be related to sexual activity.

Able to get hold of condoms	frequency	%
Yes, always	50	50.2
Yes, sometimes	18	18.2
No	1	1
Not sure	-	-
Not applicable to me	26	26.3
Missing data	4	4

Table 65 – Are you able to get hold of condoms for safer sex if and when you need them? By SEX (n=98).
'Missing data' are shown in this table because of the high number of people who sometimes do not respond to questions related to/ perceived to be related to sexual activity.

Able to get hold of condoms	female (n=37)	male (n=56)	trans (n=5)
Yes, always	5 13.5%	41 73.2%	3 60%
Yes, sometimes	5 13.5%	13 23.2%	-
No	-	1 1.8%	-
Not sure	-	-	-
Not applicable to me	25 67.6%	-	1 20%
Missing data	2 5.4%	1 1.8%	1 20%

When analysed by sex satisfaction with access to condoms was highest for males. In fact, 96.4% (n=54) of the male sample were satisfied with their access to condoms to some degree. This was higher than the satisfaction rate

found by Sigma Research among gay and bisexual male residents of Luton in their annual *Vital Statistics* survey. They found that 77.1% of their sample disagreed with the statement that they had a 'problem getting hold of condoms' (Sigma Research, 2003).

Yet, despite the general level of satisfaction with access to condoms among our respondents, 15.2% (n=15) of our sample believed access to condoms could be made easier. When those who regarded the question as 'not applicable' to them were taken out, the percentage of respondents who thought access to condoms could be improved increased to 24.6%.

Table 66 – Are there any places, or ways, in which your access to condoms could be made easier (n=99).
'Missing data' are shown in this table because of the high number of people who sometimes do not respond to questions related to/ perceived to be related to sexual activity.

Access to condoms could be made easier?	frequency	%
Yes	15	15.2
No	29	29.3
Not sure	17	17.2
Not applicable to me	33	33.3
Missing data	5	5.1

How Can Access to Condoms be Improved?

Overall 16 respondents made comments about access to condoms or how access could be improved. Several respondents perceived that condoms were not as readily available in gay pubs and clubs as they would like, or that they did not seem to be as available as they had been in the past:

"Could be more out in pubs/ clubs".

"Not so available in pubs these days".

Others focused more on the visibility of condoms in all LGBT venues in Luton or where they were placed within the venues. For example, one respondent stated condoms should be "more visible in all gay venues". Another respondent stated that condoms needed to be, "more accessible in gay bars – not on or behind the bar".

The remaining comments emphasised how condoms should be available in places other than LGBT pubs and clubs, and that the 'opening times' of services providing condoms needed to be extended. In terms of the placing of condoms a number of respondents suggested that they should be left at 'cruising grounds' or in other 'public places'. One respondent emphasised that women needed condoms for sex with other women, and that they therefore needed to be placed in venues that women used:

"Women need them for toys – so should be offered at gay places specifically for women".

Several respondents suggested vending machines outside chemists or alongside stands distributing free magazines such as *Luton at Large*. Other ideas included a postal delivery service for condoms or after 'working hours' opening at *The Lodge*. We suggest that the Steering Group works with The Lodge, the Men4Men Project and local GUM services to investigate the possibility of taking up these suggestions.

Vaccination against Hepatitis B

Although men-who-have-sex-with-men are not the only people at risk of infection with Hepatitis B, they do have an increased risk. In this respect, increasing the offer of Hepatitis B vaccine is another key part of the government's strategy on sexual health (Department of Health, 2001). We found that 42.4% of our overall sample had already been vaccinated against Hepatitis B (Table 67), while for males this figure rose to 60.7%. Significantly, the fact that 16.2% (n=6) of our female sample, and 40% (n=2) of our transsexual sample, had also been vaccinated demonstrates that the risk of Hepatitis B infection is not limited to gay and bisexual men.

Table 67 – Have you ever been fully vaccinated against Hepatitis B, including booster injections, in the last five years? (n=99)
'Missing data' are shown in this table because of the high number of people who sometimes do not respond to questions related to/ perceived to be related to sexual activity.

Vaccinated against Hepatitis B	frequency	%
Yes	42	42.4
No	28	28.3
Not sure	2	2
Not applicable to me	21	21.2
Missing data	6	6.1

Table 68 – Have you ever been fully vaccinated against Hepatitis B, including booster injections, in the last five years? By SEX (n=98).
'Missing data' are shown in this table because of the high number of people who sometimes do not respond to questions related to/ perceived to be related to sexual activity.

Vaccinated against Hepatitis B	female (n=37)	male (n=56)	trans (n=5)
Yes	6 16.2%	34 60.7%	2 40%
No	8 21.6%	19 33.9%	1 20%
Not sure	1 2.7%	1 1.8%	-
Not applicable to me	18 48.6%	1 1.8%	-
Missing data	4 10.8%	1 1.8%	1 20%

In terms of the respondents who stated that Hepatitis B vaccination was 'not applicable' to them the vast majority were women. While one man stated that Hepatitis B vaccination was 'not applicable' to him, this may be true because some people are naturally immune to the virus. More importantly, 33.9% (n=19) of men, 21.6% (n=8) of women, and 20% (n=1) of transsexuals, who felt the question was applicable to them, stated they had not been vaccinated against Hepatitis B.

Women's Health

Cervical Cancer Screening

In Luton a number of GP practices are below their targets for cervical cancer screening, with the result that Health Educators have been specifically employed as part of a pilot scheme to increase uptake of testing (Luton Primary Care Trust, 2003). All women between the ages of 25 and 64 are eligible for a free cervical smear test every three to five years. Yet, there is often confusion over whether it is necessary for women who have sex with women to be screened for cervical cancer, both among health professionals, and among the women themselves (Mitchell et al., 2001). It cannot be assumed that simply because women identify as 'lesbian' or 'gay' that their risk of cervical cancer is automatically reduced or negligible (Carr et al., 1999). Consequently, we asked how often women in our sample were 'screened for cervical cancer' in order to examine the extent to which those eligible for smear tests were taking up the option. Notably, the national standard for testing in 2000 was 80%.

Initially 46 people responded to the question about cervical cancer screening although there were only 37 people who were born as women in the sample. Although an option was provided for men to state that cervical cancer screening did not apply to them as males, five men still ticked the 'not applicable – other reason' option, while three male-to-female transsexuals did so also. In order, therefore, to achieve a more accurate picture of the frequency of cervical cancer screening Table 69 has been limited to females only. All those for whom cervical cancer screening was not applicable have also been removed from the table. For example, 5 women stated that screening was not applicable to them because they were under 25, while 2 stated screening was not applicable for 'other reasons'. No women ticked the 'not applicable – over 65' option.

Table 69 – How often are you screened for cervical cancer? For FEMALES only (n=30).

Frequency of screening	frequency	%
Never screened	7	23.3
Over 5 years ago	1	3.3
Every 3 to 5 years	17	56.7
Every 1 to 2 years	4	13.3
Missing data	1	3.3

Table 69 shows that 56.7% (n=17) of women for whom screening was applicable were going for a smear test in line with the government target of at least 'every 3 to 5 years'. In addition 13.3% (n=4) were being screened for cervical cancer more frequently that the government target (i.e. 'every 1 to 2 years'). This means that 70% of women in our sample for whom a smear test was available had had one, which is below the national target of 80%. Almost a quarter (23.3%) of our female sample, who didn't tick a 'not applicable' option, had 'never' been screened. In this respect Health Educators may also need to address the advice they give to lesbians, and to give a consistent message about whether it is still advisable for women who have not had sex with a man to undertake a smear test.

Breast Cancer Screening

A number of studies have suggested that lesbians may have increased risk of breast cancer because of a number of factors (e.g. taking fewer screening examinations, higher rates of alcohol use than among heterosexual women, and higher body mass index – Harrison, 1996). Additionally, while many lesbians do not remain childless, for those who do having no children is known to be associated with higher risk of breast cancer (Department of Health, 2001b). All women aged between 50 and 64 are routinely invited for breast cancer screening every three years under the NHS Breast Screening Programme. Women over 64 are entitled to be screened, but are encouraged to make their own appointments. We wanted to examine whether lesbians and bisexual women who were entitled to routine breast cancer screening were taking up this option. In Luton nine GP practices are below their target for breast cancer screening, with Health Educators, again, having a key role to play in increasing uptake (Luton Primary Care Trust, 2003).

Table 70 – How often are you screened for breast cancer, by AGE GROUP. For females only (n=37).

Frequency of screening	Age group				
	16 to 20	21 to 30	31 to 40	41 to 50	51 to 60
Not applicable – under 50	5 71.4%	3 50%	5 27.8%	2 40%	-
Never screened	2 28.6%	3 50%	6 33.3%	2 40%	-
Over 3 years ago	-	-	2 11.1%	1 20%	-
Every 2 to 3 years	-	-	-	-	1 100%
Every year	-	-	1 5.6%	-	-
Not applicable – other reason	-	-	4 22.2%	-	-

As with the question on cervical cancer screening, a number of male respondents had mistakenly replied to the question. Data for Table 70 has, therefore, been adapted to include female respondents only. Examination of Table 70 shows that for most women routine breast cancer screening was not

relevant because of their age. The only woman in the '51 to 60' age group was screened for breast cancer 'every 2 to 3 years'. Four women from other age groups (i.e. 31 to 40 and 41 to 50) had also been screened for breast cancer. From the small numbers involved this tentatively suggests that there are no major problems in terms of breast cancer screening among our sample.

Sexual Health: Summary and Recommendations

HIV Prevention

Overall 46.5% of our sample had tested for HIV. This figure increased to 71.4% of the male sample. 25% of the male sample had not tested for HIV.

Of those people who had taken an HIV test, 5.1% (n=5) said they were HIV positive. At the time of the survey 56.6% of the sample said they were sure that they were HIV negative (53.6% among the male sample). 24.5% said they were not sure of their HIV status (33.9% among the male sample). Small numbers of women (n=2) and trans people (n=2) also said they were unsure of their HIV status.

93.1% of respondents who felt that the issue was applicable to them said they could 'always' or 'sometimes' get hold of condoms when they needed them. However, 15.2% of the sample thought that access to condoms could be made easier. A variety of suggestions were made improving the distribution of condoms in Luton. The Steering Group should work with The Lodge, the Men4Men Project and local GUM services to investigate the possibility of taking up these suggestions.

Vaccination against Hepatitis B

42.2% of our overall sample had been vaccinated against Hepatitis B, although this figure increased to 60.7% for the male sample. 33.9% of men (n=19), 21.6% of women (n=8), and 20% of trans people (n=1), who felt the question was relevant to them, said they had not been vaccinated against Hepatitis B. The Steering Group should ensure this information is fed back to sexual health service providers in Luton.

Women's Health

70% of women in our sample for whom a smear test was available under the NHS screening programme had had a smear test. This is lower than the national target of 80% and possibly reflects continuing confusion about whether women who have sex with women need to be screened.

The Steering Group should feed this information to Luton Primary Care Trust so that GP practices and Health Educators are aware of these issues. A clear

and consistent policy should be developed for women who have sex with women about when and whether it is necessary for them to take a smear test.

The only woman among our sample for whom the NHS breast cancer screening programme was applicable because of her age had been screened appropriately.

Chapter 7

Physical Health

Like sexual health, physical health includes a vast number of areas. Consequently, we had to limit the survey to a number of areas of key interest in terms of health promotion and LGBT health research. It is important to note that the effects of heterosexism mean that more attention is often paid to the 'harmful' consequences of a LGBT 'lifestyle' than to a heterosexual lifestyle (Robertson, 1998; Wilton 2000). However, the necessity of LGBT pubs and clubs as meeting places, and the increased experience of stigmatisation among LGBT people, has begun to be speculatively linked to higher incidences of smoking, alcoholism, drugs use, and concerns about body image (e.g. Harrison, 1996; Taylor and Robertson, 1994). These in turn have been linked with higher rates of specific illnesses such as cancers, heart disease, stroke and eating disorders (Wilton 2000; Department of Health, 1998). In the survey we concentrated on four main areas: smoking; alcohol consumption; drugs use; and the extent which LGBT people used local leisure/ sports centres to exercise or keep fit.

Smoking

Evidence of higher incidences of smoking among LGBT people to date has largely been anecdotal and speculative. However, one study in the USA found that 36% of adults aged 18 and over who identified as LGBT smoked cigarettes, compared to only 25% of all adults (Albert, 2001). In order to compare levels of smoking among our LGBT sample and the general population we used the same questions that were used in the *Health and Lifestyles in the Four Counties* survey (Health Services Research Unit, 1998) that included neighbouring counties to Bedfordshire such as Buckinghamshire and Northamptonshire. These questions were also used in the LGB needs assessment for Buckinghamshire and Milton Keynes, *What are you like?* (Mitchell et al., 2001).

Ever a Smoker

Table 71 – Are you now or have you ever been a smoker? (n=99).		
Ever a smoker?	**frequency**	**%**
No	43	43.4
Yes	56	56.6

Table 71 shows that just over half of our sample (56.6%) were smokers, or had been smokers at some time. When analysed by sex, there was very little difference between the percentage of women who smoked compared to the percentage of men (Table 72). None of the respondents from Black or Asian minority ethnic groups were found to smoke (although care must be taken because of the small numbers involved).

Table 72 – Are you now or have you ever been a smoker? By SEX (n=98).			
Ever and smoker?	**female (n=37)**	**male (n=56)**	**trans (n=5)**
No	16 43.2%	23 41.1%	3 60%
Yes	21 56.8%	33 58.9%	2 40%

Smoke at Least Once a Day

Although only 56 people said that were currently smokers, or had been in the past, 59 people responded to the question about whether they currently smoked at least once a day (Table 73). Of the 59 people that answered the question in Table 72, 64.4% (n=38) smoked at least once a day. This meant that 38.4% of our overall sample smoked at least once a day. This was lower than the 44.2% who smoked at least once a day in the Buckinghamshire and Milton Keynes LGB sample (Mitchell et al., 2001), but higher than 28% of men, and 26% of women, aged 16 and over, who smoked in Britain in 2001/2002 (Summerfield and Bapp, 2004).

Table 73 – Do you currently smoke at least once a day? (n=59).		
Smoke at least once a day	**frequency**	**%**
No	21	35.6
Yes	38	64.4

Table 74 shows that the men in our sample were far more likely to smoke 'at least once a day' than women. While only 44% of women who smoked did so at least once a day, this compared to 81.3% of men who did so. This suggests that the difference in the percentage of men and women who smoke among our sample, is much higher than that found among the general population.

Table 74 – Do you currently smoke at least once a day? By SEX (n=59).			
Smoke at least once a day	**female (n=25)**	**male (n=32)**	**trans (n=2)**
No	14 56%	6 18.8%	1 50%
Yes	11 44%	26 81.3%	1 50%

Table 75 – Do you currently smoke at least once a day? By AGE (n=59)						
Smoke at least once a day	**Age group**					
	16 to 20	**21 to 30**	**31 to 40**	**41 to 50**	**51 to 60**	**61 to 70**
No	2 28.6%	4 28.6%	5 22.7%	8 57.1%	1 100%	1 100%
Yes	5 71.4%	10 71.4%	17 77.3%	6 42.9%	-	

Interesting patterns also emerged in relation to age and smoking. Table 75 shows that the percentage of smokers who smoked at least once a day is remarkably consistent across the three youngest age groups, and is also much higher than for the three older age groups. In this case smoking may be particularly concentrated among the young and those people in early middle age.

Level of Smoking among Smokers

We also asked, for those smokers who smoked at least once per day, how many times, on average, they smoked during a day. Table 76 shows, that of the 39 people who responded to this question, over half (59%, n=23) smoked between 10 and 20 times per day. Only one person smoked 41 times or more per day.

Table 76 – On average, how many times do you smoke per day? (n=39).

Average number of times smoking per day	frequency	%
Less than 10 times	4	10.3
10 to 20 times	23	59
21 to 30 times	8	20.5
31 to 40 times	3	7.7
41 times or more	1	2.6

However, although more men tended to smoke, the relationship between smoking many times each day and sex of respondent was not straightforward (see Table 77). For example, while the percentage of men (63%) smoking '10 to 20 times' per day was higher than for women (45.5%), it was also true that the percentage of women smoking '21 to 30 times' (27.3%) was higher than for men (18.5%).

Table 77 – On average, how many times do you smoke per day? By sex (n=39)

Smoke at least once a day	female (n=11)	male (n=27)	trans (n=1)
Less than 10 times	2 18.2%	2 7.4%	-
10 to 20 times	5 45.5%	17 63%	1 100%
21 to 30 times	3 27.3%	5 18.5%	-
31 to 40 times	1 9.1%	2 7.4%	-
41 times or more	-	1 3.7%	-

Luton Primary Care Trust's Annual Public Health Report notes that only 3% of smokers quit by themselves without medication. Yet, success rates increase significantly with added support, with smoking cessation services seeing success rates of up to 70%. At the moment smoking cessation group

programmes are targeted by geographical location. However, Luton Primary Care Trust may want to investigate the possibility of targeting specific social groups, including LGBT people, in a similar way to programmes developed by Milton Keynes PCT targeting gay men.

Alcohol Consumption

A number of studies have indicated higher rates of alcohol consumption among lesbians and gay men compared to their heterosexual counterparts (Taylor and Robertson, 1994; Wojciechowski, 1998). For example, Erwin (1993) reports that up to 30% of gay men and lesbians could be considered 'alcoholic', 'heavy' or 'excessive' drinkers compared to 20% for heterosexual men. In the UK surveys suggest that about 30% of men and approximately 15% of women regularly drink more than moderate amounts (1 to 2 units per day, or 7-14 units per week) of alcohol, increasing risk of high blood pressure, cancer and cirrhosis (Summerfield and Bapp, 2004).

Approximately, 90% of adults in Britain drink alcohol (Luton Primary Care Trust, 2003). Table 78 shows that 7.1% of our sample did not drink alcohol at all. This left 92.9% who drank at least some alcohol each week. Around half (58.6%, n=58) of our sample drank less than 14 units of alcohol per week or no alcohol at all. However, 41.4% (n=41) of our sample drank more than 14 units of alcohol per week.

Table 78 – On average, how many units of alcohol do you drink per week? (n=99)
ONE UNIT = 1 glass of wine, OR half a pint of lager/ beer/ cider, OR half a bottle of alcoholic soft drink, OR 1 pub measure of spirits

Number of units	frequency	%
None, I don't drink	7	7.1
1 to 4 units	20	20.2
5 to 9 units	17	17.2
10 to 14 units	14	14.1
15 to 19 units	12	12.1
20 to 24 units	3	3
25 to 29 units	6	6.1
30 to 34 units	7	7.1
35 to 39 units	3	3
40 to 44 units	3	3
45 to 49 units	1	1
50 units or more	6	6.1

When analysed by sex men drank only marginally more alcohol than women; 40.6% of women drank more than 14 units of alcohol per week compared to 46.4% of men who did so. Overall this suggests that our male, and especially our female, samples are particularly heavy drinkers compared to the 30% men, and 15% of women, who drink more than 14 units of alcohol per week in the general population (Buckinghamshire Health Authority, 2000). These figures may at least partly be accounted for by the fact that many respondents

were recruited through LGBT pubs and clubs. However, the transsexual sample, by comparison, were found to be very light drinkers (e.g. 100% of trans people drank 14 units of alcohol or less each week). In terms of age, very heavy drinking (i.e. 40 units or more) was found across the age groups, and was not particularly concentrated in one group more than any other. While all of our Black and Asian respondents drank alcohol, none were found to be heavy drinkers (i.e. none drank more than 9 units per week). The Steering Group should work with Luton Primary Care Trust and the Community Alcohol Team to further investigate alcohol consumption among lesbian, gay and bisexual people, and to find ways of addressing problem drinking.

Drugs Use

It is difficult to obtain accurate information on the scale of drug use, either nationally or locally, because of the fact that the possession of drugs is illegal. The most comprehensive survey of the level of drug use in the general population is the biannual British Crime Survey. According to the figures from this survey for 1996, almost one-third of the population have ever tried drugs, and a tenth have done so in the last year. Figures from the 2001/2002 British Crime Survey show that 15% of men, and 9% of women, aged 16-24 had taken an illicit drug in the previous year.

Table 79 – In the past year, have you used any drugs other than alcohol for recreation purposes (e.g. poppers, cannabis, ecstasy, speed, ketamine, viagra, steroids, etc.)? (n=99)

Extent of drug/s use in the past year	frequency	%
No, I don't use drugs	55	55.6
Yes, once or twice a year	15	15.2
Yes, every month or so	10	10.1
Yes, frequently (at least once a month)	19	19.2

Table 79 shows that over half of our sample (55.6%) had *not* used drugs, other than alcohol, for recreational purposes in the past year (although this was lower than the 61.7% who had not used drugs among Mitchell et al.'s (2001) sample).

Table 80 – In the past year, have you used any drugs other than alcohol for recreation purposes (e.g. poppers, cannabis, ecstasy, speed, ketamine, viagra, steroids, etc.)? (n=98)

Extent of drug/s use in the past year	female (n=37)	male (n=56)	trans (n=5)
No, I don't use drugs	28 75.7%	23 41.1%	3 60%
Yes, once or twice a year	3 8.1%	11 19.6%	1 20%
Yes, every month or so	3 8.1%	6 10.7%	1 20%
Yes, frequently (at least once a month)	3 8.1%	16 28.6%	-

This meant that 44.4% had used drugs at some stage in the past year, and that almost one in five (19.2%) had done so 'frequently' (i.e. at least once a month). Notably only 7% of the Buckinghamshire and Milton Keynes LGB sample had used drugs 'frequently' (Mitchell et al., 2001).

Table 80 shows that women and transsexual people were more likely than men not to use drugs at all. Men were also the most likely of the sexes to use drugs 'frequently'. When analysed by age drug use existed across the different age groups. No particular age group stood out as using drugs more 'frequently'. In terms of ethnicity the White Irish group stood out in terms of 'frequent' drug use. Overall 50% of this group had used drugs frequently (compared to 18.3% of the White British group), although this only represented n=4 respondents.

Exercise and Use of Leisure/ Sports Facilities

Evidence of the impact of being LGBT on levels of exercise is limited and usually very speculative. Some people have suggested a link between increased pressure to be attractive in the gay male scene (so called 'body fascism'), resulting increases in body dissatisfaction, and increased levels of physical exercise (e.g. Herzog et al., 1991; Harrison, 1996). Conversely, because lesbians can escape the pressures of heterosexual femininity to be thin, some have suggested that lesbians may be more prone to be over-weight (Warchafsky, 1992; Wojciechowski, 1998). However, Mitchell et al. (2001) found no difference between the level of physical activity among LGB people and the wider population. By contrast in our survey we focused on whether LGBT people used leisure/ sports centres or health clubs to exercise or keep fit, at least partly in direct response to a request for this information from Leisure Services. Importantly, Luton became a *Sports Action Zone* in 2001 (Luton Primary Care Trust, 2004).

First of all we asked whether respondents used 'leisure/ sports centres or health clubs in Luton for exercise or to keep fit'? Table 81 shows that around one-third (34.3%) of our sample did use leisure/ sports centres or health clubs for exercise, or to keep fit, to some extent. However, 65.7% of the sample did not.

Use of Leisure/ Sports Centres and Health Clubs

Table 81 – Do you use leisure/ sports centres or health clubs in Luton for exercise or to keep fit? (n=99)		
Extent of use of leisure/ sports centres, etc.	**frequency**	**%**
No	65	65.7
Yes, several times a week	6	6.1
Yes, at least once a week	12	12.1
Yes, at least once a month	5	5.1
Yes, but infrequently (less than once a month)	11	11.1

For those respondents who did use a leisure/ sports centre or health club in Luton, we asked them to specify which centre or club they used, or used the most. Table 82 shows that the 'Living Well' gym in the centre of Luton was by far the most used centre/ club among our sample, with one respondent specifically stating that it was "very friendly".

Table 82 – Which leisure/ sports centre or health club do you use or use the most often? (n=34) Ranked from most to least used.		
Leisure/ sports centre or health club	**frequency**	**%**
Living Well	11	32.3
Lea Manor Recreation Centre	4	11.8
Wardown Swimming Pool	4	11.8
Luton Regional Sports Centre	3	8.8
Dunstable sports/ leisure centre	2	5.9
Hightown Recreation Centre	2	5.9
Bodylines Gym	1	2.9
College gym	1	2.9
David Lloyd	1	2.9
Leisure Plaza	1	2.9
Putteridge	1	2.9
Snady Sports Centre	1	2.9
Vauxhall Sports Club	1	2.9
Missing data	1	2.9

When the extent to which centres/ clubs were used was analysed by sex, women were more likely to use them on a regular basis than men or trans people (Table 83). In fact, 71.4% of men *didn't* use leisure/ sports centres or clubs to exercise/ keep fit, and a further 16.1% only used them 'infrequently'. However, trans people were even less likely to use centres or clubs than men.

Table 83 – Do you use leisure/ sports centres or health clubs in Luton for exercise or to keep fit? By SEX (n=98)			
Extent of use of leisure/ sports centres, etc.	**female (n=37)**	**male (n=56)**	**trans (n=5)**
No	20 54.1%	40 71.4%	4 80%
Yes, several times a week	5 13.5%	1 1.8%	-
Yes, at least once a week	7 18.9%	5 8.9%	-
Yes, at least once a month	4 10.8%	1 1.8%	-
Yes, but infrequently (less than once a month)	1 2.7%	9 16.1%	1 20%

The fact that four out of the five of the transsexual respondents did not use centres or clubs, and that the only other transsexual respondent did so

'infrequently', was at least partly reflected in comments that such spaces were "not transgender friendly" and that appropriate changing facilities were not available. For example, in the additional comments section of the questionnaire one respondent wrote: "need cubicles in male changing rooms for FTM [female to male transsexuals]". We recommend that Luton Borough Council work towards providing the option of single cubicles or changing areas in all of its leisure/ sports facilities. This would not only reflect the needs of trans people, but would also account for the needs of privacy related to religion or disability.

Reasons for Not Using Leisure/ Sports Centres among LGBT People

Of course, the fact that the majority of our respondents did not use leisure/ sports centres or health clubs to exercise, or keep fit, does not imply that they undertake no exercise at all. There are many ways in which people can exercise/ keep fit that does not involve going to a leisure/ sports centre or health club (e.g. cycling, walking, gardening, etc.). Many people prefer to exercise at home, with this option being the second most frequently occurring reason given among our sample for not using leisure/ sports centres in Luton (see Table 84).

Table 84 – Reasons given for not using sports/ leisure centres or health clubs to exercise/ keep fit Luton.
Ranked from most to least frequently given reason.

Reason	frequency	%
Not convenient to where I live (n=68)	18	26.5
I prefer to exercise/ keep fit at home (n=69)	14	20.3
Don't have time to exercise/ keep fit (n=68)	11	16.2
I don't perceive facilities in Luton to be LGBT-friendly (n=67)	11	16.4
Facilities in Luton are too expensive (n=69)	10	14.5
Other (e.g. exercise outdoors, live in less enlightened area, not aware what's available) (n=67)	10	14.9
Not interested in exercise/ keeping fit (n=68)	9	13.2
Not convenient to where I work/ study (n=68)	9	13.2
Facilities in Luton are poor (n=67)	3	4.5
Facilities outside Luton are better (n=67)	2	3
I don't perceive facilities to be friendly for other reasons (e.g. to women) (n=67)	0	0

Preferring to exercise 'outdoors' also featured among the 'other' reasons for not doing so. The comments below are typical of some of those made by respondents:

“I did belong to a gym but got bored with the exercises. I now ride a bicycle and do things like DIY, gardening, etc. for exercise”.

“I have not gone to a health club for the last four years. However, I do a little at home”.

Finally, we explored the reasons why respondents felt that they did not want to use leisure/ sports centres or health clubs in Luton (see Table 84). In particular, we wanted to find out the extent to which these facilities were not perceived as LGBT-friendly compared to other possible reasons. Notably, of those people for whom the question was relevant, 26.5% (n=18) stated that their main reason for not using sports/ leisure centres or health clubs in Luton was that they were ‘not convenient to where I live’. This was closely followed by the 20.3% of respondents who preferred to ‘exercise/ keep fit at home’. However, 16.2% (n=11) respondents also said that they didn’t ‘have time to exercise/ keep fit’. Very few people perceived facilities in Luton to be poor, or that facilities outside of the town were better.

In terms of our key question, 16.4% (n=11) respondents said they thought that sports/ leisure centres or health clubs in Luton were not friendly to LGBT people (i.e. 11.1% of the entire survey sample). This meant that a significant minority of respondents were put off of using sports/ leisure centres because they perceived them not to be LGBT-friendly. Notably, the percentage of transsexuals (40%, n=2) and men (15%, n=6) who felt such centres/ clubs were not LGBT-friendly was higher than the percentage of women (9.1%, n=2) who felt this way. In terms of age groups, respondents in the 41 to 50 age group were most likely to perceive centres/ clubs not to be LGBT-friendly (26.7%, n=4). Importantly, 40% (n=4) of those with a long-term illness/ disability perceived sports/ leisure centres or health clubs not to be LGBT-friendly compared to 14% (n=7) respondents without a health problem or disability. None of the Black or Asian respondents perceived sports/ leisure centres or health clubs to be unfriendly to LGBT people.

Physical Health: Summary and Recommendations

Smoking

Although 56.6% of our sample were smokers, or had been at some time in the past, only 38.4% of the overall sample smoked at least once a day at the time of the survey. However, this is higher than the 28% of men, and 26% of women, who smoke in the general British population.

Of the 59 people in our sample who smoked at least once a day, 81.3% of men did so, compared to 44% of women. Most male, female and transsexual smokers smoked between 10 and 20 times a day.

The Steering Group should explore with Luton Primary Care Trust's smoking cessation services the possibility of establishing a cessation group targeted at LGBT people.

Alcohol Consumption

While trans people in our sample were found to drink very little alcohol, men and women were found to be heavy drinkers compared to the general population; 46.4% of men, and 40.6% of women, drank 14 or more units of alcohol per week compared to 30% and 15% for men and women respectively in the general population. However, 58.6% of the overall LGBT sample drank less than 14 units of alcohol per week or none at all.

The Steering Group should work with Luton Primary Care Trust and the Community Alcohol Team to further investigate alcohol consumption among lesbian, gay and bisexual people, and to find ways of addressing problem drinking.

Drugs Use

Although 55.6% of respondents had not used drugs, this was lower than the 61.7% of LGB people who had not used drugs in a directly comparable sample for Buckinghamshire and Milton Keynes. 44.4% of those sampled had used drugs other than alcohol for recreational purposes at least once in the past year; 19.2% had done so frequently (i.e. at least once a month) compared to 7% in the Buckinghamshire and Milton Keynes sample.

The Steering Group should work with appropriate agencies in Luton to help LGBT people avoid problematic drug users.

Exercise and Use of Leisure/ Sports Facilities

Around one-third (34.3%) of our sample used leisure/ sports centres or health clubs in Luton to exercise or keep fit. The 'Living Well' gym stood out as the facility that was used the most among LGBT people. Many people preferred to exercise outdoors or at home.

16.4% of those people who didn't use leisure/ sports centres or health clubs in Luton said a key reason for their decision was that they felt such spaces were not LGBT-friendly. Men and transsexuals were more likely to feel this way, with particular issues arising for trans people in terms of changing areas.

We recommend that the Steering Group works with Luton Borough Council Leisure Services to ensure that non-discrimination policies against LGBT are clearly in place and displayed. The council should also work towards offering cubicle changing facilities, for both male and female changing areas, in all its leisure/ sports centres or health clubs.

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