Health needs assessment of lesbian, gay, bisexual, transgender and non-binary people

FULL RESEARCH FINDINGS REPORT

Prepared for:

NHS Greater Glasgow & Clyde, NHS Lothian and Public Health Scotland

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Traci Leven
TRACI LEVEN RESEARCH | GLENORCHY, WEST BALGROCHAN ROAD, TORRANCE G64 4DH 07939898722

Foreword

I am pleased to introduce this survey report which is the final part of the Health Needs Assessment of Lesbian, Gay, Bisexual, Transgender and Non-Binary people (LGBT+) in Scotland.

The Health Needs Assessment was instigated in 2019, with the aim to describe in detail the inequalities in health and wellbeing experienced by Scotland's LGBT+ communities and, through dialogue with LGBT+ people, to identify ways in which our public health systems could work with LGBT+ people to bring about the changes most likely to make a positive difference.

This Scotland-wide survey, undertaken in the summer of 2021 after a delay arising from the COVID 19 pandemic, saw LGBT+ people respond in large numbers to share their experiences and, importantly, their wishes for COVID recovery priorities.

The COVID 19 pandemic has impacted all our lives, including the LGBT+ community. Where there is a difference, however, is that, prior to the pandemic, the health and wellbeing of the LGBT+ population was already markedly poorer than that of the background population of Scotland. LGBT+ people therefore experienced the challenges of the pandemic from a different starting position than many other people in society, meaning that the impact of COVID has, in some instances, been particularly detrimental. As we begin to recover as a society, we therefore need to ensure that this recovery addresses the issues reported here.

This report makes for difficult reading. There is not a single indicator of health and wellbeing reported where the outcomes are not poor and deeply concerning. There is also still much work to do to make sure our health services in Scotland are fully inclusive for LGBT+ people. The findings especially in relation to mental health are particularly profound. Whilst it is evident that ongoing work is needed on all aspects of health and wellbeing for LGBT+ people, mental health is clearly where much of this effort needs to focus.

I particularly welcome the co-produced recommendations framed by LGBT+ stakeholders and public health practitioners. They are ambitious but achievable. Already work has started towards addressing some of the themes. Scotland has taken strong steps towards providing LGBT+ inclusive education in our schools. We have also commenced work on modernising our national gender identity services through our NHS Gender Identity Service Strategic Action Framework.

With the publication of this report I look forward to seeing an acceleration of the change needed to realise our aspiration of a Scotland that is safe, welcoming, inclusive and healthy for all LGBT+ people.

Professor Nicola Steedman,

Scottish Deputy Chief Medical Officer

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Abbreviations

ADHD	Attention Deficit and Hyperactivity Disorder
ASD	Autistic Spectrum Disorder
GGC	Greater Glasgow & Clyde
GIC	Gender Identity Clinic
GRS	Gender Reassignment Surgery
LGB	Lesbian, gay and bisexual
LGBT+	Lesbian, gay, bisexual, transgender and non-binary and all other non-heterosexual and non-cis identities
MSM	Men who have sex with men
NHSGGC	NHS Greater Glasgow & Clyde
RSHP	Relationships, Sexual Health and Parenthood (in Education)
SHRE	Sexual Health and Relationship Education
WSW	Women who have sex with women

Executive Summary

Health Needs Assessment

The health needs assessment (HNA) was commissioned by NHS Greater Glasgow and Clyde (NHSGGC) and NHS Lothian – and from 2020 onwards Public Health Scotland - who recognised that there are gaps in knowledge about the health and wellbeing of LGBT+ groups. The comprehensive HNA sought to better inform approaches to public health for LGBT+ people, differentiated for each of seven groups: lesbian and gay women, gay men, bisexual women, bisexual men, trans women, trans men (trans masculine) and non-binary people across the Greater Glasgow & Clyde and Lothian areas.

The initial plan was to conduct the HNA in three stages – a literature review, qualitative engagement with LGBT+ people and staff providing services to LGBT+ people, and a health and wellbeing survey of LGBT+ people. The COVID pandemic caused some augmentation of the research and lengthening of the original timescale. The full HNA ultimately comprised:

- A **literature review (2019)-** focussing on published and grey literature from the previous 10 years in the UK with a particular emphasis on Scotland. See http://hdl.handle.net/11289/580318.

- **Qualitative research (2019)** including engagement via interviews and focus groups with 175 LGBT+ people and services and staff supporting LGBT+ communities. See https://www.stor.scot.nhs.uk/handle/11289/580258.

- **Qualitative research on the effects of the pandemic (2020)** through online focus groups with 32 LGBT+ people. See: https://www.stor.scot.nhs.uk/handle/11289/580300

- **Qualitive work with LGBT+ Deaf and Deafblind people (2021)** with three participations (unpublished).

- **A national online survey (2021)** with 2,358 LGBT+ respondents.

Overall Findings

Overall, the HNA has evidenced that LGBT+ people face health inequalities on every measure of wellbeing (social, physical, mental and emotional, financial etc). This is true for all LGBT+ groups, but non-binary and trans people consistently demonstrate the worst health and wellbeing indicators and bisexual women also have particularly poor indicators for mental wellbeing.

Some of the key findings from the HNA are presented here followed by the recommendations proposed.

Social Health

Loneliness and Isolation: All elements of the HNA highlighted that LGBT+ people are much more likely than others to feel isolated and/or lonely, and the COVID pandemic exacerbated this, with LGBT+ people particularly affected when they were unable to connect with the LGBT+ community. Nearly three in four (73%) survey respondents said they ever felt isolated from family and friends and nearly two in five (38%) had felt lonely all of the time or often in the previous two weeks. Trans and non-binary people showed the highest levels of isolation and loneliness.

Discrimination and negative attitudes: While LGBT+ people felt that generally society had become more accepting of same sex couples and LGB identities, attitudes towards trans and non-binary people were not felt to have become as accepting, and indeed some felt these had taken a 'backward step' and a negative narrative around trans identities had become prevalent particularly on social media often in reference to the debate around the Gender Recognition Act. The qualitative research also highlighted the issue of biphobia and 'bi-erasure' faced by bisexual men and women. Overall, nearly half (44%) of LGBT+ people in the survey said they had been discriminated against in the last year, but this was highest for non-binary (65%), trans masculine (62%) and trans women (55%).

Role of the LGBT+ Community: In the qualitative research, many LGBT+ people stressed the importance of being part of the LGBT+ community on their wellbeing. Being part of this community provided them with support, validation and a sense of belonging. However, there was also much discussion about the negative aspects of the LGBT+ community and how this could be detrimental to mental wellbeing. This included the LGBT+ community itself being perceived as not fully inclusive (e.g. biphobia and transphobia from within the community, and discrimination on the basis of disability, race or religion). Free text responses in the 2021 survey highlighted an emerging division between sections of the LGB community (particularly cis women) and trans people (particularly trans women). Survey responses indicate an increasing sense, among some sections, of the loosening of ties among LGBT+ identities as an umbrella concept.

Abusive Relationships

Several LGBT+ participants in the 2019 qualitative research described a history of abusive and violent relationships and sexual encounters. Some groups felt that they were particularly vulnerable to falling prey to abusive and unhealthy relationships and these included disabled people, autistic people, bisexual women and trans women. The survey findings show that 37% of LGBT+ respondents had ever experienced an abusive relationship; identity groups with the highest proportion reporting abusive relationships were trans masculine (48%), non-binary (45%), bisexual women (43%) and trans women (38%). Those with a limiting condition or illness and those with autism or ADHD were more likely to have experienced an abusive relationship. Only 17% of those who had been in an abusive relationship had accessed any help or support.

Physical Health

The literature review highlighted evidence that LGBT+ people are less likely than others to rate their health positively and overall, LGBT+ people (particularly trans and non-binary)

appear to be more likely than others to have an illness or disability. The survey corroborated this – only 59% overall rated their general health positively. Gay men and gay/lesbian women were the most likely to rate their health positively, while trans masculine and non-binary people were the least likely. A third (33%) of LGBT+ people had a long-term condition or illness that substantially interferes with their day to day activities. Trans and non-binary people were the most likely to have such conditions.

Neurodiversity

The literature review highlighted evidence that Autistic Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD) may be more prevalent among LGBT+ people, particularly trans people. The qualitative research showed how LGBT+ people with these conditions could be particularly isolated and or/vulnerable to abuse. Having both gender dysphoria and ASD or ADHD could confound diagnosis of either condition. The survey found that 23% of trans masculine and 26% of non-binary people had ADHD; 29% of trans masculine and 26% of non-binary people had ASD.

Mental and Emotional Wellbeing

General mental health, depression and anxiety: The literature review identified a wealth of evidence indicating that LGBT+ people in Scotland are at much higher risk of mental health problems than heterosexual/cisgender people. Studies have linked mental health problems with minority stress, but have also highlighted that mental health problems are compounded by experiences such as bullying, discrimination, hate crimes and social isolation. This was also apparent from the qualitative research in which the issues around social and mental health were clearly interlinked. Experience of both depression and anxiety was very common, and most LGBT+ people in the qualitative research indicated that they had suffered from both. The survey showed that overall more than half (54%) of respondents said they had mental health problems e.g. depression/anxiety/stress, but this was higher for trans masculine (75%), non-binary people (72%) and bisexual women (61%). Only one in four (25%) survey respondents rated their general mental and emotional wellbeing positively – but this was lowest for non-binary (9%) and trans masculine (12%).

Self-Harm, eating disorders: Overall, 58% of survey respondents had self-harmed but self-harm was most prevalent among trans masculine (83%), non-binary people (82%) and bisexual women (70%). Nearly two in three (64%) respondents indicated signs of eating disorders (eating and making themselves sick, restricting or binging on food). Signs of eating disorders were most prevalent among trans masculine, non-binary people and bisexual women.

Suicidal thoughts and behaviours: The literature review included many sources which demonstrate a high prevalence of suicidal thoughts and behaviours among LGBT+ people. Indeed, many of those who engaged with the qualitative research had contemplated or attempted suicide. Trans and non-binary people were particularly likely to speak about suicidal thoughts, although these tended to subside after transition. For all LGBT+ groups, those who appeared most susceptible to suicidal thoughts included those growing up in cultural or religious groups who were not accepting of LGBT+ identities, those who felt isolated or did not have supportive family or friends, and victims of abuse. Asylum seekers were especially likely to have attempted suicide. Of those who answered the question in the survey, nearly one in three (31%) said that they had ever made an attempt to end their life. Although

the prevalence of suicide attempts was high across all LGBT+ groups, it was highest among trans masculine and non-binary people, with nearly half of respondents in these groups saying they had made a suicide attempt.

Behaviours Impacting Wellbeing

Smoking: The literature review showed that smoking rates were higher for LGBT+ people than for straight cis people. Many of those who engaged with the qualitative research were smokers. Some linked this to mental health (e.g. using smoking as stress relief), and it was felt that depression and other mental health problems were not conducive to a successful attempt to stop smoking. One in seven (14%) respondents to the survey were current smokers – higher than the latest available data for Scotland (9%).

Alcohol: The literature review cited numerous sources which show that LGBT+ people are more likely to drink alcohol at high or problematic levels. This was substantiated by the qualitative research, with many interviews and group discussions involving much discussion around alcohol as an issue for many LGBT+ people. Some used alcohol at problematic levels, and some had a history of addiction to alcohol. One of the common reasons for using alcohol excessively was 'self medication' and as a coping mechanism to deal with depression, anxiety and stress. Many also pointed to the fact that the gay scene and other LGBT+ social spaces were almost exclusively focussed on alcohol or in places where alcohol was served. Some felt that the only way to socialise with other LGBT+ people or to meet potential partners was to go to bars and clubs and this could lead them to drink more alcohol than they would otherwise. Alcohol was also used by many as a means of losing social and sexual inhibitions. Most (82%) survey respondents said they drank alcohol, at least sometimes. One in four (26%) drank twice a week or more. Alcohol consumption was most prevalent among gay and bisexual men – one in three of whom drank alcohol twice a week or more.

Drugs: In the qualitative research, use of illegal drugs and legal highs were not reported to the same extent as alcohol, but a significant proportion of LGBT+ people who engaged with the research spoke of using drugs either historically or currently. Use of drugs was often linked to mental health problems – both as a consequence and cause of mental health problems. Some gay and bisexual men also used drugs for chemsex and this could be problematic as it was often associated with risky sex or men finding themselves in vulnerable situations. Survey findings show that just under half (44%) of LGBT+ people had used drugs.

Physical activity: The survey showed that there were large sections of LGBT+ people who had a desire to participate in physical activity (e.g. gym, exercise classes, team sports) but who did not currently do so. The qualitative research highlighted a number of barriers to participation in sport and exercise. Gay men in particular felt excluded from the 'laddish culture' in many sports and some spoke about anxieties around communal changing and showering with straight men in sports facilities. Trans and non-binary people had practical and emotional barriers to participation in sports and physical activity including communal or gender-segregated changing rooms at gyms and other sports venues which caused high levels of anxiety or were deemed completely inappropriate. There were also practical considerations around what to wear for sports and exercise, and many trans people said they would feel too self-conscious exercising in any way with other people around. Gender segregation in sports and strict rules about gender were also barriers to trans and non-binary people who were interested in participating competitively. The survey corroborated all these barriers, but cost was also identified as a significant barrier to participation for many.

Online activity: The qualitative research in 2019 highlighted that some trans and particularly non-binary people often used online gaming as a means of interacting in a non-gendered way, or trying out genders in a virtual environment. Among Gender Identity Clinic (GIC) professionals, there was some concern that this led to people not spent sufficient time socialising in the real world in their preferred gender. Social media was largely viewed as a very good way for people to connect to other LGBT+ people, but also social media could be very detrimental to mental health and self-confidence where negative messages and attitudes relating to LGBT+ people were prevalent. The damaging effects of social media were augmented during lockdown, and this included a period of heightened anti-trans rhetoric on social media, at a time when people were feeling isolated and vulnerable. Nearly all (92%) survey respondents used social media daily. One in nine (11%) survey respondents gave responses indicating a Social Media Disorder.

Financial Wellbeing and Homelessness

The qualitative research revealed significant financial impacts which were directly or indirectly related to LGBT+ identities. These includes many LGBT+ being compelled, due to lack of access or long waiting times, to pay for private treatment services such as gender identity services, mental health support and fertility services. There were also financial impacts of young LGBT+ people leaving the family home to live independently due to family relationship difficulties, rural to urban migration to access LGBT+ services and social support, cost of travel to use LGBT+ services, and the financial impacts of addictions. These issues also made homelessness more common among LGBT+ people. Most (88%) survey respondents had financial worries at least some of the time. One in six (18%) had experienced food insecurity in the previous 12 months. One in eight (13%) had ever been homeless.

Experience of Health Services

GP Services: The qualitative research found that overall, most were happy with the care they received from their GP and most of those who were out to their GP had positive experiences. However, there were also issues around heteronormative assumptions, examples of GPs misdiagnosing people through assumptions made about their sexuality or gender identity, inadequate knowledge about some identities, and some concerns around confidentiality. In the survey, one in seven (15%) trans women and trans masculine people felt that they had been treated unfairly due to their LGBT+ status the last time they used their GP service, compared to less than 5% of all other groups.

Mental health services: Use of mental health services in the last year was most common among trans masculine (44%) and non-binary (40%) people. Of all those who had used mental health services, 64% said the staff showed an appropriate understanding of LGTB+ issues. In the qualitative research, there was huge frustration at the long waiting lists of mental health services. Across all LGBT+ groups there was much reliance on third sector providers for counselling and support, many of which were dedicated LGBT+ services. Also, many had used private mental health services.

Gender Identity Clinics (GIC): The qualitative research in 2019 highlighted huge frustration and dissatisfaction with the GIC in both Glasgow and Edinburgh. Waiting times for an initial appointment at that time were around 18 months. For those who had made the decision to transition, this was a long and difficult wait during which they largely felt unsupported. Many opted to seek private treatment for hormones or buy hormones on the

internet. By the time of the 2021 survey, waiting times for the GIC had increased to approximately three years, and trans and non-binary people awaiting treatment were frustrated with the lack of communication from the GIC. In the survey, those who had been waiting six months or more were asked to describe the impact this had on them. Descriptions echoed the accounts from the qualitative research, with mental health impacts by far the most commonly described. Many spoke of anxiety, depression and anguish caused by the prolonged wait and continued dysphoria. Some mentioned suicidal thoughts and self-harm. There were also very significant financial impacts from funding private treatment, and physical impacts (e.g. from continued chest binding). The qualitative research highlighted that those using the GIC will often hide significant information such as mental health problems, suicide attempts, and even true gender identity for fear that treatment would be delayed or denied. This was confirmed by survey responses with significant proportions not disclosing these. Just one in four (26%) rated their experience of the GIC positively.

Wish List and Recommendations

Recommendation setting event: An online event was held in March 2022 at which a summary of the findings presented in the report was presented. There were 160 attendees from across Scotland, comprising NHS staff, Scottish Government and 3rd sector organisations. Attendees were then tasked with discussing each of the nine 'wish list' items identified in the qualitative research and suggesting recommendations based on these. The wish list items from the qualitative research are presented below together with the recommendations relating to them.

Wish list item: LGBT+ spaces for socialising without a focus on alcohol

1. **A mapping exercise should be conducted to map existing provision of groups and activities for LGBT+ people, identifying good practice and gaps in provision in terms of geography and identity groups.**
2. **Every local authority in Scotland should provide or fund at least some groups or activities specifically for LGBT+ people.** It is recognised that remote and rural areas are unlikely to have large and diverse LGBT+ populations. Provision of groups and activities must be to scale of population. Where demographics allow, provision of groups and activities must encompass cultural, sport and physical activity, social interest groups as well as targeting specific identity groups.
3. **An inclusive LGBT+ social space (hub or café) should be established at least in the largest cities in Scotland (e.g. Glasgow, Edinburgh, Dundee, Aberdeen, Inverness).** These should be welcoming, inclusive and safe spaces for people from all LGBT+ groups.
4. **The development of LGBT+ social spaces and opportunities should be community-led.** To do this well, local areas will need to ensure local 3rd sector organisations are sufficiently resourced.

Wish list item: LGBT+ education in schools

5. **Investigate the extent to which LGBT+ inclusive aspects of Relationship, Sexual Health and Parenthood education (RSHP) and other curricular areas are being used and applied in schools.**
6. **Ensure staff training and continual professional development provides staff with the confidence to deliver inclusive education.**

7. **Schools should strive to achieve a charter mark or other formal recognition of inclusivity.**
8. **School based approaches to reducing abuse/sexual violence (e.g. *Equally Safe)* should be reviewed for LGBT+ inclusiveness.**

Wish list item: Training for health and other staff

9. **LGBT+ awareness and inclusivity training should be mandatory and organisations should be accountable for keeping up to date with LGBT+ training needs.** Such training would be applicable across all public services and open to all 3rd sector and private sector.
10. **LGBT+ training should be reviewed and updated and capacity should be built to deliver training.** This will require financial investment. Third sector organisations may be best place to deliver such training. LGBT+ communities should be involved in the development.
11. **NES should work with NHS Boards and LGBT+ communities to produce a new LGBT+ Awareness e-learning module for NHS staff across Scotland.**
12. **General LGBT+ inclusivity training should be delivered to all staff in all positions within organisations. Speciality training should also be developed for specific roles to address specific inclusive practice (e.g. for mental health care; sexual and reproductive health care; trauma informed practice development, etc).**
13. **LGBT+ issues and inclusiveness should be incorporated into undergraduate and post graduate education across disciplines including medicine, nursing, social work, education, etc.**

Wish list item: Mental health waiting lists and appropriate services

14. **Investment should be made in mainstream NHS mental health services to ensure shorter waiting lists for counselling and other therapies.**
15. **Training for mainstream mental health professionals (see recommendations 9-13) should ensure that they have the awareness, knowledge and skills to treat LGBT+ people appropriately.**
16. **Provide more funding to 3rd sector organisations to expand services in dedicated LGBT+ counselling and non-therapeutic early intervention.** This should include dedicated referral routes for those waiting to use Gender Identity services and for asylum seekers.

Wish list item: Improvements to the GIC

17. **Consistent and universal protocols should be developed and applied, supported by relevant training, to ensure that primary care services are involved in transgender and non-binary health care. This would include bridging hormones for those on the waiting list and shared care agreements and shared pathways.**
18. **Online video consultations, initiated during the pandemic, should continue and be offered as part of the core service delivery model for the Gender Identity Clinics (GIC).**

19. **Considerable investment is needed to increase capacity and reduce waiting times within the GIC.**
20. **To increase capacity, more clinicians need to be encouraged into the speciality. Training programmes or the development of a specialist post-graduate programme in trans healthcare with a Scottish university may be instrumental in this.**
21. **Redesign services to be more person-centred and patient-led in order to reduce the extent to which GIC clinicians are perceived to act as 'gatekeepers' to accessing care.**
22. **Improve communication through investment in GIC admin and support, including:**
    a. Increasing the number of administrative staff allocated to support GIC services
    b. Streamline admin processes to ensure there are no delays for letters and reports, and investigate how enquiries can be responded to more quickly
    c. Investigate the possibility of a 'care navigator' system which would mean those referred to the GIC would have a named person they could contact who would support them through the process and system.
23. **Reform to GIC and trans health care should be informed by former service users.**

Wish list item: More services being visibly LGBT+ inclusive

24. **Organisations should be clear that their services are inclusive and should work with LGBT+ people to design and monitor provision. They should ensure that their website(s) and their physical environment where services are run (including services delivered in people's homes), clearly demonstrate that all people are welcome to use their service.** This should be backed up with appropriate training.
25. **NHS Scotland/NHS Boards should ensure all generated letters clearly demonstrate that all NHS services are inclusive.**
26. **Pro-active engagement with LGBT+ people should seek to maximise uptake of NHS screening services.**
27. **Complaints processes and complaints logging should be structured in a way that it is possible to search for complaints which relate to discrimination relating to protected characteristics including sexual orientation and trans or non-binary status. Complaints processes should be transparent.**
28. **NHS and other public services should engage in formal accreditation or external assessments to demonstrate inclusivity and increase confidence in service users.**

Wish list item: Support for LGBT+ victims of domestic abuse

29. **All services which provide for victims of domestic abuse and sexual violence should be demonstrably LGBT+ inclusive.** This may include staff training (see recommendation numbers 9 to 13) and ensuring visible inclusivity (see recommendation numbers 23 to 26). Health professionals and others must be made aware of inclusive support services in order to appropriately signpost.

30. **Establish a dedicated service for LGBT+ victims of domestic abuse and sexual violence,** and this must be publicised and promoted to LGBT+ communities and professionals.
31. **There is a need for a campaign raising awareness of partner abuse and sexual violence in LGBT+ relationships**, in order to help victims recognise incidents and seek help, and boost awareness among professionals and the general population.
32. **Development of services and an awareness raising campaign should involve the LGBT+ community, including those with lived experience of domestic abuse/sexual violence.**

Wish list item: Provision of inclusive facilities and opportunities for sport and physical activity

33. **A clear framework of inclusivity should be established for sports and leisure providers to use as a tool for implementing a plan of proactive LGBT+ access and participation.**
34. **Relevant stakeholders should develop clear national strategic guidance for providers that supports access to facilities.**
35. **Consideration must be given to both dedicated physical activity opportunities for LGBT+ people and equitable access to regular facilities, clubs and sessions.** This should involve consultation with the LGBT+ community.
36. **Provision of dedicated LGBT+ opportunities for sports and physical activity should be considered in light of the findings from the mapping exercise advocated in Recommendation No 1.**
37. **A working group should be tasked to explore and consider the opportunities and possibilities of an LGBT+ thematic community sports hub in large population centres** (e.g. in the way disability sport is a thematic approach to provision).

Wish list item: Provision for LGBT+ Asylum Seekers

38. **LGBT+ asylum applicants should be offered supported access to a range of health and wellbeing services including counselling and mental health services delivered in partnership between trusted 3rd sector organisations with supported referral to NHS services where required.** Organisations providing support must recognise the sensitivities and needs of those who are both asylum seekers and LGBT+ people.
39. **Asylum applicants should have an opportunity, through sensitive enquiry by the Home Office, to disclose their LGBT+ identities and be supported by link workers aligned to the asylum application process (and latterly within named accommodation centres) to engage with local support structures. When submitting an application in Scotland, applicants should – as a minimum – be given information in their own language on NHS services and the Scottish Refugee Council. Consideration should be given to routine referral to the Scottish Refugee Council.**
40. **Asylum applicants should have unrestricted access to relevant health and social care information, developed in partnership between public sector and**

3rd sector bodies. This information should be available from a range of safe and trusted public spaces and should seek to reassure rights to support.

Final over-arching recommendation

41. Directors of Public Health and Public Health Scotland are asked to champion the recommendations from this report within their local health boards, and nationally with COSLA and Scottish Government.

Contents

1. Introduction

Background

The Scottish Government has made a commitment to 'making Scotland a better, healthier place for everyone' and to tackle health inequalities. Health and wellbeing varies significantly according to many factors. In Scotland, those living in poverty and areas of deprivation are consistently shown to have poorer health outcomes for a range of indicators. Health inequalities are further compounded by differing experiences based on a person's identity including those characteristics protected under the Equality Act (2010). This includes those who identify as lesbian, gay, bisexual, those who are transgender and/or non-binary (LGBT+).

The Research

NHS Greater Glasgow & Clyde (NHSGGC) and NHS Lothian recognised that there are gaps in knowledge about the health and wellbeing of LGBT+ groups. In order to better inform approaches to public health for LGBT+ people, they commissioned a comprehensive health needs assessment of LGBT+ people in both health board areas, differentiated for each of seven groups:

- Lesbian and gay women
- Gay men
- Bisexual women
- Bisexual men
- Trans women
- Trans men[1]
- Non-binary people

The health needs assessment was initially planned to be conducted in three stages:

1. A literature review
2. Qualitative engagement with LGBT+ people and with staff directly involved in providing services for LGBT+ people
3. Health and wellbeing survey of LGBT+ people

The literature review and qualitative engagement were conducted in 2019. The findings are presented in separate reports:

- The literature review focussed on published and grey literature from the previous 10 years in the UK with a particular emphasis on Scotland. The review included measures of health and wellbeing outcomes, determinants of health and wellbeing and experiences of engaging with health services for LGBT+ people. The literature review can be found at http://hdl.handle.net/11289/580318.

[1] During a stakeholder event between the literature review and the qualitative research, guidance from the community was to change the group 'trans men' to 'trans masculine' as this is a common term used by the community themselves. The group 'trans masculine' used in this report (and other reports from the Health Needs Assessment) includes those who identify as male and trans, or either 'trans men' or 'trans masculine'.

- The qualitative research findings which included engagement with 175 LGBT+ people and services and staff supporting LGBT+ communities can be found at https://www.stor.scot.nhs.uk/handle/11289/580258.

The third stage, a national survey of LGBT+ people, was curtailed by the COVID pandemic. Moreover, it was recognised that the pandemic had significantly changed the lives and experiences of LGBT+ people and therefore additional qualitative work was undertaken in October 2020 to explore the effects of the pandemic and lockdown on LGBT people.

- The qualitative research findings from 2020 focussing on the effects of the pandemic with 32 LGBT+ people can be found at: https://www.stor.scot.nhs.uk/handle/11289/580300

A further additional small piece of qualitative work was conducted in 2021 with LGBT+ Deaf and Deafblind people. Only three participants were recruited for this work, and a separate report has not been published to protect anonymity, but the findings have informed the overall health needs assessment presented in this document.

The final stage of the health needs assessment was the postponed Scottish nationwide survey of LGBT+ people, conducted in 2021.

This Report

This report presents the findings from all stages of the health needs assessment. The emphasis is on the findings from the survey, presented in this report for the first time. More detailed findings from the literature review, 2019 qualitative research and the 2020 COVID-focussed research can be found in their respective reports, but relevant findings from these are included in summary to contextualise and the survey findings and provide more comprehensive evidence for each the survey topics.

Authorship

This report has been prepared by Traci Leven of Traci Leven Research who conducted the literature review, qualitative engagement, follow-up Covid qualitative engagement, engagement with Deaf LGBT+ people, and undertook the analysis of the LGBT+ quantitative survey.

Notes on the Presentation of Survey Findings

All survey findings presented in Chapters 4-11 are reported as a percentage of all respondents who gave a response, and bar charts show the percentage for each of the seven LGBT+ groups. **Only findings which showed a significant difference ($p \leq 0.01$) between LGBT+ groups are reported.** Findings for the survey respondents as a whole include the 121 'other' respondents who are not included in the seven LGBT+ distinct groups (see Table 3.1 in Chapter 3).

In addition, Chapter 12 provides differentiated findings for intersections, with significant ($p \leq 0.01$) differences for key variables shown for

- people with limiting conditions/illnesses compared to those without
- those with autism or ADHD compared to those without
- those living in large towns/cities, those in suburban areas/small towns and those in rural areas/small villages
- those in the most deprived areas compared to those in the least deprived areas.

A note on rounding and interpreting percentages

Findings are reported to the nearest whole percentage. Due to rounding, not all responses will necessarily appear to add up to the quoted overall figure. For example, in Chapter 4 the overall proportion who agreed that they belonged to the local area is 40%, comprising 11% who strongly agreed and 30% who agreed. The two categories appear to total 41%, but this is due to rounding. In fact, 10.6% strongly agreed and 29.6% agreed, giving a total of 40.2% overall who agreed.

Columns and bars presented in charts are built with statistics to one decimal place, but the figures on the charts are usually rounded to the nearest whole number.

Most percentages are presented to the nearest whole number. However, there are some instances where a small proportion gave a particular response and it is helpful to examine statistics to one decimal place.

Some questions, for example Q48 which asks about the perpetrator of discrimination (reported in Figure 4.16), allow the respondent to select more than one category, so total responses can add up to more than 100%.

Where figures in charts are listed as '0%' this means exactly zero. Where the proportion is less than 0.5% but more than zero, this is annotated as '<1%'.

Where fewer than five respondents gave a response, this is listed as '<5'.

Unless otherwise stated, the reporting of a proportion who gave a response exclude 'don't know' and 'prefer not to say' responses.

Lack of comparator data

The initial intention (pre-pandemic) was to include questions in the survey which would allow comparisons to findings from wider population surveys in Scotland, in order to compare the health indicators of LGBT+ people compared to the wider population. However, it is now not possible to meaningfully compare findings from this survey with findings from Scottish surveys for which the latest available data is pre-COVID. For example, the most recent Greater Glasgow and Clyde health and wellbeing survey was in 2017/18 which showed that 86% of adults had a positive perception of their mental and emotional wellbeing, in huge contrast to the 25% in the LGBT+ survey who gave the same response – but it is impossible to determine how much of this difference can be attributed to the circumstances of the pandemic and how much represents a difference associated with LGBT+ populations.

However, there was a Scottish Health Survey which was conducted by telephone in August-September 2020[2]. References to the findings from the Scottish Health Survey 2020 are therefore used for context in this report where available.

Stakeholder Event

An online stakeholder event was held in March 2022 at which a summary of the findings presented in the report was presented. There were 160 attendees from across Scotland, comprising NHS staff, Scottish Government and 3rd sector organisations. Attendees were then tasked with discussing each of the nine 'wish list' items identified in the qualitative

[2] https://www.gov.scot/publications/scottish-health-survey-telephone-survey-august-september-2020-main-report/

research and suggesting recommendations based on these. The recommendations set out in the final chapter of the report are informed by the output from the stakeholder event.

2. Survey Methods

Survey Development[3]

It was initially planned to conduct the survey in the spring of 2020. It was planned that the survey would quantify the key issues identified in the earlier qualitative engagement and, where possible, include questions used in other population health surveys which would enable comparison of findings for LGBT+ people to those of the background population of Scotland. An engagement event was held on 23rd January 2020 to feedback to LGBT+ organisations and stakeholders the findings of the qualitative report and consult those present in shaping the question set and engagement methods for the survey.

It was agreed that an online survey widely promoted through social media platforms, with the option of paper based surveys on request, would be the optimal way to reach LGBT+ people. It was also acknowledged that with a largely online approach to the survey it would be possible to conduct the survey on a Scotland wide basis, rather than focus solely on the two health board areas previously included, with no additional resource required.

It was also acknowledged that the survey tool would have to be lengthier than most online surveys to capture the broad range of themes required. However, the feedback also suggested that many LGBT+ would welcome a chance to provide their views and experiences to improve public health responses and services and it was recommended that incentivising participation through a prize draw would be appropriate.

A survey tool was subsequently developed and readied for cognitive testing. However, with the onset of the COVID 19 pandemic, all work on the Needs Assessment was paused and several members of the steering group were reassigned to other roles to support the pandemic response.

When recovery enabled work to resume on the Needs Assessment in August 2020, the Scottish Public Health Network joined the steering group given the national context for the survey. It was evident that the previous survey tool was no longer entirely appropriate for the COVID 19 context. The steering group recognised the need to develop a new survey tool which included the context of COVID 19, but which stayed true to measuring the range of issues already identified in the needs assessment to date.

To support the revised survey tool development. Traci Leven was commissioned to undertake additional qualitative work with LGBT+ people, including with many of those that had taken part in the previous interviews, to identify the COVID 19 impacts and experiences of LGBT+ people. The final report of this additional work completed in November 2020 informed the redevelopment of a new survey tool.

The survey tool was piloted over March 2021 through contacts with LGBT+ stakeholders in a number of health board areas to capture both urban and more rural perspectives and to gather experiences from across the LGBT+ spectrum. Piloting confirmed that the survey took on average 20-30 minutes to complete. The final version of the survey tool was built using the Smart Survey online package.

[3] This section has been prepared by NHSGGC

Although the user testing highlighted a number of changes for the survey tool, unfortunately a small number of errors were included in the final version of the survey tool. The most significant of these was a missing variable in the ethnicity field which means that it is not possible to provide accurate ethnicity data on the survey participants.

Survey Conduct

The online survey went live on 11th June 2021 and was intended to run initially to the 20th August. In the event, the survey remained live until the 1st September.

Publicity and promotional material was developed by Public Health Scotland for use with email and social media dissemination. A standard email was developed which was shared by with all partners and stakeholders in the survey and which encouraged onward dissemination through national and local networks by both NHS and other statutory partners and through several third sector organisations and networks. This was augmented by social media coverage initially through Twitter which was initiated by Public Health Scotland with organisations and individuals encouraged to share widely.

All publicity materials included a hyperlink which took participants directly to the survey page.

The main page provided an overview of the survey and content, the time it was likely to take to complete it, that the survey was anonymous, that particular questions could be skipped and contact details for the survey team.

Both the survey front page and covering publicity information made clear that paper copies of the survey could be provided on request and that translated versions of the survey could also be provided on requests. In the event, no requests for paper copies or for translated content were received.

The survey was open to anyone who lived Scotland who identified at LGBT+ and who was over the age of 16 at the time of completion.

Since a range of sensitive questions were included in the survey, these were prefaced by a warning in advance of the questions and links to a list of support organisations was included in the survey.

The survey included an opportunity for participants who had completed the survey to be entered into a prize draw. The prizes consisted of four vouchers for online retailers each valued at £250. This was the final page on the survey and required people to leave contact information. 1,359 people completed this question and four winners were selected at random using a random number generator and all subsequently claimed their prizes.

The smart survey software allowed the survey steering group to monitor responses to the survey as it progressed. This meant that the steering group could ascertain whether there were particular parts of the LGBT+ population that were not completing the survey either in relation to their identities, demographics.

In early August it was identified that young people and adults over the age of 50 were under-represented in completed responses. Therefore the steering group sought to purchase adverts on social media channels in a bid to boost uptake of these demographics.

There were challenges in doing so as several preferred social media platforms declined to carry the adverts either due to the age range of those who could complete the survey or because there were blanket policies on refusing health related surveys.

Adverts were run on Twitter between 20th to 31st August mainly focussing on the older population and on Tiktok between 18th and 31st August targeting younger people.

The advert had a total of 44,323 impressions on Twitter with 6,204 click throughs to the users had the chance to see and engage with the advert with 3,694 click throughs to the advert to find out more information. Of the Twitter impressions, 38,927 were in those aged over 50 of which 78.5% were identified as female.

The advert had a total of 395,074 impressions on Tiktok with 4,485 click throughs to the advert to find out more information. 70% of all Tiktok impressions were identified a female. Of those that clicked through the advert on Tiktok, 2,794 were aged under 18 and 1,691 were aged 18 – 24. This activity resulted in a more balanced age demographic in the sample.

The other population group under-represented in the sample were people from BME communities. The steering group attempted to resolve this by undertaking a further wave of enhanced communication to BME organisations and networks. However, notwithstanding the error in the ethnicity field in the survey (which related to people from a White British background), this did not yield increased uptake in those identifying as from a BME background.

Data Cleaning and Preparation

Raw survey data was sent to Traci Leven (Traci Leven Research) for cleaning and preparation prior to analysis. All data preparation was conducted using the SPSS statistical package. The data was in two separate datasets – complete and incomplete responses. The raw data consisted of 1,938 completed responses and 1,718 partial responses. The first task was to define and retain inscope cases. The cases removed were:

- **All blank cases**
- **All obvious duplicates** – i.e. people providing identical responses from the same IP address. Often, respondents made a partial response, quickly followed by another partial response or a complete response. There were also some obvious duplicates in the complete dataset. Where it was clearly the same person, duplicates were removed. There remain many responses from duplicate IP addresses in the dataset, but this can be legitimate – e.g. where people in the same household or office use the same advice. There is no way of knowing whether some respondents completed the survey again on a different device, so some duplicates are likely to remain in the dataset.
- **All partial responses where the respondent had not proceeded beyond question 15**
- **All cases where respondents were both heterosexual and cis** – most of these were in the partial dataset (straight cis respondents likely realised at an early stage that the survey was not aimed at them, but there were also 80 cases in the complete dataset)**.**

After removing these cases, the remaining partial responses were merged with the complete responses, giving a single dataset of 2,358 respondents (1,833 complete and 525 partial).

Further tasks in the data cleaning process comprised:

- Assigning missing values (e.g. 'prefer not to say' and 'don't know' responses which will not routinely be included in analysis)
- Adding variable labels
- Correcting illogical responses where the survey has not limited responses (e.g. where the respondent has answered 'prefer not to say' but also given a response).
- Correcting data for all variables allowing multiple responses which were all pre-coded as if the answer is 'no' if an answer was not given or respondents were routed past the question
- Creating new variables to categorise free-text responses.

A further task was to create new variables from the existing data, including a variable to categorise respondents into LGBT+ groups (see Chapter 3), and scoring respondents on standard scales used within the questionnaire.

3. Survey: Respondent Profile

Identity Groups

Responses from the questionnaire were used to categorise respondents into the seven identity groups used in the earlier components of the health needs assessment to differentiate findings. This is done in order to explore the differences in experiences and needs for these groups, but it is recognised that categorising people in this way is not perfect: some LGBT+ people have a distaste of labels and/or have fluidity in how they identify, and there are many identities within the LGBT+ rainbow, not all of them fitting within these seven categories. Moreover, the categories are based on both orientation and gender identity, and therefore they are not mutually exclusive. For the purpose of categorisation, gender identity has taken precedence over sexual orientation - i.e. if a respondent identifies as trans or non-binary, they have been categorised according to their trans/non-binary status regardless of their sexual orientation. It should be noted that only a small percentage of trans and non-binary respondents identified as heterosexual/straight (13% of trans women; 8% of trans masculine and 1% of non-binary people).

The LGBT+ identity groups, categorised for the purpose of analysis are shown in Table 3.1

Table 3.1: LGBT+ Identity Groups

Group	Number of respondents	% of respondents	Notes
Gay/lesbian women	421	18%	Includes all who identified as female, did not identify as trans and identified as gay or lesbian.
Bisexual women	406	17%	Includes all who identified as female, did not identify as trans and identified as bisexual, pansexual or omnisexual.
Gay men	557	24%	Includes all who identified as male, did not identify as trans, and identified as gay.
Bisexual men	96	4%	Includes all who identified as male, did not identify as trans and identified as bisexual, pansexual or omnisexual.
Trans women	126	5%	Includes all who identified as female (or trans woman) and as a trans person/trans history.
Trans masculine	152	6%	Includes all who identified as male, trans masculine or trans man and as a trans person/trans history
Non-binary	479	20%	Includes all who used any term other than male, female or trans male/female to describe their gender. This included non-binary, agender, genderflux, genderqueer, bigender, demi-gender, gender fluid and intersex.
Others	121	5%	All other respondents who could not be categorised into the seven groups of study – this includes asexual, queer and those who did not provide information about either their gender or their orientation so could not be categorised.
Total	2,358	100%	

Additional Notes:

1.Where respondents identified as asexual but had an LGB romantic orientation (e.g. gay-romantic or bi-romantic), they have been categorised as according to their orientation (e.g. gay men, bisexual women etc).

2. Where respondents identified as **both** 'trans masculine' and 'non-binary', they have been coded as 'trans masculine' for the purposes of classification.

The identity groups above are used to explore differences in findings throughout this report. Analysis by identity groups excludes 'others', but those in the 'others' group are included where findings are presented for the LGBT+ survey respondents as a whole.

In total, 23% of all respondents said they considered themselves a trans person or have a trans history. In addition to all those categorised as trans masculine or trans women, 57% of those in the non-binary category said they considered themselves a trans person or had a trans history.

The breakdown of all respondents by their sexual orientation is shown in Table 3.2.

Table 3.2: Sexual Orientation of Respondents

Sexual Orientation	Number of respondents	% of respondents
Heterosexual/straight	40	2%
Gay/lesbian	1,180	50%
Bisexual/pansexual	883	37%
Asexual	79	3%
Queer/other	120	5%
Don't know or questioning	16	1%
Prefer not to say/no answer	40	2%

Age and Gender

As the table below shows, there were more female than male respondents to the survey, and 21% of respondents did not identify as either male or female.

Table 3.3: Gender of Respondents

Gender	Number of respondents	% of respondents
Male	815	35%
Female	1,026	44%
Non-binary (all gender identities other than male/female)	479	21%

Base: All those who specified their gender (or said they had no gender): N= 2,320

The age profile of survey respondents shows that 74% were under the age of 40. Only 4% were aged 60 or more.

Table 3.4: Age of Respondents

Age	Number of respondents	% of respondents
16-19	412	18%
20-24	384	17%
25-29	337	15%
30-39	537	24%
40-49	269	12%
50-59	233	10%
60-69	73	3%
70+	14	1%

Base: All those who specified their age band: N= 2,259

Deprivation

There were 1,450 respondents who gave their full postcode, allowing categorisation by SIMD (Scottish Index of Multiple Deprivation). These were fairly evenly spread across each of the SIMD quintiles, as Table 3.5 shows.

Table 3.5 : Scottish Index of Multiple Deprivation (SIMD) Quintiles

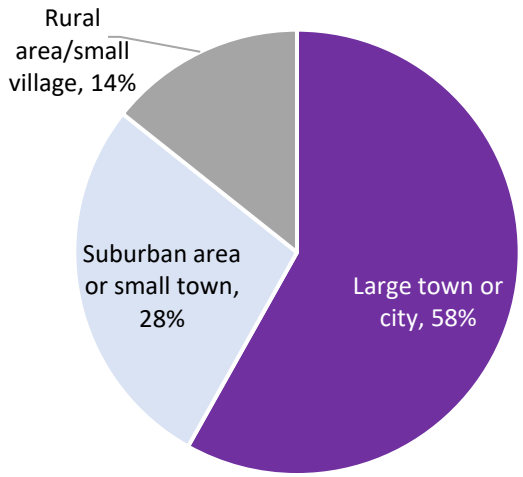
SIMD Quintile	Number of respondents	% of respondents
1 (Most deprived)	250	17%
2	299	21%
3	282	19%
4	320	22%
5 (Least deprived)	299	21%

Base: All respondents who gave a postcode (N=1,450)

Locality

When respondents were asked to describe the place they live, nearly three in five (58%) said they lived in a large town or city, while 28% lived in a suburban area/small town and 14% lived in a rural area or small village.

Figure 3.1: Type of Locality



Together, Greater Glasgow and Clyde and Lothian health board areas accounted for 59% of all survey respondents, as Table 3.6 shows.

Table 3.6: Health Board Areas

Health Board	Number of respondents	% of respondents
Ayrshire and Arran	61	3.5%
Borders	39	2.2%
Dumfries and Galloway	38	2.2%
Fife	94	5.3%
Forth Valley	57	3.2%
Grampian	142	8.1%
Greater Glasgow & Clyde	605	34.4%
Highland	73	4.2%
Lanarkshire	90	5.1%
Lothian	428	24.3%
Orkney	9	0.5%
Shetland	10	0.6%
Tayside	105	6.0%
Western Isles	8	0.5%

Base: All respondents who specified their Health Board: N=1,759

All 32 Scottish local authorities were represented across the survey respondents, but by far the greatest representation was from Glasgow City Council area (24%) and Edinburgh City Council (18%), as shown in Table 3.7.

Table 3.7: Local Authority Areas

Local Authority	Number of respondents	% of respondents
Aberdeen City	77	4.3%
Aberdeenshire	50	2.8%
Angus	23	1.3%
Argyll and Bute	32	1.8%
City of Edinburgh	318	18.0%
Clackmannanshire	16	0.9%
Dumfries and Galloway	35	2.0%
Dundee City	62	3.5%
East Ayrshire	22	1.2%
East Dunbartonshire	29	1.6%
East Lothian	36	2.0%
East Renfrewshire	27	1.5%
Eilean Siar	5	0.3%
Falkirk	21	1.2%
Fife	92	5.2%
Glasgow City	426	24.1%
Highland	46	2.6%
Inverclyde	16	0.9%
Midlothian	48	2.7%
Moray	19	1.1%
North Ayrshire	27	1.5%
North Lanarkshire	44	2.5%
Orkney Islands	9	0.5%
Perth and Kinross	26	1.5%
Renfrewshire	67	3.8%
Scottish Borders	39	2.2%
Shetland Islands	10	0.6%
South Ayrshire	14	0.8%
South Lanarkshire	64	3.6%
Stirling Council	20	1.1%
West Dunbartonshire	20	1.1%
West Lothian	31	1.8%

Base: All respondents who specified their Health Board: N=1,771

Religion/Belief

As Table 3.8 shows, more than two in three respondents said they had no religion/belief or that they were atheist. Christianity was the most common religion – 13% identified as Roman Catholic, Church of Scotland or other Christian.

Table 3.8: Religion/Belief

Religion/Belief	Number of respondents	% of respondents
None	844	47.6%
Atheist	485	27.4%
Roman Catholic	91	3.9%
Pagan	76	4.3%
Other Christian	73	4.1%
Church of Scotland	63	3.6%
Agnostic*	31	1.7%
Buddhist	19	1.1%
Spiritual	15	0.8%
Jewish	13	0.7%
Quaker*	8	0.5%
Hindu	5	0.3%
Muslim	<5	<0.2%
Other	47	2.7%

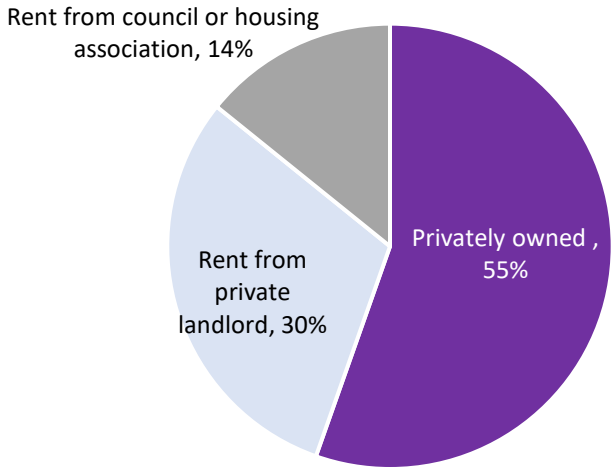
Base: All respondents who specified their religion/belief: N=1,772

* Denotes religions/beliefs not listed on the questionnaire, but were identified by those who selected 'other' and specified a particular response in common with at least 5 other respondents.

Home Tenure and Living Situation

Just over half (55%) of respondents lived in owner-occupied homes, while 30% rented privately and 14% lived in social housing.

Figure 3.2: Tenure



More than one in five (22%) respondents lived alone. Two in five (39%) lived with their partner (including those who lived with their partner and children), and 28% lived with their parent(s).

Table 3.9: Living Situation

Living Situation	Number of respondents	% of respondents
I live myself	378	22%
With partner	570	33%
With my children	35	2%
With partner and children	119	7%
In student accommodation	17	1%
In a retirement/care home with my carer(s)	<5	<1%
With parents	483	28%
With friends	150	9%

Base: All respondents who specified their living situation: N=1,753

Employment Status

Three in five respondents were employed either full time (48%) or part-time (13%). Including those on zero hours contracts and the self employed, two in three (67%) were in paid employment. Two in five (19%) respondents were in full-time education.

Table 3.10: Employment Status

Employment Status	Number of respondents	% of respondents
Employee in full-time job (35+ hours per week)	864	48%
Employee in part-time job (less than 35 hours per week)	236	13%
Employed on a zero hours contract	36	2%
Self-employed – fully or part-time	67	4%
Government supported training or employment	5	<1%
Unemployed and available for work	88	5%
Full-time education at school, college or university	15	1%
Wholly retired from work	37	2%
Looking after the family/home	12	1%
Permanently sick/disabled	80	4%

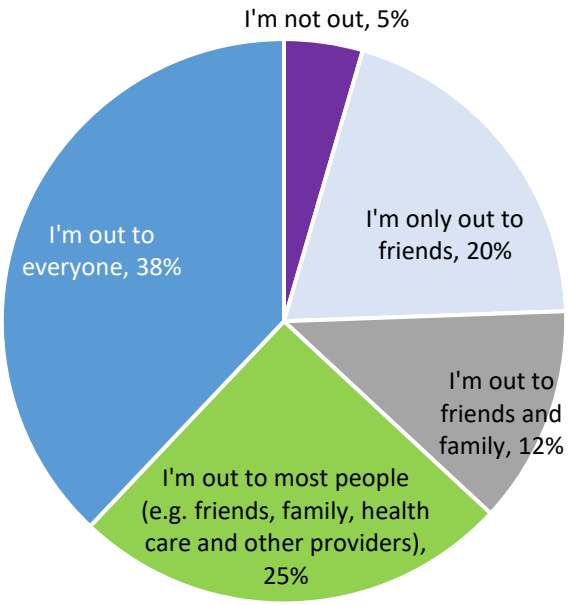
Base: All respondents who specified their employment status: N=1,784

4. Social Health

Being Out

Fewer than two in four (38%) survey respondents said that they were out to everyone. One in four (24%) said they were not out at all or only out to friends.

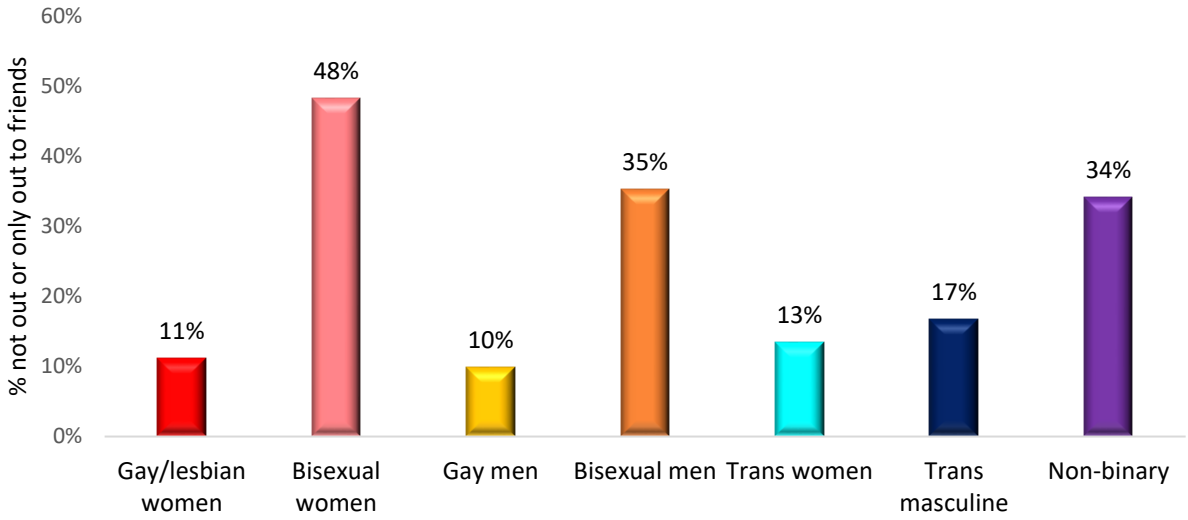
Figure 4.1: How 'out' are you?



Base: N=2,227

The extent to which people were out varied considerably by LGBT+ identity. Bisexual women and men and non-binary people were the least likely to be out. Nearly half (48%) of bisexual women said that they were not out or only out to friends.

Figure 4.2: Proportion Not Out or Only Out to Friends by LGBT+ Group



The qualitative research revealed that reasons for not being (fully) out included:

- Fear of rejection
- Faith and cultural influences
- Experience of discrimination
- HIV stigma
- Shame/internalised homophobia
- Exposure to negative opinions online/in other media
- Exposure to 'low level' homophobic attitudes (e.g. in the workplace)
- Not seen as relevant/important

The fact that most trans women and trans masculine people were largely out reflects the lived experiences described in the qualitative research that changing gender was an unescapably public life event - coming out was not optional, but a necessity as they changed their appearance, name and gender identity. For many trans people in the early stages of transition or who felt they did not 'pass' as cis, being 'out' was not entirely optional either:

> *"I don't go out of my way to tell people I'm trans, but by most people's standards I'm not passing (as a woman), so when I introduce myself as (female name) people get the gist, there's no need to say more about it… it's not really possible to be an in-the-closet trans person".*
>
> Trans woman

The large proportion of bisexual women and men who said they were not out or only out to friends is perhaps indicative of the difficulty many bisexual people in the qualitative research expressed regarding coming out. Many felt that assumptions were made about them based on their current partner, and it was not easy to assert their bisexual identity to counteract assumptions that they were either straight or gay depending on who they were currently dating. Some expressed fatigue at having to continually come out as bisexual; others welcomed the 'passing privilege' a relationship with someone of the opposite sex afforded them which meant they could introduce their partner to their family etc without ever referencing their bisexual identity.

The survey showed that bisexual women and men were much less likely than gay/lesbian women and men to say that GPs, employers, education providers, housing providers and care providers knew about their sexual orientation.

Table 4.1: Proportion Who Said Each of The Following Knows about Their Sexual Orientation by LGB Group

	Gay/lesbian women	Bisexual women	Gay men	Bisexual men
GP	67%	24%	82%	23%
Employer	84%	44%	92%	55%
Education provider	64%	31%	77%	37%
Housing provider	59%	20%	65%	33%
Care provider	59%	16%	62%	41%

Note: excludes all 'don't know' 'prefer not to say' and 'not applicable' responses.

Table 4.2 shows the proportion of trans and non-binary people who said their employer and each type of service provider knew about their trans or non-binary status. Non-binary people were much less likely than trans women or trans masculine people to say that each one knew about their gender status.

Table 4.2: Proportion Who Said Each of The Following Knows about Their Trans or Non-Binary Status by Trans and Non-Binary Groups

	Trans women	Trans masculine	Non-binary
GP	92%	75%	27%
Employer	75%	47%	25%
Education provider	52%	64%	28%
Housing provider	55%	38%	14%
Care provider	45%	48%	20%

Note: excludes all 'don't know' 'prefer not to say' and 'not applicable' responses.

Loneliness and Isolation

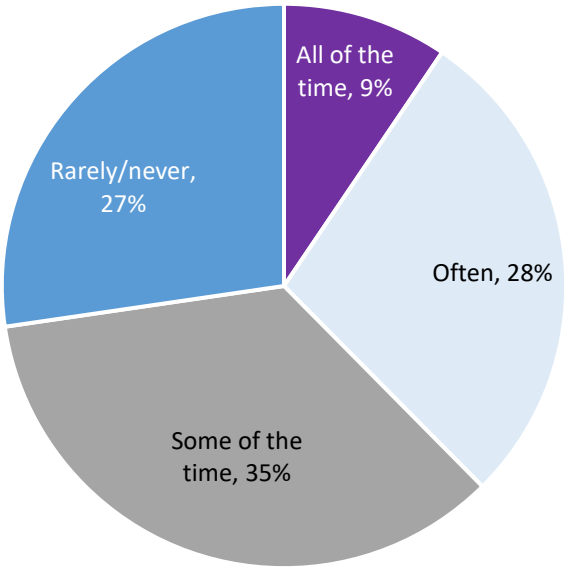
The literature review highlighted many sources of evidence pointing to LGBT+ people being much more likely than others to feel isolated and/or lonely. The qualitative research found that many felt there was a lack of LGBT+ friendly spaces for socialising. Many felt that it was vital to link with other LGBT+ people in social settings, but they lamented the lack of social spaces to do this, particularly anywhere that did not focus on alcohol. The lack of opportunity to engage with other LGBT+ people contributed to feelings of isolation for some. The subsequent Covid research in 2020 demonstrated that while the pandemic may have led to feelings of isolation and loneliness throughout the general population, LGBT+ people may have been particularly affected where they lost the ability to connect with the LGBT+ community.

Nearly three in four (73%) survey respondents said they ever felt isolated from family and friends. When asked whether this had changed due to COVID, most (78%) said it had

changed for the worse, but 4% said it had changed for the better and 18% said there had been no change.

Nearly two in five (38%) LGBT+ people said they had felt lonely all of the time or often in the previous two weeks.

Figure 4.3: How often have you felt lonely in the past two weeks?



Findings on loneliness contrast starkly with the findings from the Scottish Health Survey in 2020 which showed that 19% of adults in Scotland had ever felt lonely in the previous two weeks (compared to 73% in the LGBT+ survey).

As Figures 4.4 and 4.5 show, non-binary and trans people were the most likely to have felt isolated from family/friends and to have felt lonely in the previous two weeks. The difference between non-binary/trans people and LGB people was most marked for loneliness (Figure 4.5).

Figure 4.4: Proportion who ever Felt Isolated from Friends/Family by LGBT+ Group

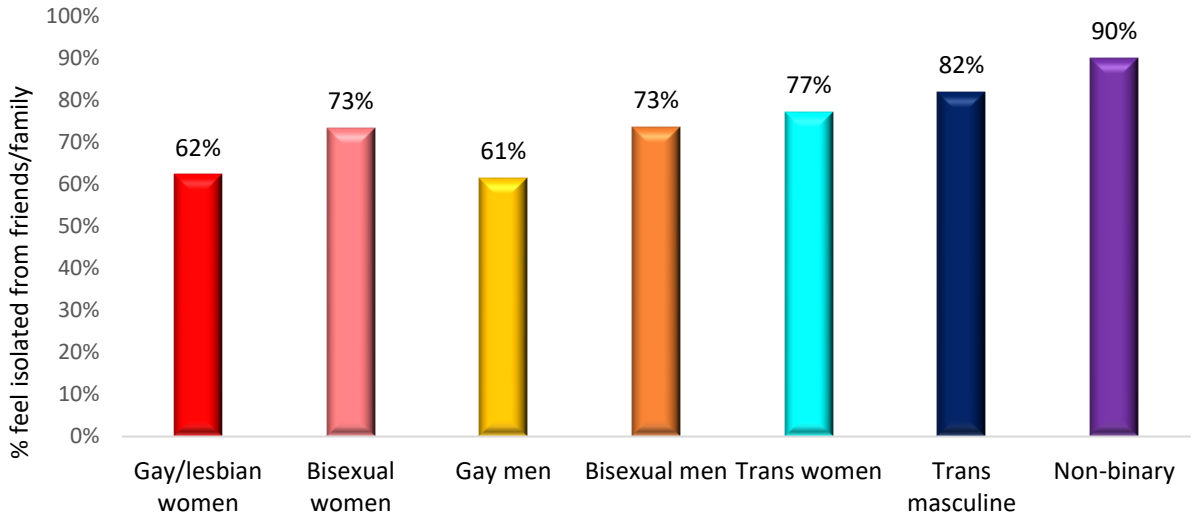
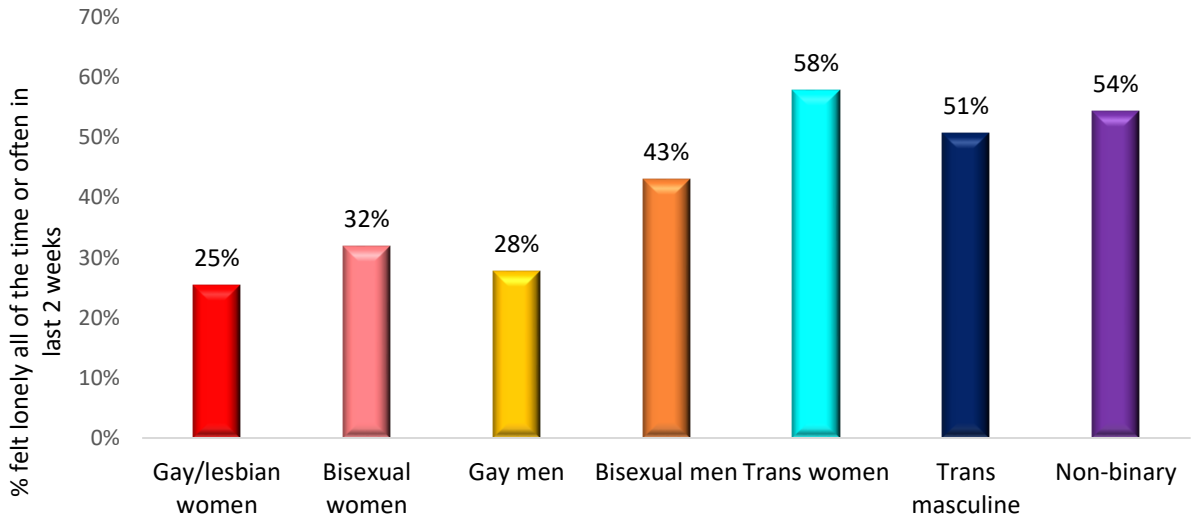


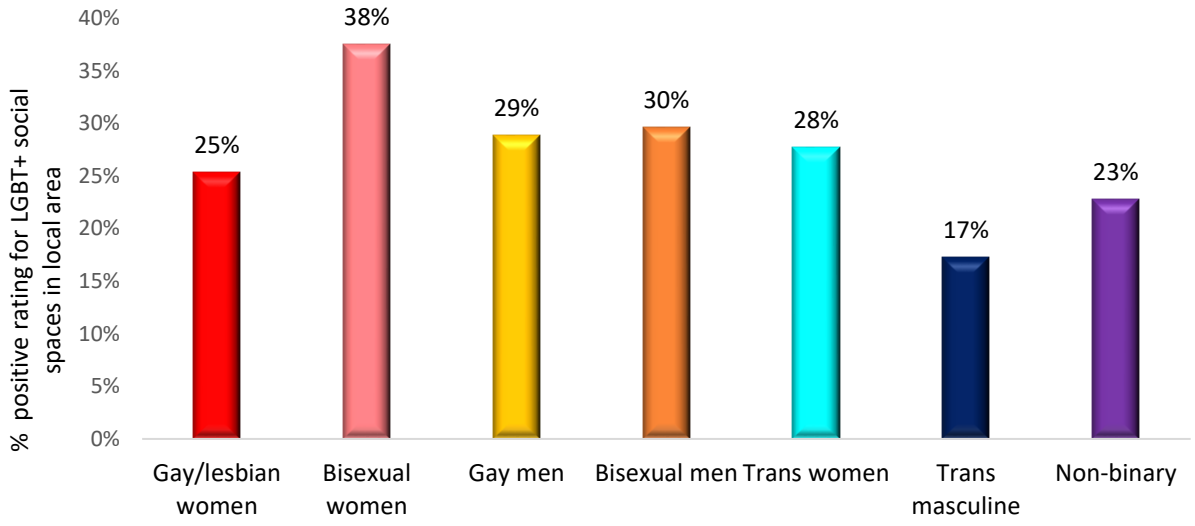
Figure 4.5: Proportion who Felt Lonely All of the Time or Often in the Last 2 Weeks by LGBT+ Group



LGBT+ Inclusive Social Spaces

Survey respondents were asked how they would rate their area for LGBT+ inclusive spaces. Just over one in four (27%) rated this positively – either very good (5%) or good (23%), while 38% said it was poor and 35% said very poor. Trans masculine and non-binary people were the least likely to rate their area positively and bisexual women were the most likely, as shown in the Figure 4.6.

Figure 4.6: Proportion who Rated their Area Positively for LGBT+ Inclusive Social Spaces



As Chapter 12 (Intersections) shows, those living in cities and large towns were more likely than those in suburbs/small towns or rural areas/villages to rate their area positively for LGBT+ inclusive spaces. Views of this were also more likely to be positive in the least deprived areas compared to the most deprived areas.

Community Involvement

Belonging and Feeling Valued

In the 2020 qualitative research, some participants commented that a positive benefit from the pandemic was a new or enhanced sense of belonging to their local community. Some may have felt rather detached from their local community before, or had stronger ties with a wider LGBT+ community rather than those in their local area, but the enforced time spent in their local area together with a general sense of solidarity and camaraderie, led to a new appreciation for their local community.

> *"Before COVID, we often spent our evenings and weekends going other places, but for five or six months we didn't leave* (our local area in Lothian) *where we live and just getting to know our local community so well was a huge benefit. We got to know all of our local retailers who were still operating, we got to know friends who live locally a lot better, from a safe social distance…I feel a much greater sense of belonging to our local community now".*
>
> Gay/lesbian woman

However, the survey findings from 2021 suggest that many LGBT+ people remain with a sense of detachment from their local community.

Two in five (40%) survey respondents either strongly agreed (11%) or agreed (30%) that they felt they belonged to their local area. A further 32% said they neither agreed nor disagreed, 18% disagreed and 10% strongly disagreed.

Only one in four (26%) survey respondents either strongly agreed (6%) or agreed (20%) that they felt valued as a member of their community. A further 40% neither agreed nor disagreed, 22% disagreed and 12% strongly disagreed.

Feeling of belonging and feeling valued was lowest among trans and non-binary people. Bisexual men were also among the groups who had the lowest proportion who felt valued as members of their community.

Figure 4.7: Proportion who Agreed/Strongly Agreed that they Feel They Belong to their Local Area by LGBT+ Group

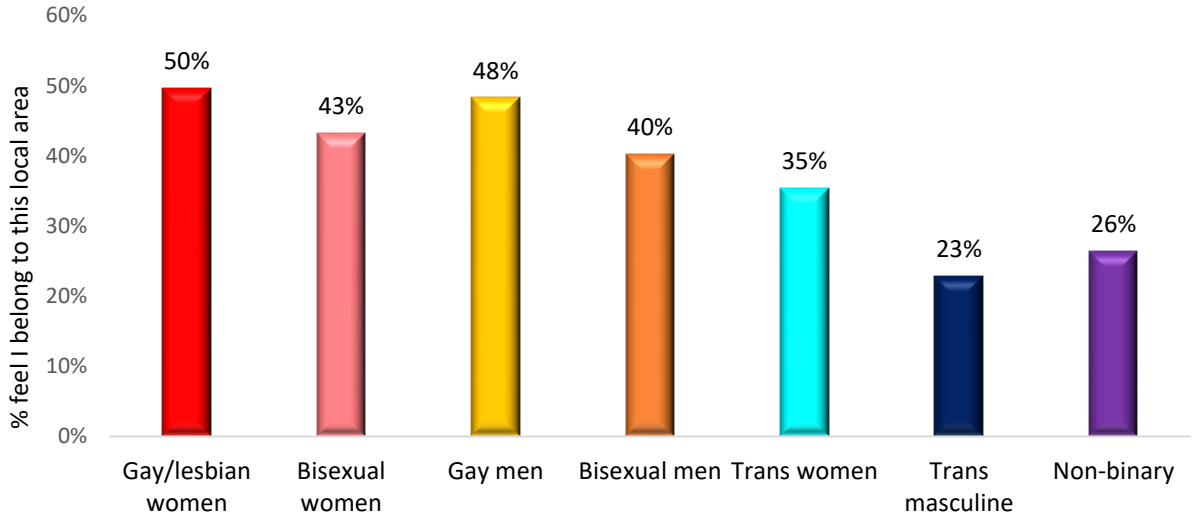
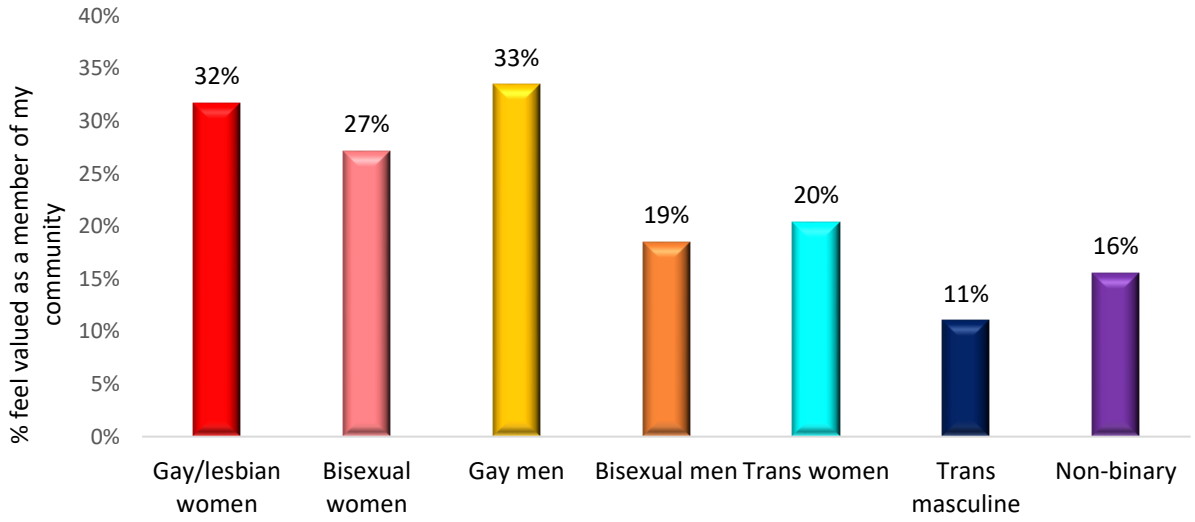


Figure 4.8: Proportion who Agreed/Strongly Agreed that they Feel Valued as Member of Their Community by LGBT+ Group

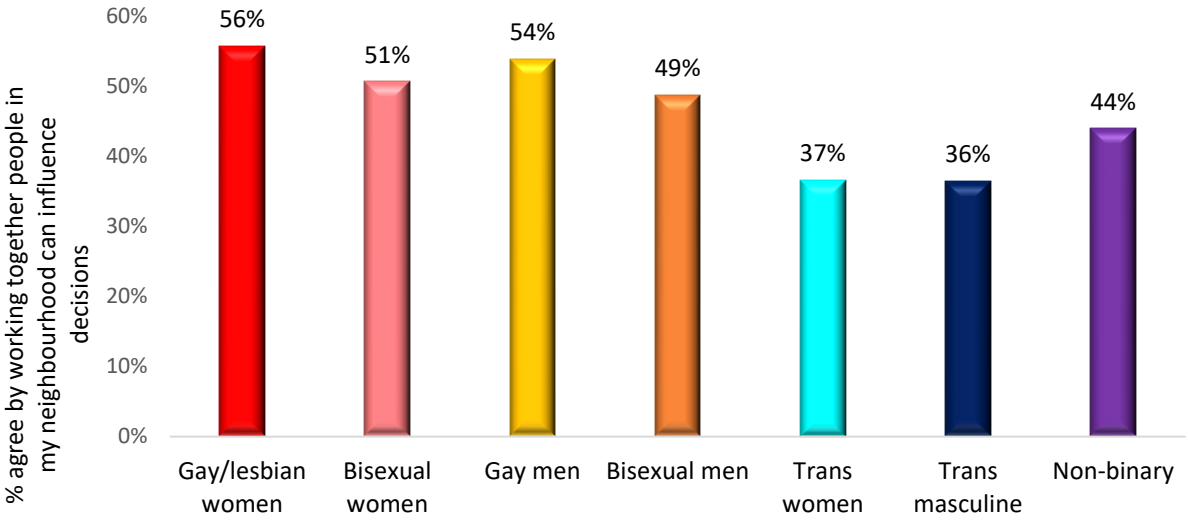


Working Together

Survey respondents were asked the extent to which they agreed with the statement '*By working together, people in my neighbourhood can influence decisions that affect my neighbourhood'*. Half (49%) agreed with this – either strongly agreed (11%) or agreed (38%)

while 27% neither agreed nor disagreed, 15% disagreed and 8% strongly disagreed. Trans people were the least likely to agree with this.

Figure 4.9: Proportion who Agreed/Strongly Agreed that by Working Together People in Their Neighbourhood Can Influence Decisions That Affect Their Neighbourhood by LGBT+ Group



Reciprocity and Trust

Survey respondents were asked the extent to which they agreed with these statements:

"This is a neighbourhood where neighbours look out for each other"; and

"Generally speaking, I can trust people in my local area".

The first statement is a measure of reciprocity and the second is a measure of trust. Less than half (44%) had a positive perception of reciprocity and a similar proportion (44%) had a positive perception of trust.

Trans and/or non-binary people and bisexual men were less likely than other LGBT+ groups to have a positive perception of reciprocity or trust.

Figure 4.10: Proportion who had a Positive Perception of Reciprocity by LGBT+ Group

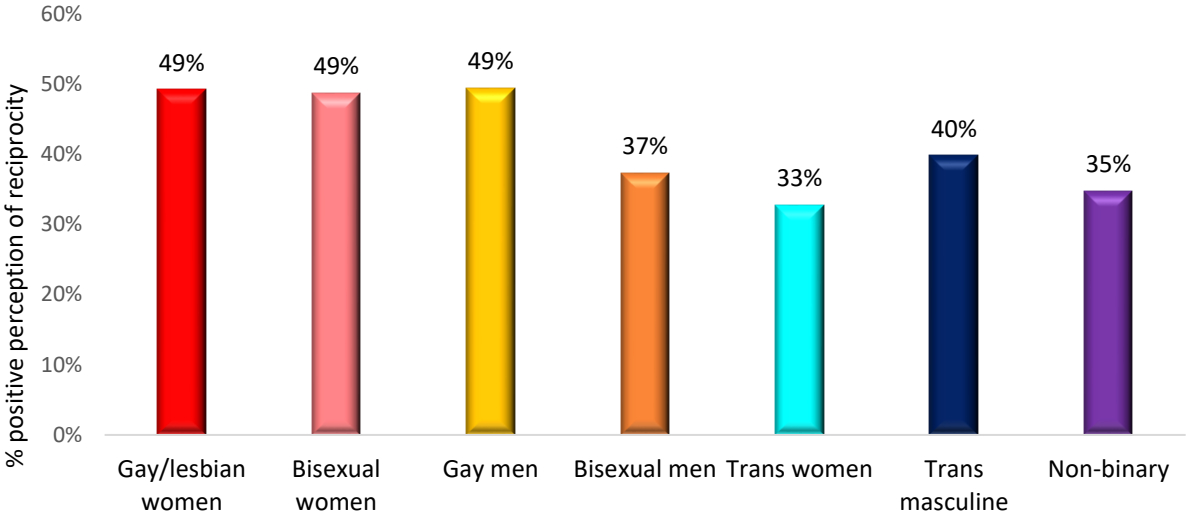
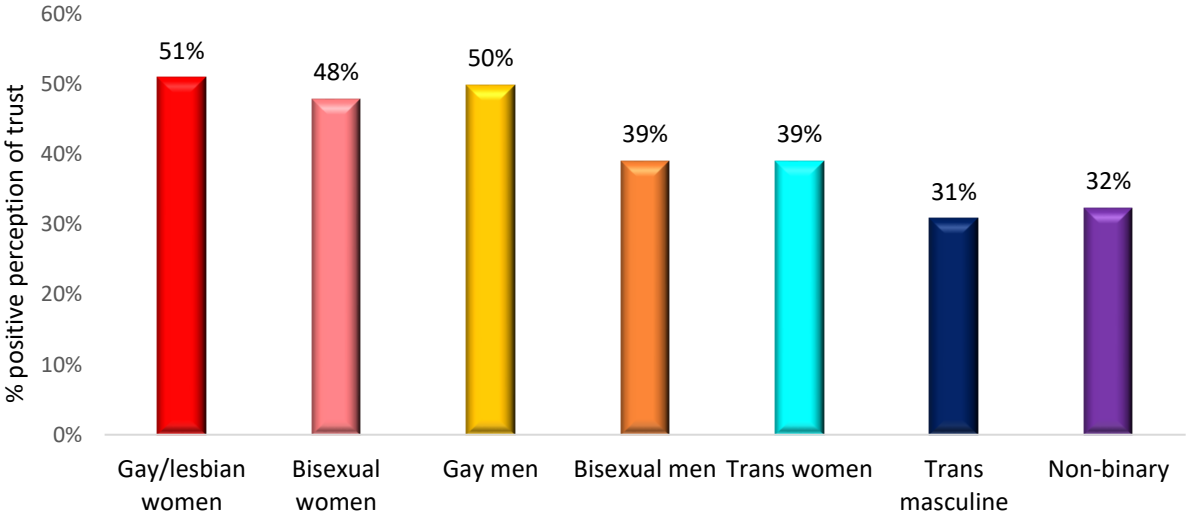


Figure 4.11: Proportion who had a Positive Perception of Trust by LGBT+ Group



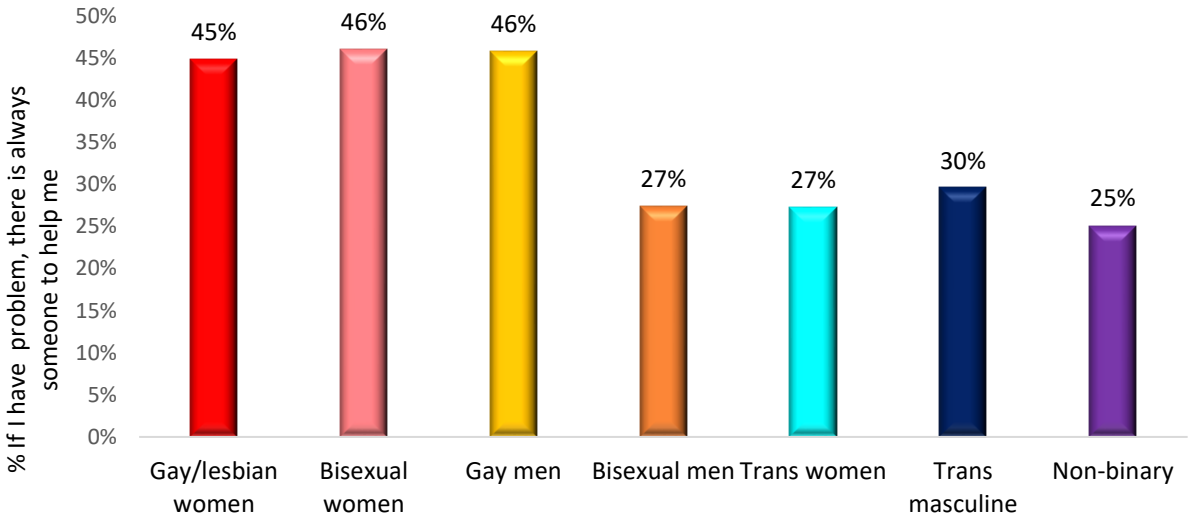
Local Friendships

Just over two in five (43%) said they agreed (31%) or strongly agreed (12%) that the friendships and associations they have with other people in their area mean a lot to them.

Just under two in five (39%) said they agreed (30%) or strongly agreed (9%) that if they have a problem there is always someone to help them.

There was no significant difference among LGBT+ groups for the proportion who valued local friendships. However, trans and non-binary people and bisexual men were less likely than those in other LGBT+ groups to say that there was always someone there to help if they had a problem.

Figure 4.12: Proportion who Agreed There Was Always Someone to Help Them if They Had a Problem by LGBT+ Group



Volunteering and Activism

The literature review highlighted that LBG people were much more likely than heterosexual people to be volunteers and to engage in activism. This was reinforced by the qualitative interviews and group discussions, with most participants demonstrating past or current experience of volunteering in some way. The vast majority of voluntary activity centred on LGBT+ services or campaigning for LGBT+ issues. The motivations for volunteering, particularly in LGBT+ services were:

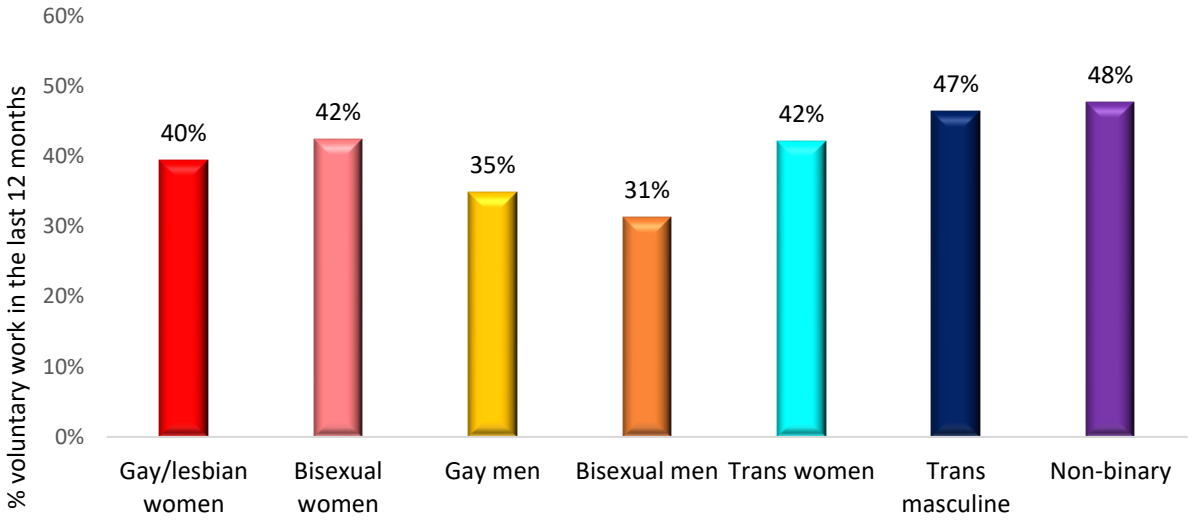
- Being involved and included in the LGBT+ community, making friends and socialising with LGBT+ people
- Helping young LGBT+ people ('being the person I needed when I was younger')
- Giving back to the community and/or a particular organisation who had helped them
- Political or social activism to improve lives of LGBT+ people.

Benefits which LGBT+ people reported they had received from volunteering were the development of skills, improvement to self-esteem, less isolation and a sense of belonging to the community.

The 2020 research showed that some LGBT+ people were unable to continue in their established volunteering roles when the COVID restrictions were introduced, and this contributed to feelings of isolation and disconnect from the LGBT+ community. However, several participants had found new ways of volunteering during the pandemic.

The survey showed that two in five (41%) respondents had given up any time in the previous 12 months to help any clubs, charities, campaigns or organisations in an unpaid capacity. There was some variation in volunteering levels across LGBT+ groups, with gay and bisexual men being the least likely to volunteer (although even in these groups, one in three had volunteered in the last year).

Figure 4.13: Proportion who had done Voluntary Work in the Last 12 Months by LGBT+ Group

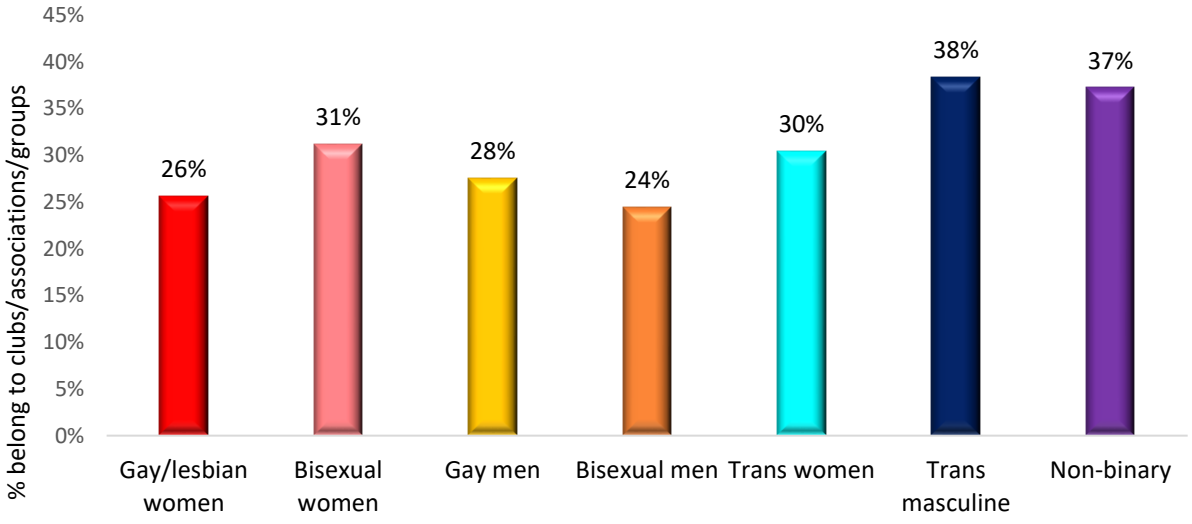


Two in four (39%) survey respondents said that in the last 12 months they had taken any actions in an attempt to solve a problem affecting people in their local area (e.g. contacted a media organisation, council, councillor, MSP or MP; organised a petition, etc). Levels of activism did not vary significantly by LGBT+ group.

Belonging to Clubs and Associations

Three in ten (31%) survey respondents said they belonged to any social clubs, associations, church groups or anything similar. Trans masculine and non-binary people were the most likely to belong to these.

Figure 4.14: Proportion who Belong to Clubs/Associations/Groups by LGBT+ Group



Discrimination and Negative Attitudes

General Exposure to Discriminatory and Negative Attitudes

A common theme in the interviews and group discussions in 2019 was the change in recent years to society in general becoming more accepting of LGBT+ people, particularly people with gay and lesbian identities. This was in part attributed to equality legislation. Societal attitudes towards trans, non-binary and bisexual people were felt not to have become as accepting to the same degree. Indeed, many felt that attitudes towards trans people, particularly trans women, had taken a 'backward step' in recent times, largely attributed to a very negative narrative around trans identities widely reported in the media and particularly social media, often in reference to the campaign around the Gender Recognition Act. Many felt that inflammatory media reporting had a measurable impact on how trans and non-binary people were treated in public:

> *"The massive media attack on the trans community has had a drip-down effect on the general public. They believe it – the public are becoming visibly more hostile. I have had people sit at my table (on a train), realise I'm trans, and then get up and leave. That's a new thing, and it's totally down to the toxic reporting in the media".*
>
> Non-binary

The 2020 research on the impact of the pandemic also highlighted the view among participants that social media, and even mainstream media, had become more sated with anti-LGBT+ (particularly anti-trans) comments since the start of lockdown, and this was particularly impactful at a time when people were feeling vulnerable and isolated.

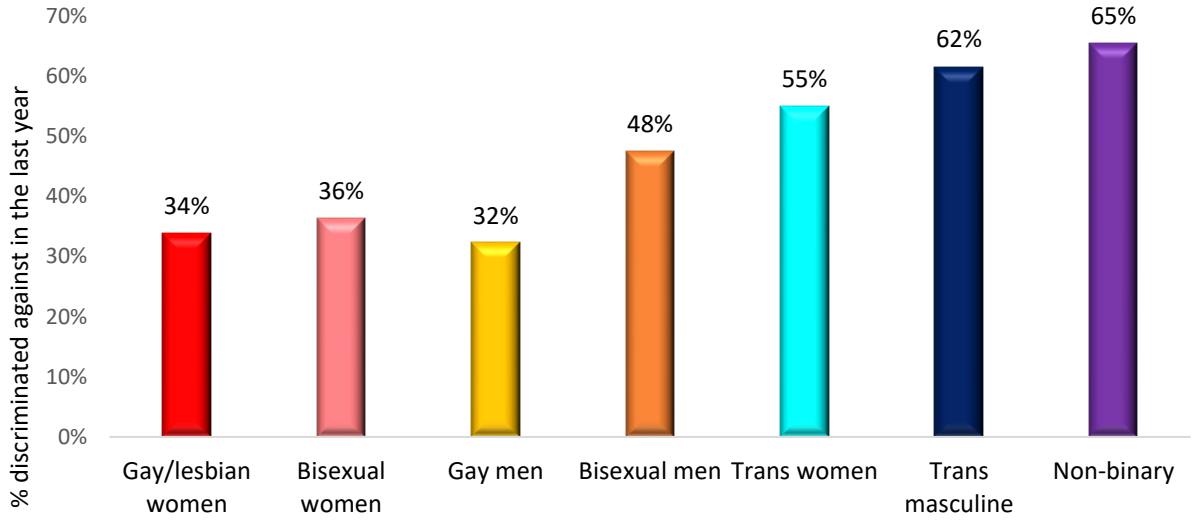
Non-binary people felt that there was a lack of understanding about non-binary gender identities and constantly battled against ignorance and insensitivities. Often they felt they had to either accept being misunderstood and mis-pronounced etc or become perpetual educators explaining how they identify.

The qualitative research showed that bisexual men and women often faced biphobic attitudes and/or lack of understanding about bisexual identities. They faced common stereotyping of bisexual people being seen as 'greedy' or promiscuous. 'Bi-erasure' was often referred to, with common perceptions of bisexuality being invalidated in society.

Targeted Discrimination

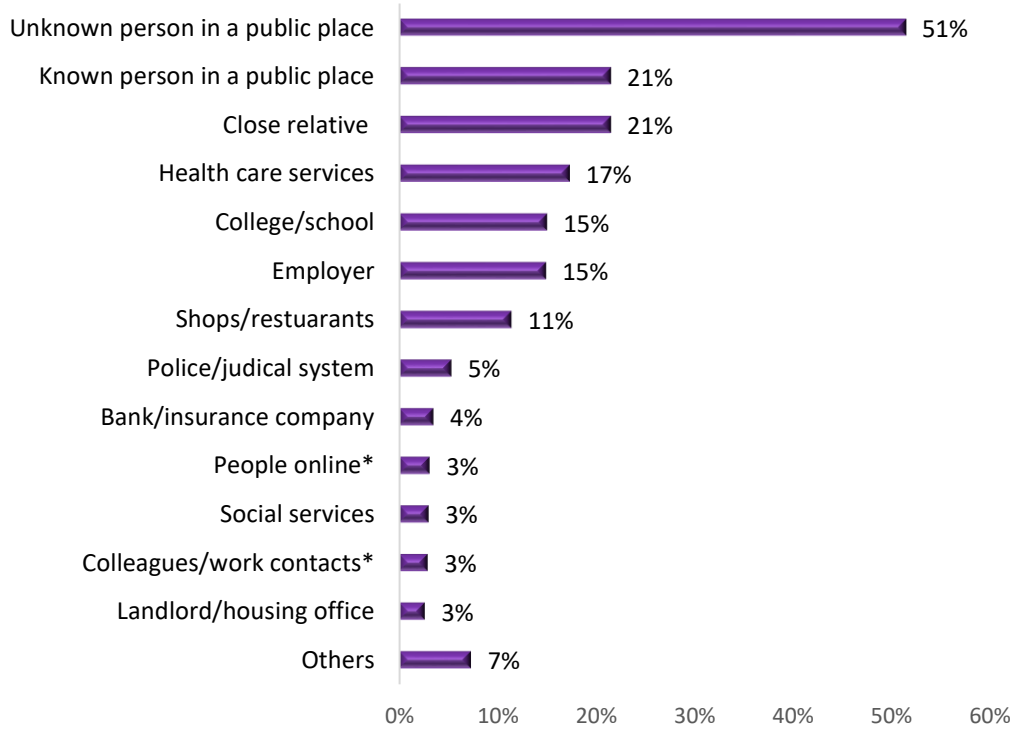
Just under half (44%) of all survey participants said they had been discriminated against in the last year for any reason – either occasionally (31%) or on several occasions (14%). Trans and non-binary people were the most likely to have been discriminated against.

Figure 4.15: Proportion who had been Discriminated Against in the Last Year by LGBT+ Group



Those who had experienced discrimination were asked who discriminated against them in the last year. The most common responses were unknown person in a public place (51%), known person in a public place (21%) and close relative (21%).

Figure 4.16: Who Discriminated Against You in the Last Year?

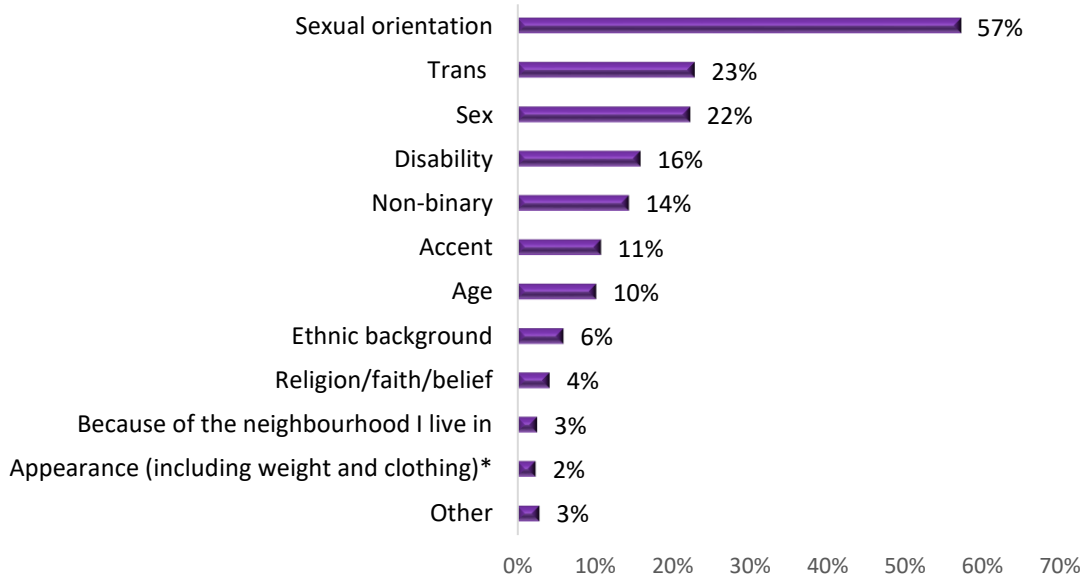


* denotes responses which were not in the list on the questionnaire, but which were described by >20 respondents who answered 'other' and specified the noted response.

Base: All those who had experienced discrimination in the last year and described who had done so (N=931).

Of the 939 respondents who had been discriminated against in the last year and who gave a reason, the most common reasons for discrimination were sexual orientation (57%), trans (23%) and sex (22%), as shown in Figure 4.17.

Figure 4.17: Why were you discriminated against?



* denotes responses which were not in the list on the questionnaire, but which were described by >20 respondents who answered 'other' and specified the noted response.
Base: All those who had experienced discrimination in the last year and described the reason (N=939).

Looking at specific LGBT+ groups:

- 87% of trans women and 90% of trans masculine respondents who had been discriminated against in the last year said that trans was the reason for the discrimination
- Among non-binary respondents who had experienced discrimination, 47% said non-binary was the basis of the discrimination and 31% gave 'trans' as the reason
- Sexual orientation was given as reason for discrimination by:
    - 79% of gay men
    - 75% of gay/lesbian women
    - 69% of bisexual men
    - 42% of bisexual women
    - 42% of trans masculine
    - 24% of trans women.

Role of the LGBT+ Community

In the qualitative research, many LGBT+ people stressed the importance of being part of the LGBT+ community on their wellbeing. Being part of this community provided them with support, validation and a sense of belonging. Nonetheless, there was also much discussion

about the negative aspects of the LGBT+ community and how this could be detrimental to mental wellbeing.

Firstly, the LGBT+ community itself was not felt to be fully inclusive, and LGBT+ participants talked about:

- Biphobia from within the LGBT+ community
- Transphobia from within the LGBT+ community
- Lack of inclusion of people with identities other than LGBT, such as asexual
- Discrimination and lack of access for disabled people
- Discrimination on the basis of race and/or religion
- Rejection of certain LGBT+ identities or intersections as potential partners (including bisexual people, disabled people).

LGBT+ people found discrimination from within the LGBT+ community particularly hurtful:

> *"I find biphobia from within the community more hurtful because although we might not have the same orientations, we've all been through similar things of trying to work out who we are, and it's just as difficult coming to terms with the fact that you're bi as it is if you're gay, and it's just as difficult coming out to people. When* (biphobia) *comes from someone that's not in the community, I can tell myself that it comes from a place of ignorance or innocence – they just don't get it. That I can forgive. But when someone who had the same experiences as me still acts like that, I find that harder to get on board with".*
>
> Bisexual woman

Gay and bisexual men also talked about the 'toxicity' of the gay scene, characterised by:

- An emphasis on physical appearance and pressures to conform to unrealistic expectations of physique
- Idealisation of 'macho' gay men and 'camp shaming'
- A scene where alcohol and drugs are an integral part and a key focus of social activity
- Promiscuous, risky and exploitative sexual behaviour
- A concentration of men with insecurities, mental health problems and addictions which could have a negative effect on one another.

Those who did not have identities or labels of lesbian, gay, bisexual or trans could feel excluded or unsure of their eligibility when services etc. advertised or named themselves as catering for 'LGBT' people. For these people, it was felt that the '+' at the end was important in order for them to know the service included them or they would be welcome:

> *"When I see something that says it is an LGBT group, I'm looking for that 'plus'. I'm looking for something to say 'we mean everybody', and not these specific four".*
>
> Asexual woman

Newly emerging divisions

Although this was not an issue the 2021 survey directly sought to investigate, free text responses at various stages in the questionnaire highlighted an emerging division between sections of the LGB community (particularly cis women) and trans people, particularly trans

women. These views indicate that for some people the concept of a single LGBT+ community may be seen as problematic.

Some survey responses indicated that they would like to see the loosening of ties among LGBT+ identities as an umbrella concept. For example, a response to being asked what would make a difference to your mental and emotional wellbeing was:

> *"It would be helpful to approach all "LGBT+" issues separately as the issues for various "letters" making up that acronym differ significantly: not only between lesbians and gay men on account of the difference in sex but even more so between L and G on one side and the T on the other. Sexual orientation and having a gender identity are very different issues".*

And responses to the question 'what would you like to see for LGBT+ people as society recovers from COVID included:

> *"Providing specific and separate services for Lesbian, Gay, Bisexual and Transgender people. Lesbians do not share the same issues as gay men. Transgender people have wholly different needs and face different social issues than same sex attracted people and it's unfair to all groups to lump them together. For example as a lesbian there are no female only dating sites that cater to my needs".*

Some lesbians/gay women went further and felt that the LGBT+ community had now become intolerant or unwelcoming to lesbians. Although less common, some gay men in the survey also expressed a need to link with other gay men in exclusively male contexts separate from inclusive LGBT+ spaces. There was also concern expressed in some survey responses where gay and bisexual people felt attacked for expressing interest in only cis partners.

Trans people, in their free text responses, frequently called for more understanding and acceptance of trans people from both within and outside the LGBT+ community including in governmental policies and public figures where they felt victimised by 'radical feminism' and other anti-trans rhetoric. Some advocated work to resolve the divisive and damaging debate. For example, another response to what they would like to see for LGBT+ people as society recovers from COVID was:

> *"More dialogue between moderate individuals to counterbalance the confrontational and destructive voices of recent years in the gender critical radical feminist vs. trans activist debate. Recognition that the vast majority of trans people are very private individuals who just wish to operate under the radar and have nothing whatsoever in common with domestic abusers, sexual predators or paedophiles".*

In addition, the 2020 qualitative research had highlighted a heightened period of anti-trans rhetoric on social media, causing distress among the trans community during lockdown; survey responses suggest that some trans people felt an increasing sense of victimisation from within the LGBT+ community.

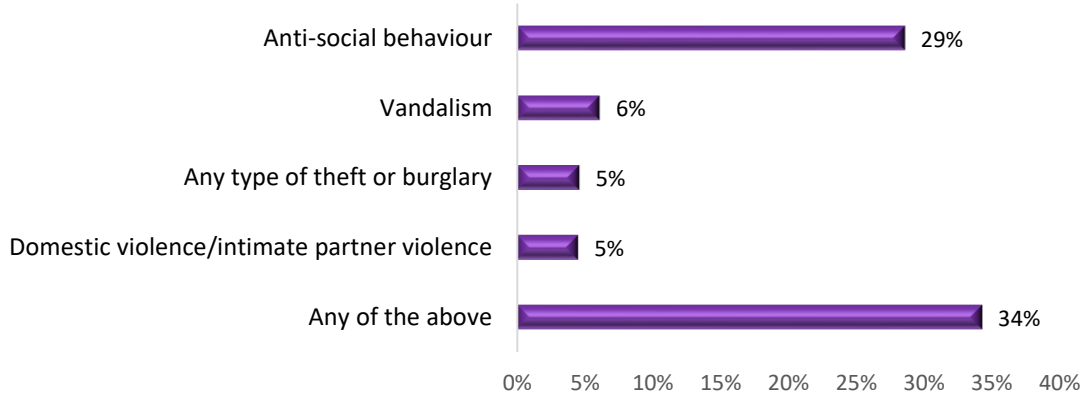
It is worth noting that these areas were not the focus of the survey.

Experience of Crime

Many LGBT+ people who participated in the qualitative research recounted incidents where they had been threatened or intimidated because of their identity – but they rarely viewed incidents such as being shouted at in the street or name calling as 'hate crime', and did not report them to the police. Some mentioned recognising some incidents as hate crime only some months or years after the event. There were, however, some who had experienced incidents which were very serious and unambiguously hate crimes including serious assaults which had resulted in hospitalisation. There were also incidents of being followed and threatened which had been frightening.

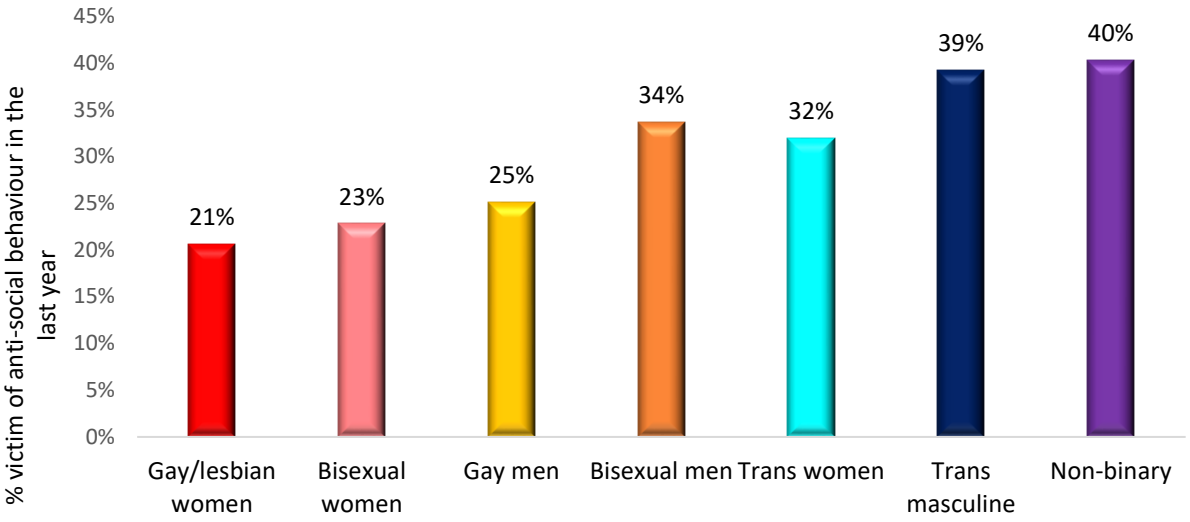
The survey asked respondents whether they had been the victim of four particular types of crime in the last year. These did not cover assault (other than domestic violence) or hate crimes. The crimes included were anti-social behaviour, theft or burglary, vandalism and domestic violence/intimate partner violence. One in three (34%) respondents had been a victim of at least one of these crimes in the last year. The most common was anti-social behaviour.

Figure 4.18: Proportion who had been the Victim of Four Types of Crime in the Last Year



Trans masculine and non-binary respondents were the most likely to say they had been the victim of anti-social behaviour in the last year.

Figure 4.19: Proportion who had been the Victim of Anti-Social Behaviour in the Last Year by LGBT Group



Feeling Safe or Unsafe

The survey did not measure feeling of safety, but evidence from the qualitative research can be found on page 14 of the qualitative research report.

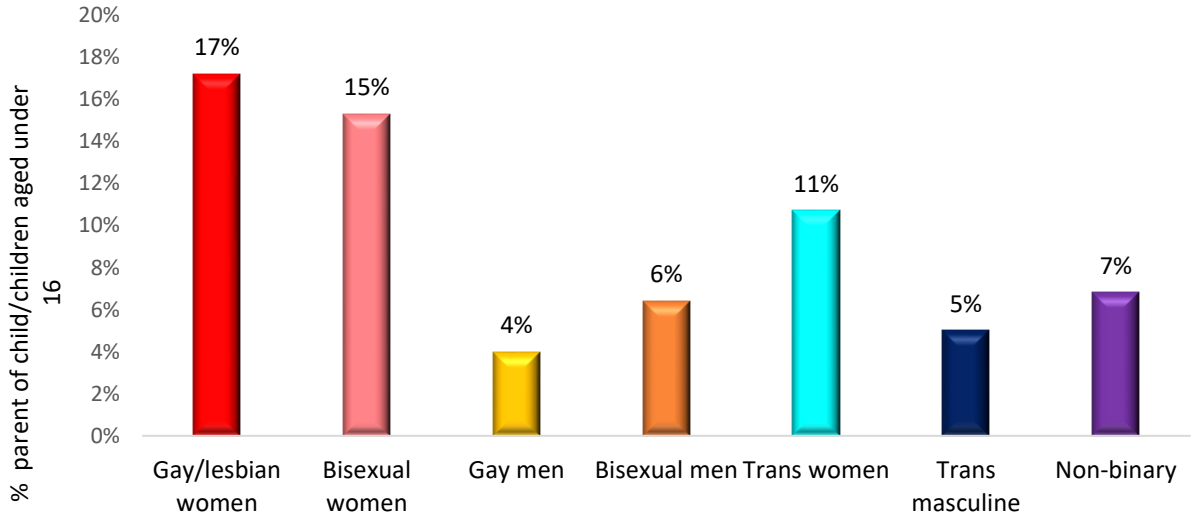
5. Parenting, Relationships and Caring

Parenting

The literature review referenced evidence from surveys that many LGBT people would *expect* to face discrimination if they were seeking to foster or adopt a child or enrolling a child at school etc. However, the qualitative research found that the experiences of those LGBT+ people who were parents were largely positive. While many had had concerns or anxieties about becoming parents (either through fertility/pregnancy, adoption or kinship care) with fears that they would face discrimination, concerns largely proved unfounded. None of the parents who engaged with the qualitative research had experienced any discrimination from schools or nurseries, all of which were felt to be welcoming and inclusive for LGBT+ parents and their children. Children were generally felt to be largely accepting and unconcerned when they encountered children who had same sex parents or trans parents.

Survey respondents were asked whether they were a parent/carer for a child under the age of 16 by the means of being a biological parent, step parent, carer, kinship carer or foster/adoptive parent. An error on the questionnaire meant that there was not an option for respondents to indicate that they were a co-parent of child who was not biologically theirs (e.g. in the case of same sex couples where one parent is the biological parent and the other is the co-parent). In total one in ten (10%) respondents were parents of children aged under 16 by one of the listed means – seven percent were biological parents, and three percent by other means. Women were much more likely than men or non-binary people to be parents, as shown in Figure 5.1.

Figure 5.1: Percentage who Were Parents of Children Aged Under 16 by LGBT+ Group



Those who were parents of children were asked whether they, their partner or any child of theirs had experienced LGBT+ related discrimination from a number of places. The small number of respondents who answered for each place (only parents and those who had used each of the services answered) means it is not possible to provide a detailed analysis, however the findings show that despite the positive experiences reported in the qualitative research, a sizeable proportion of parents had experienced discrimination:

- Of the 133 respondents who answered about being parents of a child at school, 41 (31%) said that they had experience of LGBT+ related discrimination at school, more commonly directed at the respondent (22%) than the child (14%) or the partner (8%).
- Of the 135 parents who answered, 37 (27%) said they had experienced discrimination from other parents – directed at themselves (24%), their partner (7%) or their child (7%).
- Of the 130 parents who answered, 34 (26%) said they had experienced LGBT+ related discrimination from other children – directed at themselves (12%), their partner (<5%) or their child (18%).
- Of the 109 respondents who answered regarding nursery/early learning, 11 (10%) had experience of LGBT+ related discrimination in this setting.
- Of the 57 respondents who answered, five (9%) had experienced discrimination from social services.
- Fewer than five respondents had experienced discrimination from a childcare provider or foster/adoption service.

Respondents who were parents of children aged under 16 were asked whether COVID had changed their experience as a parent or carer due to home-schooling and working from home. Of the 170 parents who answered, more than half (54%) said that their experience as a parent had deteriorated - either a little (35%) or a lot (19%), while 28% said it had not changed and 18% said it had improved a little.

Relationships

Relationship Status

Just over half (56%) of survey respondents indicated that they were currently in a relationship – either having a regular partner (39%) or being married/in a civil partnership (16%).

Those who were in a relationship were asked whether the quality of their relationship changed due to COVID. A majority identified a change to the quality of the relationship – 33% said that it was more positive than negative, 24% said that it was more negative than positive, and 43% said that the quality of their relationship was much the same.

Abusive Relationships

Several LGBT+ participants in the 2019 qualitative research described a history of abusive and violent relationships and sexual encounters.

Some groups felt that they were particularly vulnerable to falling prey to abusive and unhealthy relationships and these included:

- **Disabled people** who felt physically vulnerable, often suffered from low self-esteem and felt that their pool of potential partners was very limited and therefore they were more likely to settle for relationships that were unhealthy. A lack of sexual health and relationship education for disabled people was also felt to leave disabled people ill-equipped to make appropriate choices with regards to relationships.

  Indeed, as shown in Chapter 12, the survey found that LGBT+ people who had a limiting condition or illness were more likely than others to have experienced an abusive relationship (49% compared to 31%).

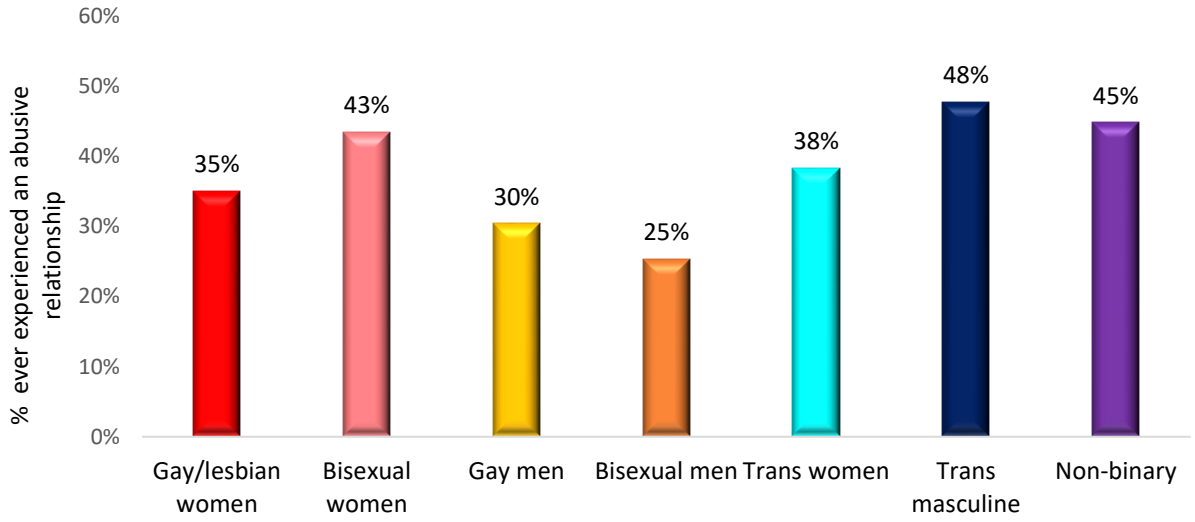
- **Autistic people** who were less equipped to recognise healthy or unhealthy attachments or relationships and less likely to have awareness around issues of consent.
  Indeed, as shown in Chapter 12, those with autism or ADHD were more likely than others to report experience of being in an abusive relationships.

- **Bisexual women** often felt they were vulnerable to abusive or unhealthy relationships because:
  - Bisexual women were often fetishized by men, and a common assumption was they would be 'up for a threesome' with a woman, and could be persuaded to engage in sexual behaviour they were not comfortable with
  - Partners made assumptions that that their bisexuality meant they would be accepting/tolerant of non-monogamous relationships
  - Partners made assumptions that their bisexuality meant they would be unfaithful with someone of the opposite gender, meaning partners could become unreasonably jealous or controlling
  - Partners denied their bisexual identity, insisting they were either lesbian or straight based on the partner's gender/identity
  - Bisexual women may be more willing to stay in an abusive or unhealthy relationship because they found it more difficult to find partners (the perception was straight men generally preferred to be with straight women; lesbian women generally preferred to be with lesbian women).

- **Trans women** who, similar to bisexual women also felt that their 'potential pool' of partners was smaller and also that they were frequently fetishized for being trans.

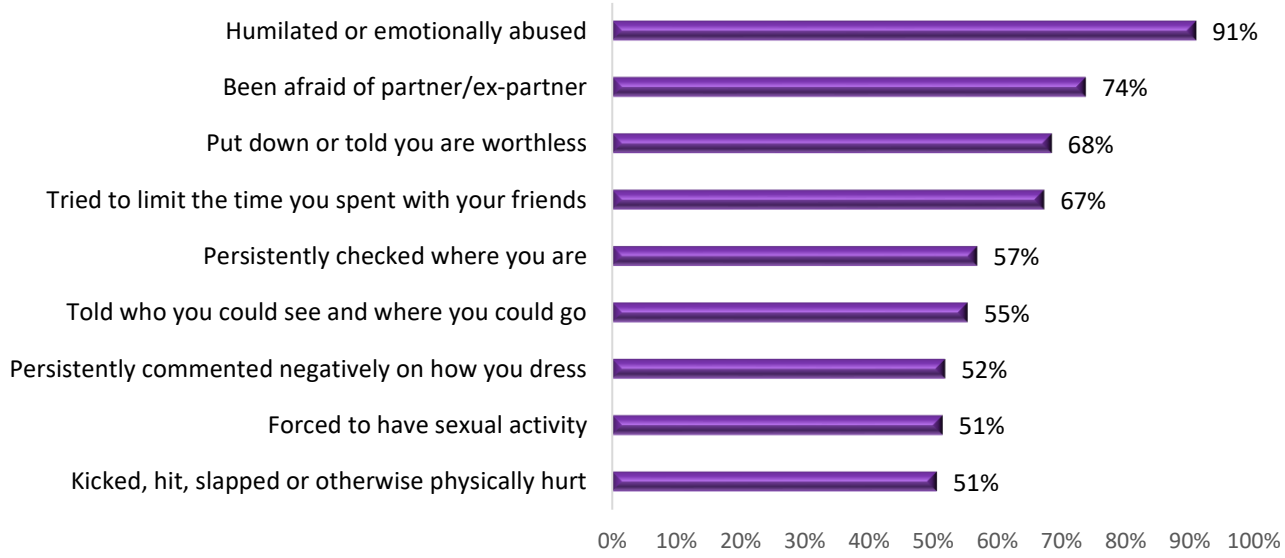
The survey asked whether respondents had ever experienced an abusive relationship. Of the 1,857 LGBT+ people who answered, 37% said they had. As Figure 5.2 shows, at least a quarter of people in all LGBT+ groups had experience of abusive relationships, but it was most common among trans masculine and non-binary people and among bisexual women.

Figure 5.2: Percentage who had Ever Experienced an Abusive Relationship



Those who said they had experienced an abusive relationship were asked about the nature of abuse experienced in relation to current and previous partners.

Figure 5.3: Types of Abuse Experienced (of those who had experienced any abusive relationship)



Base: Those who had experienced abusive relationships and answered for each type of abuse (N=668-680).

There were 107 respondents who indicated that they had been in an abusive relationship during lockdown. Of these, 44% said that the abuse increased during lockdown, 25% said it decreased and 31% said it stayed much the same.

The qualitative research found that victims of abuse within same-sex relationships pointed to the lack of public awareness relating to same-sex abuse, meaning they sometimes failed to identify the behaviour as abusive at first. Moreover, service provision to support victims of sexual violence or domestic abuse was considered lacking for any situations other than male perpetrators against female victims.

> *"I was sexually assaulted by a woman. I spoke to* (a third sector organisation supporting victims of sexual violence) *and it was just not geared up for that at all – all the literature and their website and everything was about men perpetrating against woman. Being the victim of sexual assault is traumatic and isolating, and trying to get help was even more isolating".*
>
> Bisexual woman

The survey asked those who had experienced an abusive relationship whether they had accessed any help or support with domestic abuse. Just 17% of those who had been in an abusive relationship had accessed any help or support.

Caring

The literature review included some evidence that young LGB people may be more likely than others to live with family members with disabilities or long term conditions and were more likely to be young carers.

One in six (17%) survey respondents said they were carers[4] and a further 1% said they had been a carer but had to stop due to COVID. There was no significant difference in the prevalence of caring across LGBT+ groups.

The prevalence of caring was similar to that measured by the Scottish Health Survey in 2020, which was 19%. However, caring measured by the Scottish Health Survey was more prevalent among those aged 45 and over, and the differing age profiles of the two surveys distort the comparison. When limited to under 50s, 16% of LGBT+ people were carers which compares to 12% of those aged 16-44 in the Scottish Health Survey.

Among carers, two in three (67%) said their caring responsibilities had increased due to COVID (31% said increased a lot and 36% said increased a little), while 6% said they had decreased and 27% said their caring responsibilities were much the same.

Carers were asked how their caring had affected their mental and emotional wellbeing. Only a small proportion of carers (7%) said that their caring had affected them more positively than negatively, while 53% said more negatively than positively and 40% said their caring had affected them equally positively and negatively.

[4] Caring was defined as looking after, or giving any regular help to support family members, friends, neighbours or others because of long-term physical or mental ill-health or disability, or problems related to old age (excluding any caring that is done as part of any paid employment or formal volunteering).

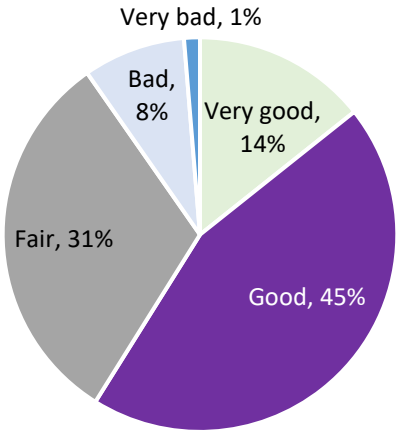
6. Physical Health

The literature review highlighted evidence that LGB people are less likely than others to rate their health positively and overall, LGBT+ people (particularly trans and non-binary) appear to be more likely than others to have an illness or disability. The literature review also highlighted some particular health problems which may be more prevalent among some LGBT+ groups including some kinds of cancers.

General Health

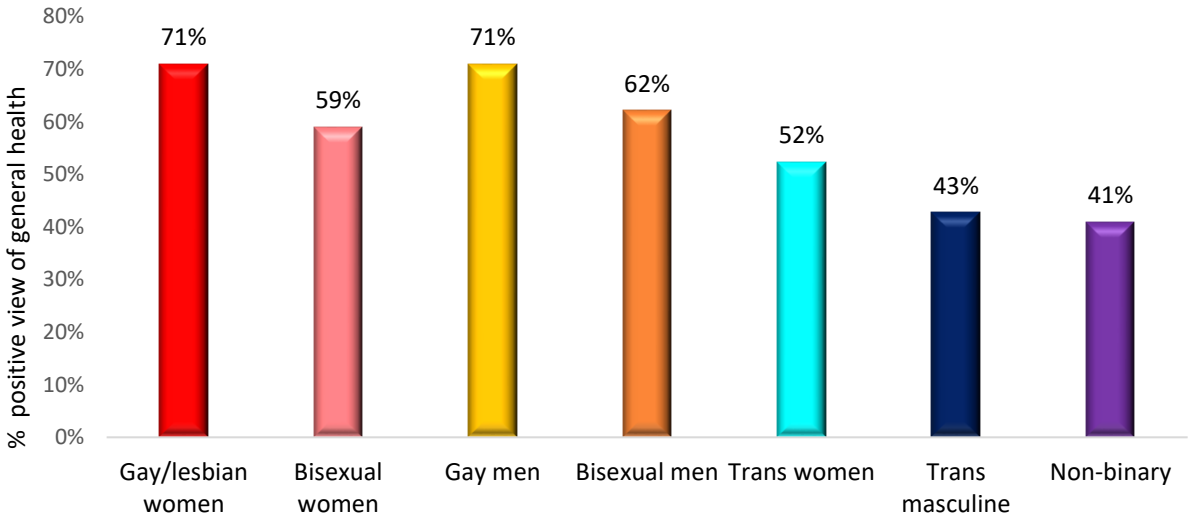
Three in five (59%) survey respondents rated their general health positively – either 'very good (14%) or good (45%).

Figure 6.1: How is your health in general?



The proportion who rated their general health positively varied by LGBT+ groups. Gay men and gay/lesbian women were the most likely to rate their health positively, while trans masculine and non-binary people were the least likely.

Figure 6.2: Proportion who Rate their General Health Positively by LGBT+ Group



Although the age profiles are somewhat different, as an indicative comparison 59% of LGBT+ people aged under 50 described their general health as very good or good, compared to 88% of those aged 16-44 in the Scottish Health Survey in 2020.

Experience of COVID and Shielding

COVID

Seven in ten (71%) were able to say they had not had COVID; 7% said they did not know and 15% said they had not been diagnosed with COVID, but suspected that they had had it. Seven percent of respondents had been diagnosed with COVID (including 1% who were still ill with it at the time of the survey).

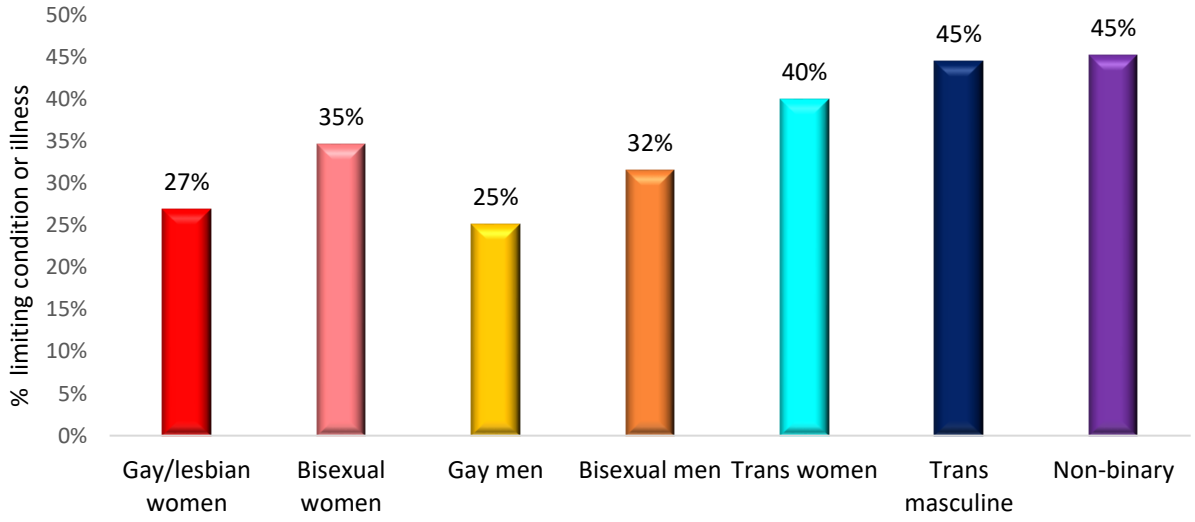
Shielding

One in nine (11%) survey respondents lived in a shielding household – either being on the shielding list themselves (4%) or living with someone on the shielding list (7%).

Conditions and Illnesses

One in three (33%) survey respondents said they had a long-term condition or illness that substantially interfered with their day to day activities. Trans and non-binary people were the most likely to have such conditions.

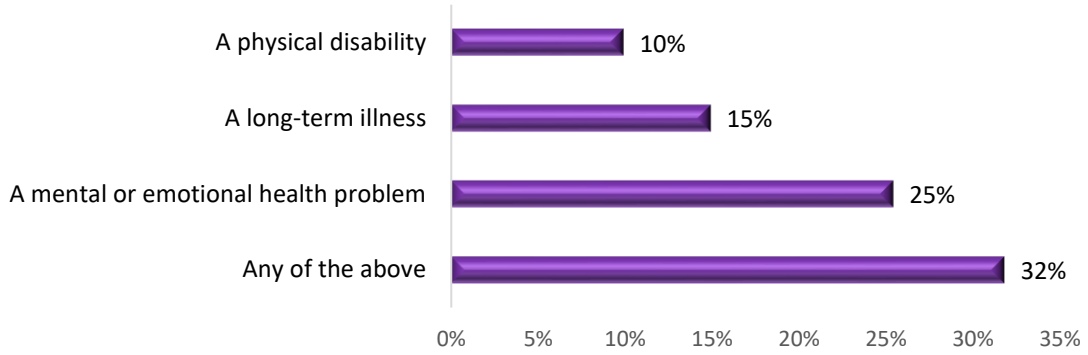
Figure 6.3: Proportion who Have a Limiting Long-Term Condition or Illness by LGBT+ Group



Again with the caveat of different age profiles, 21% of adults aged 16-44 in the Scottish Health Survey in 2020 said they had a limiting condition or illness, which compares to 33% of those aged under 50 in the LGBT+ survey.

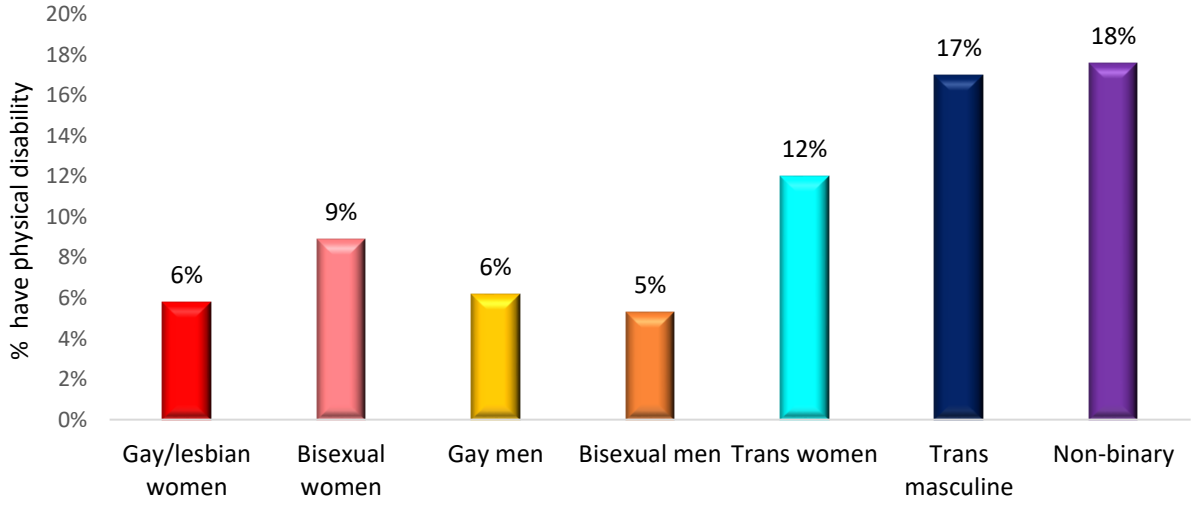
One in four (25%) respondents said they had a mental or emotional health problem; 15% had a long-term illness and 10% had a physical disability. Overall, one in three had at least one of these types of condition.

Figure 6.4: Proportion who Had Each Type of Condition



Non-binary and trans masculine people were the most likely to have a physical disability, as Figure 6.5 shows.

Figure 6.5: Proportion who Had a Physical Disability by LGBT+ Group

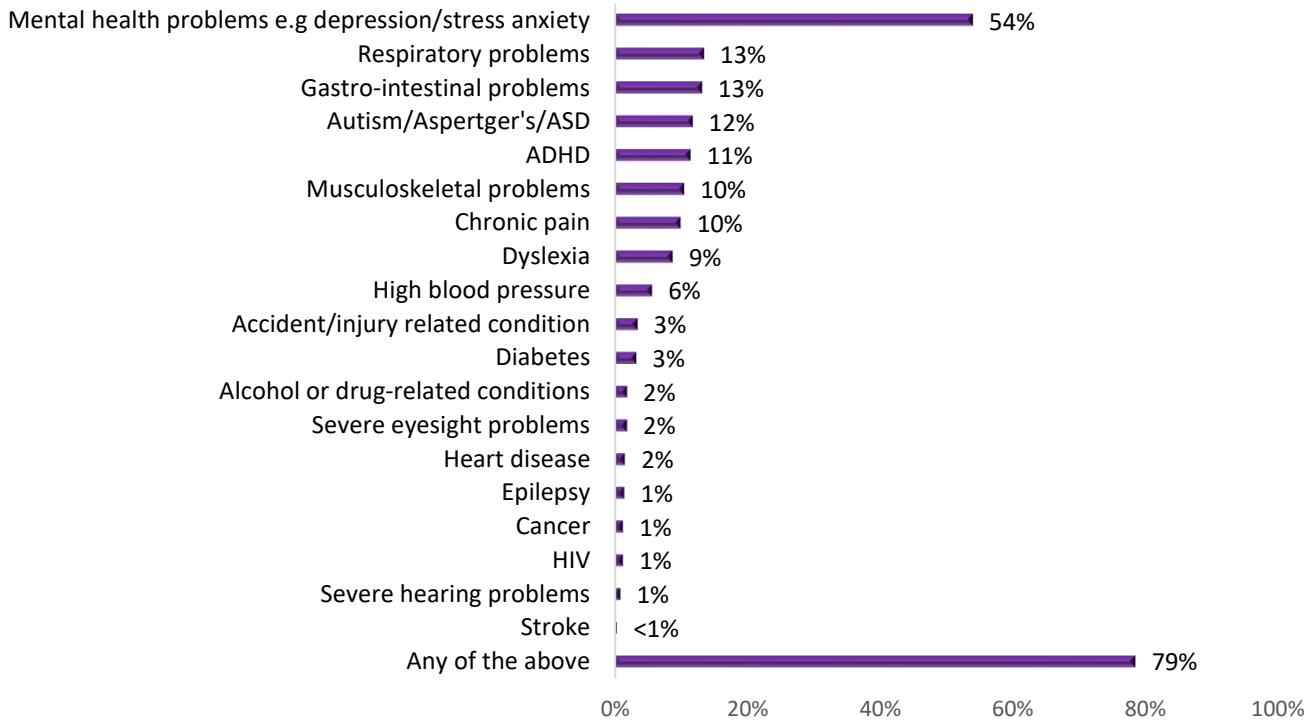


There were additionally significant differences for the prevalence of limiting mental/emotional health problems across LGBT+ groups – these are described in Chapter 8.

Figure 6.6 shows the proportion of respondents who had specific conditions. Overall, nearly four in five (79%) had at least one of the listed conditions. By far the most common was mental health problems (e.g. depression/stress anxiety) – more than half (54%) of respondents said they had this condition[5].

[5] The 54% who said they had a mental health condition is different to the 25% in the previous question who said that they had a mental or emotional health problem that substantially interfered with their day to day activities.

Figure 6.6: Proportion who Had Each Listed Condition



Chapters 7 and 8 explore differences in neurodiversity and in mental health indicators by LGBT+ groups. For physical conditions, the following differences are significant:

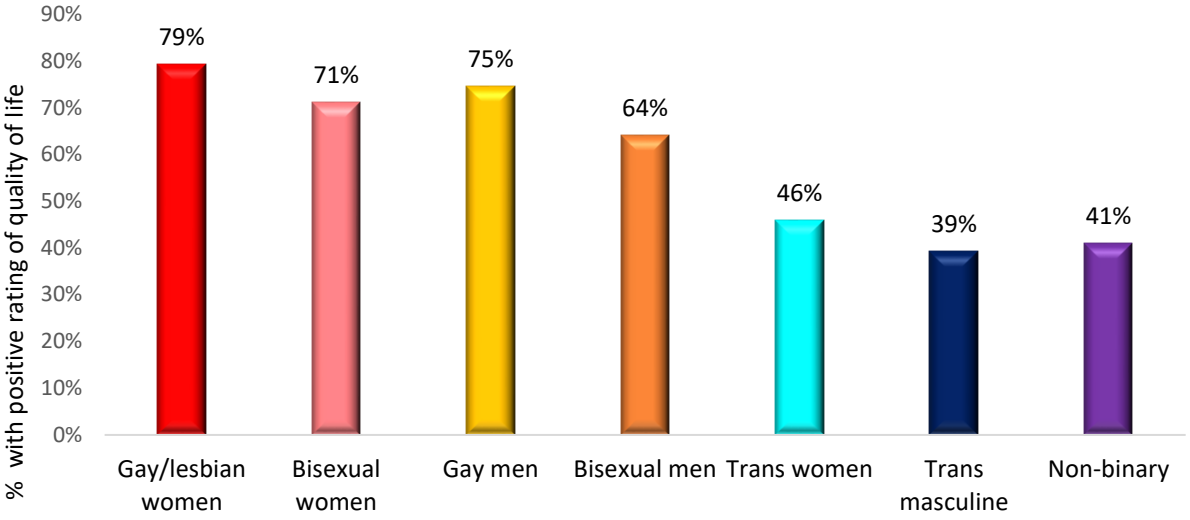
- Non-binary people were the most likely to have chronic pain (17% non-binary; 12% bisexual women; 11% trans masculine; 9% trans women; 7% gay/lesbian women; 6% gay men; 3% bisexual men).
- High blood pressure was most common among trans women and gay men (12% trans women; 10% gay men; 9% bisexual men; 6% gay/lesbian women; 3% trans masculine; 2% bisexual women; 2% non-binary).
- Nearly all cases of HIV were among gay men. One in 20 (5%) respondents who were gay men had a diagnosis of HIV.

Quality of Life

Just over three in five (63%) survey respondents rated their overall quality of life positively – saying it was either very good (17%) or good (46%). A further 28% described their quality of life as fair, 7% said it was bad and 2% said very bad.

Trans and non-binary people were the least likely to rate their quality of life positively, while gay/lesbian women were the most likely.

Figure 6.7: Proportion who had a Positive Rating of their Overall Quality of Life by LGBT+ Group



Respondents were asked whether their quality of life had changed during COVID. One in four (24%) said their quality of life was much the same, 13% said it had improved and 62% said it had deteriorated.

7. Neurodiversity

The literature review highlighted evidence that LGBT+ people may be more likely to have learning or developmental differences including dyslexia, Autistic Spectrum Disorder (ASD)/Asperger's and Attention Deficit Hyperactivity Disorder (ADHD). There was particular evidence for a higher prevalence of ASD among transgender young people.

The qualitative research included participants with these conditions. Having these conditions, particularly ASD, made it difficult for LGBT+ people to meet people and socialise. This was compounded by the fact that many queer spaces (gay clubs etc) are too noisy, busy and over-stimulating, meaning they are often not accessible to those with ASD. Therefore autistic LGBT+ people were often especially isolated, having few opportunities to engage with the LGBT+ community or meet potential partners.

Those with autism and other neural differences appeared to be particularly vulnerable to abusive or unhealthy relationships.

ASD also made it difficult for some to work out their sexuality or gender identity:

> *"I think my autism impacted my sexuality at a young age, because I was trying to imitate everyone else- to work out what I needed to do to be like them, which is the autism. I knew I felt different in terms of sexuality, but I also felt different in lots of other ways. And in TV shows I didn't see anything different either- it was always male and female couples, even if the characters were animals and I thought, ok- this is how it works. I understood that I was different and I didn't want to be. So I buried down anything that seemed different to other people".*
>
> Gay/lesbian woman

Trans and non-binary people with ASD and other conditions which affected their socialiation and communication, often found it difficult to articulate their feelings around their gender dysphoria or how they identified or wanted to present. This caused difficulties when accessing the GIC, and on the part of the GIC, it made it difficult to diagnose dysphoria or identify appropriate interventions.

Not only could ASD or other conditions make gender dysphoria diagnosis difficult, this could also work in reverse, with the identification of autism being made more complex for trans people:

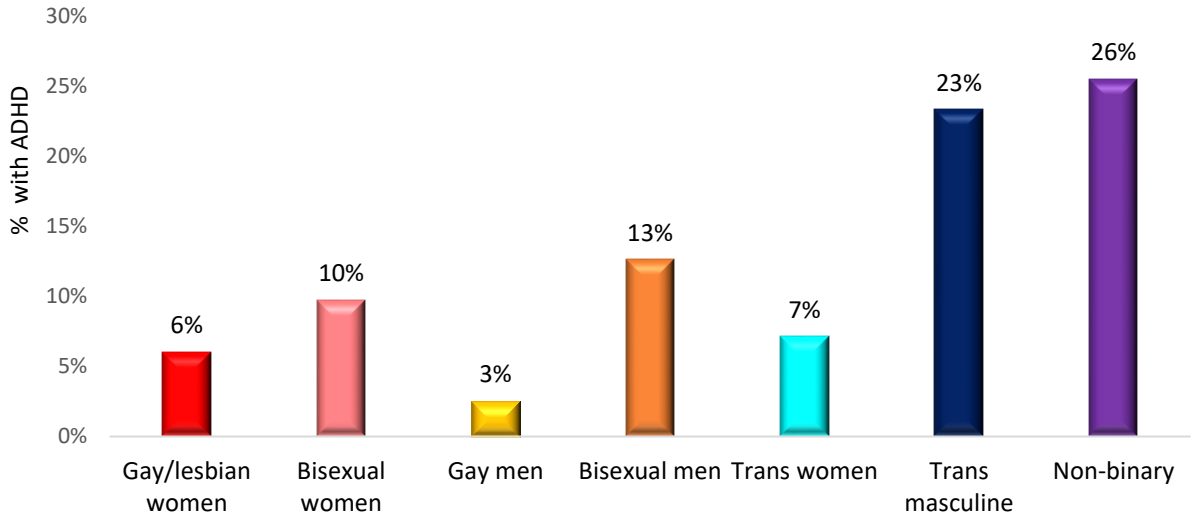
> *"Autism diagnosis can be tricky when you're transgender. Whether you're trans or have autism obviously you're going to feel different from most people. So when you're getting a diagnosis they have to make sure that you feel different because of autism, and not because of your gender or your identity or whatever. When you're in an assessment for autism, they basically have to rule out everything. Like is it your trans status that's having an impact on how you socialise or is it autistic traits? You're likely to be kind of isolated because of your identity and it can give you anxiety. So it can make diagnosis harder, and I think it takes longer. I think it's more likely to go missed if you're trans".*
>
> Trans masculine

For those with any of these neurodiverse conditions, there was a common expression of the difficulties of being "doubly different" relating to both their condition and their LGBT+ identity, making it particularly difficult for them to feel that they fit in.

ADHD

As the previous chapter showed, 11% of survey respondents overall said they had ADHD. However, one in four trans masculine and non-binary people said they had ADHD, while prevalence was lowest for gay men, as Figure 7.1 shows.

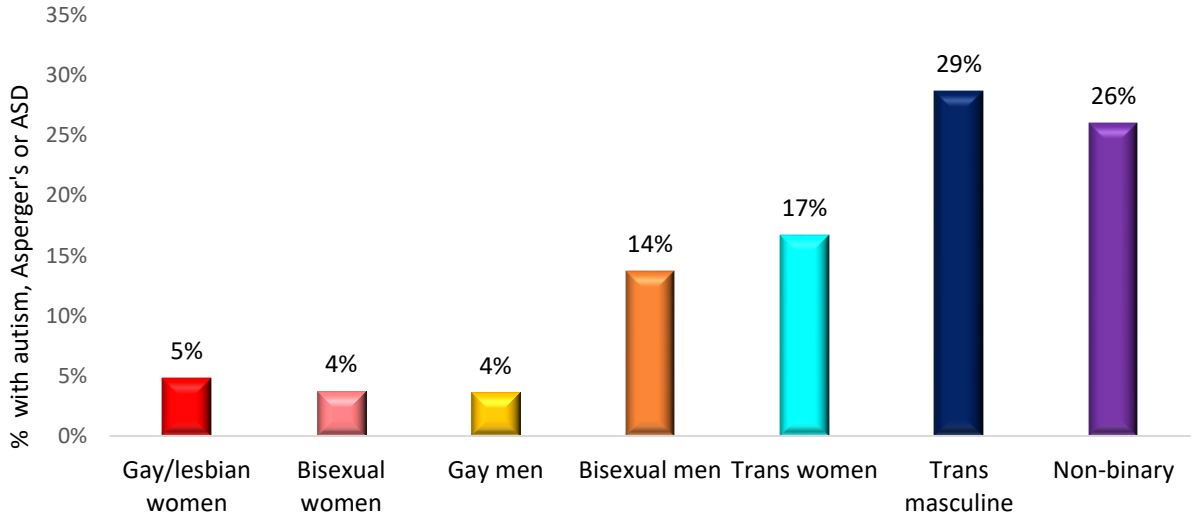
Figure 7.1: Prevalence of ADHD by LGBT+ Group



Autism/Asperger's/ASD

As the previous chapter showed, 12% of survey respondents said they had autism, Asperger's or ASD. As with ADHD, prevalence of autistic conditions was highest for trans masculine and non-binary people, and was also much more common among trans women and bisexual men than it was for gay men, gay/lesbian women or bisexual women.

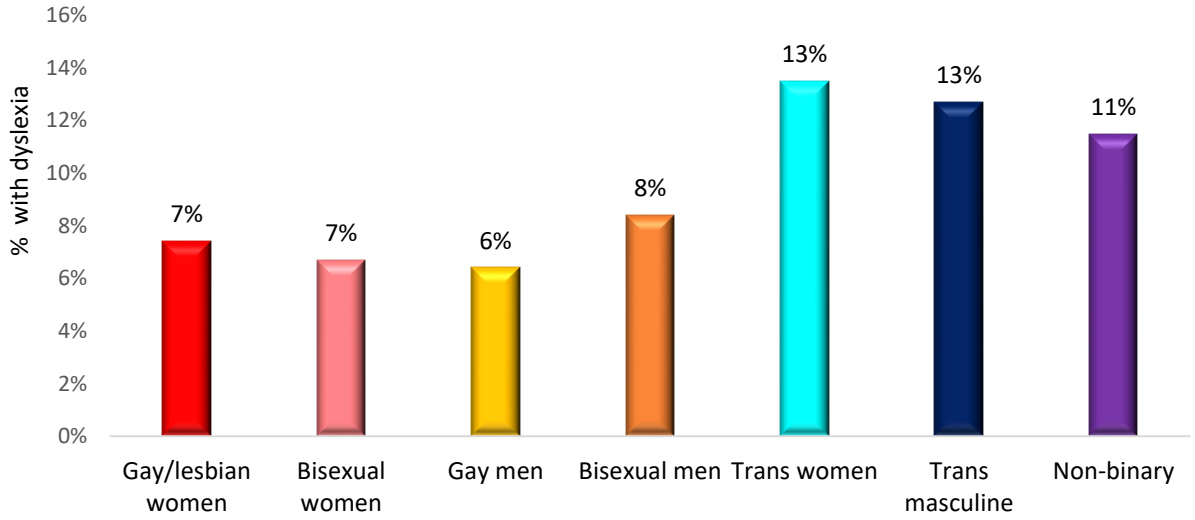
Figure 7.2: Prevalence of Autism/Asperger's/ASD by LGBT+ Group



Dyslexia

Overall, 9% of survey respondents said they had dyslexia (similar to national estimates of 10%[6]). Although the prevalence of dyslexia did not differ between LGBT+ groups to the same striking extent as ADHD and autistic conditions, trans and non-binary people were more likely than cis people with LGB identities to say they were dyslexic, as shown below.

Figure 7.3: Prevalence of Dyslexia by LGBT+ Group



Chapter 12 (Intersections) shows that neurodiversity was associated with poorer wellbeing indicators, including social health, mental wellbeing, and experience of abusive relationships.

[6] Source: Dyslexia Scotland

8. Mental and Emotional Wellbeing

General Mental Health, Depression and Anxiety

The literature review identified a wealth of evidence which indicated that LGBT+ people in Scotland are at much higher risk of mental health problems than heterosexual/cisgender people.

The literature review showed that studies have linked mental health problems with minority stress, but have also highlighted that mental health problems are compounded by experiences such as bullying, discrimination, hate crimes and social isolation. This was also apparent from the qualitative research in which the issues around social and mental health were clearly interlinked. Other people's attitudes and actions clearly had a direct effect on mental health:

> *"I've had a lot of issues with anxiety and stress for pretty much as long as I can remember. It was made worse by people not accepting me, especially the two long-term partners I had before – they would just deny whenever I tried to bring up my identity. That's kind of shattered my self-esteem to the point..I guess the anxiety of how people are going to view me – that worry is always in the back of my mind".*
>
> Non-binary

> *"You become hyper-aware of the possibility of being judged. For 40 odd years I was told people like me were sick, perverted. You internalize that, and you have guilt and shame".*
>
> Trans woman

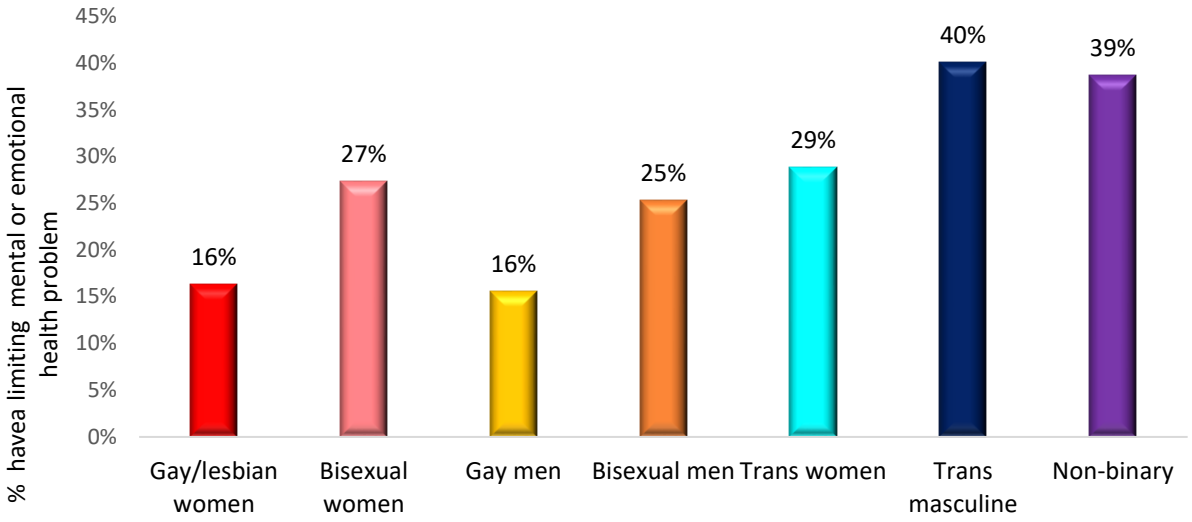
Experience of both depression and anxiety was very common, and most LGBT+ people in the qualitative research indicated that they had suffered from both.

A common theme for all LGBT+ identities was the struggle to work out their sexual orientation and/or their gender identity, and the toll which their period preceding their self-discovery took on their mental health. Coming out was not always an immediate facilitator of improved mental health, and it often depended on how people around them reacted to their identity. Coming out was often problematic or traumatic particularly for trans and non-binary people, as they often faced a lack of understanding (particularly for non-binary people) and had to consider and implement how they presented in their new identity.

The decision to transition usually marked a period of resolution and an improvement in mental health for trans people, but mental health problems could subsequently be significantly exacerbated by the lengthy waiting period to access the services at Gender Identity Clinics which itself caused both depression and anxiety as trans people felt in limbo and unable to proceed with their medical transition. Moreover, trans people frequently said they avoided seeking help for mental health problems for fear that this would be used as a reason for refusing or delaying access to medical transition.

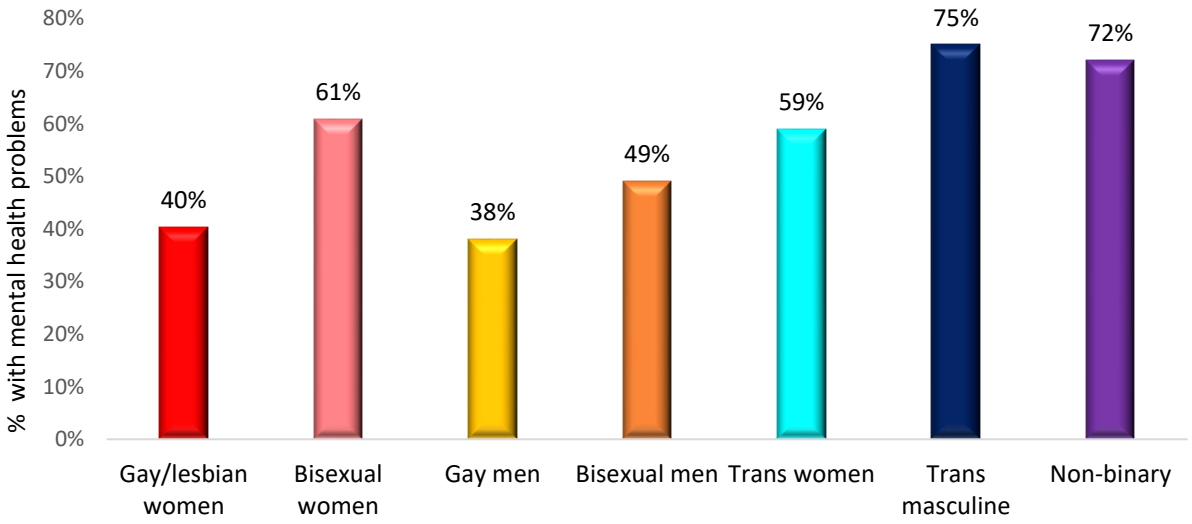
As shown in Chapter 6, the survey findings showed that 25% of respondents had a current long term mental or emotional health problem. This varied significantly across LGBT+ groups – ranging from 16% of gay men and gay/lesbian women to 40% of trans masculine and non-binary people, as Figure 8.1 shows.

Figure 8.1: Proportion who Had a Mental or Emotional Health Problem by LGBT+ Group



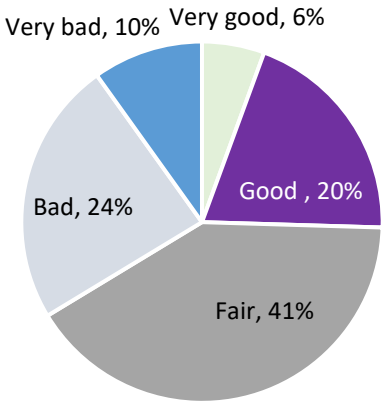
Also, as shown in Chapter 6, when presented with a list of conditions, 54% of respondents said they had mental health problems e.g. depression/anxiety/stress. Again, this varied considerably by LGBT+ group, as Figure 8.2 shows, ranging from 38% of gay men to 75% of trans masculine. There was a high prevalence of mental health problems among bisexual women (61%), which strengthens evidence highlighted in the literature review as bisexual women being one of the groups most likely to have experiences mental ill health including anxiety.

Figure 8.2: Proportion with a Mental Health Problem (e.g. depression, stress, anxiety) by LGBT+ Group



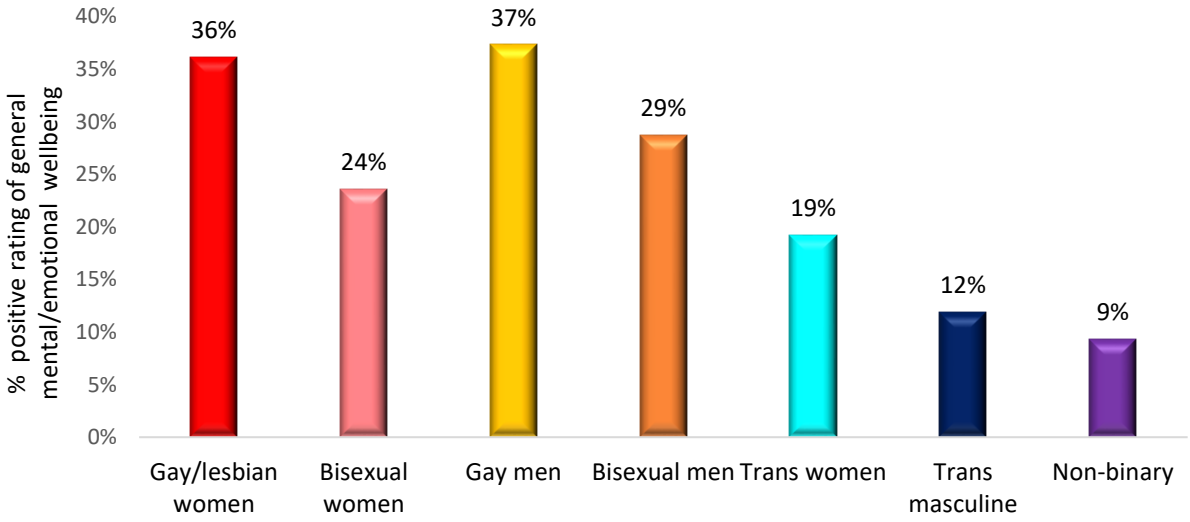
Only one in four (25%) survey respondents rated their general mental and emotional wellbeing positively – either good (20%) or very good (6%).

Figure 8.3: How would you describe your general mental and emotional wellbeing?



Gay men and gay/lesbian women were the most likely to rate their general mental/emotional wellbeing positively (although even in these groups, fewer than two in five gave a positive rating), and trans masculine and non-binary people were the least likely to give a positive rating.

Figure 8.4: Proportion with a Positive Rating of their Mental/Emotional Wellbeing by LGBT+ Group



Respondents were asked whether their mental or emotional wellbeing had changed due to COVID. Responses showed that:

- One in five (20%) said their mental/emotional wellbeing was much the same;
- 8% said their mental/emotional wellbeing had improved due to COVID (6% said improved a little, and 2% said improved a lot);
- 72% said their mental/emotional wellbeing had deteriorated due to COVID (43% said deteriorated a little and 29% said deteriorated a lot).

The qualitative research in 2020 highlighted multiple reasons for deteriorating mental health during the pandemic including:

- **Financial pressures and/or job insecurity**
- **Bereavement**
- **Lack of access to usual support networks and activities to boost mental health:** Those who had a history of mental health problems had often found ways of managing or boosting their mental health including visiting social venues, gyms or exercise classes, support groups or less formal friend groups etc, and they felt cut adrift from these and mentally vulnerable when lockdown was imposed.

> *"I've definitely struggled more with anxiety and depression and feeling quite isolated. I was relying quite heavily on the CAMHS groups and LGBT groups I was attending once a week, and seeing my friends each week. I had a routine at the gym and had all these coping mechanisms in place to manage my mental health. When the gyms closed I started to feel more depressed because I was isolated and then the lack of structure hit me quite hard, especially because I live alone".*
>
> Trans Masculine

> *"I always got support from my Village Family – they counteracted all the negativity. You've got all the negativity in your own head, your doubts about transition, and all that kind of stuff – and you go onto social media which is an absolute cesspool for trans people. Prior to lockdown, I had a correction for all that in going out as me and spending time with my affirming friends who have only ever known me as* (name). *So to lose all that, to be taken from the positive validation that you have in your life and all the opportunities to just go through the world as you, was very significant. I certainly doubted the whole transition thing much more during that period than I have ever done in my life. Previously I felt that things were really positive and moving forward and everything was going well, and now it's just like being stuck in a room by yourself and going 'oh my God, everyone on the internet hates us, why am I doing this?".*
>
> Trans woman

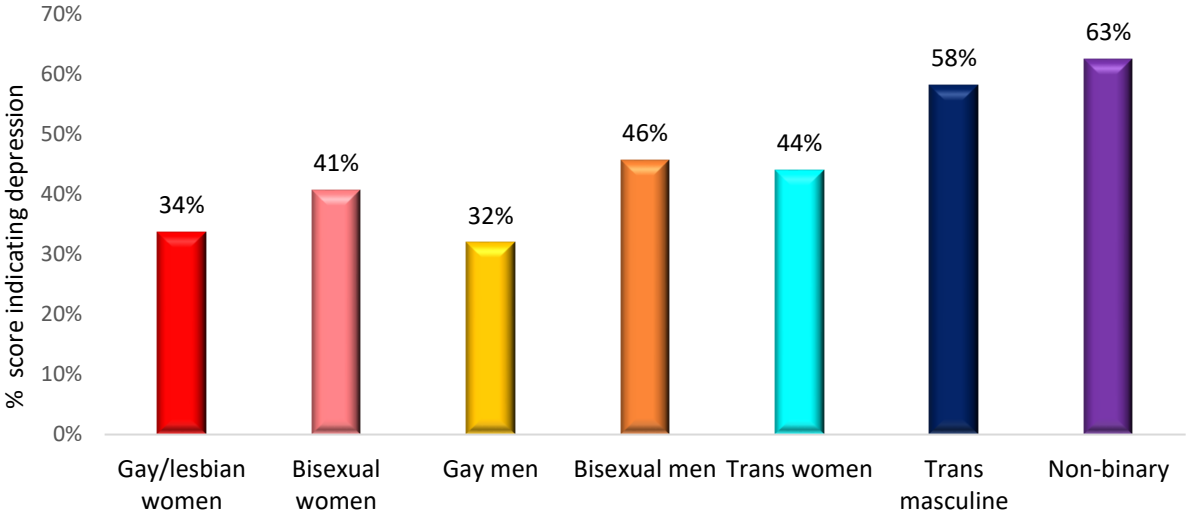
- **Bombardment of news:** Many participants talked about feeling overwhelmed and anxious when watching, reading or listening to the news during the pandemic and felt that over-exposure to the news was detrimental to mental health. Also, social media appeared to become more sated with hateful anti-LGBT+ (particularly anti-trans) comments since the start of lockdown.
- **Fear and anxiety about the spread of the virus and its dangers**
- **Lack of things to do:** Some felt bereft of positive activities such as work or study during the pandemic period, which was detrimental to mental health.

The survey included two questions which form the PHQ-2[7] measure of depression. Responses to these questions show that 43% of all survey respondents had a score which indicates they were depressed. Non-binary and trans masculine respondents were the most likely to have scores indicating depression –around three in five respondents in these groups were

[7] http://cqaimh.org/pdf/tool_phq2.pdf

depressed according to this measure. Gay men and gay/lesbian women were the least likely to have scores indicating depression, but even in these groups one in three were depressed.

Figure 8.5: Proportion who Had PHQ-2 Scores Indicating Depression by LGBT+ Group

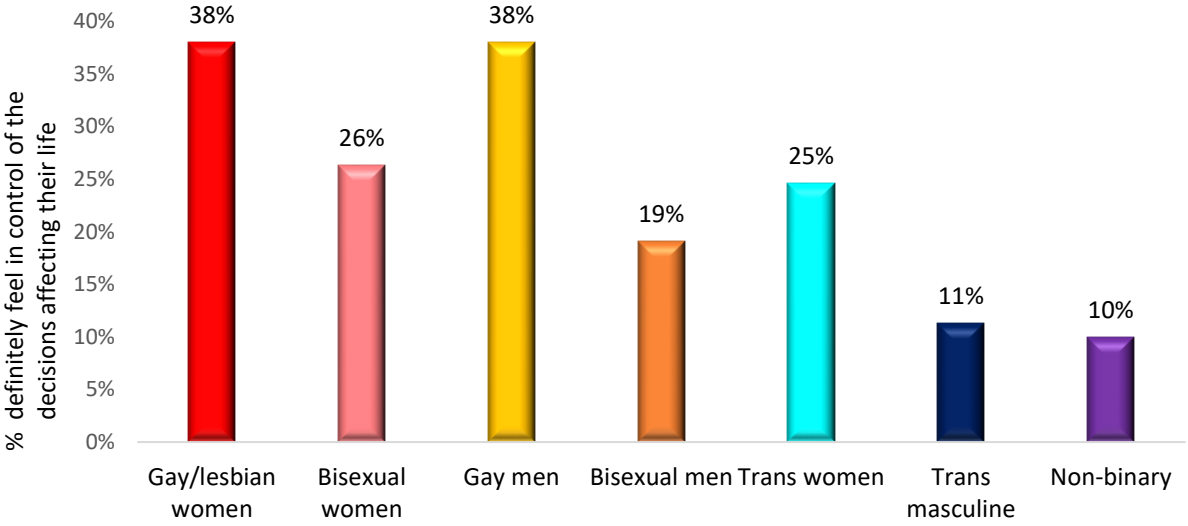


Feeling in Control

Survey respondents were asked whether they felt in control of decisions that affect their life, such as planning their budget, moving house or changing job. Just over one in four (27%) said they definitely felt in control of these types of decision, half (50%) did to some extent and 23% said they did not feel in control of these decisions.

Trans masculine and non-binary people were the least likely to say they definitely felt in control of the decisions affecting their life, and gay/lesbian women and gay men were the most likely to definitely feel in control. It is noteworthy that gay men were twice as likely as bisexual men to feel in control of the decisions affecting their life.

Figure 8.6: Proportion who Definitely Feel in Control of the Decisions Affecting Their Life by LGBT+ Group



When asked whether their feeling of control of these decisions had changed due to COVID:

- Just under half (47%) said it was much the same
- 7% said it had improved (5% said improved a little and 2% said improved a lot)17%
- 46% said it had deteriorated (31% said deteriorated a little and 15% said deteriorated a lot).

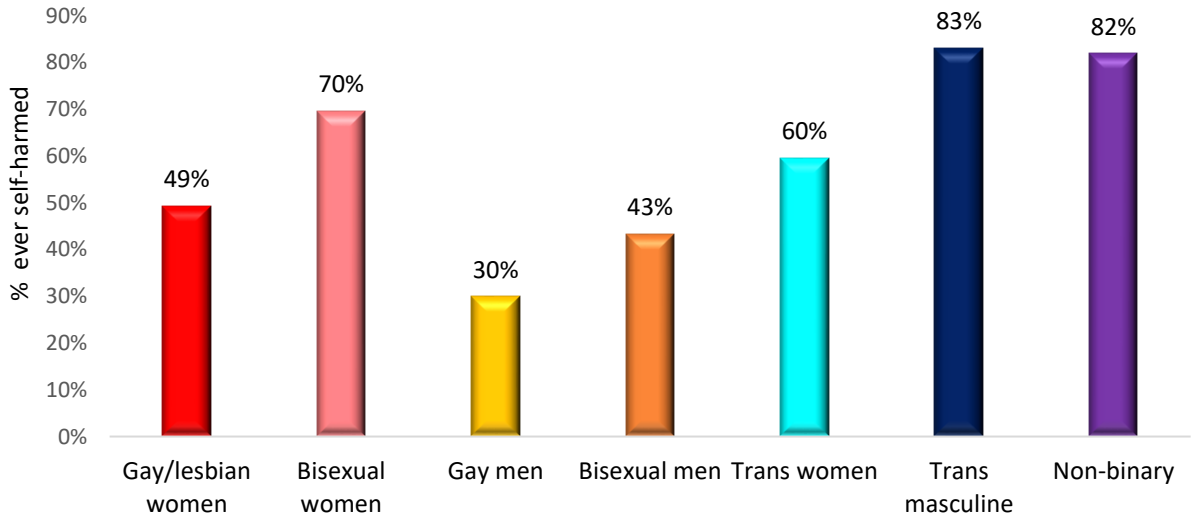
Self-Harm

The literature review highlighted the prevalence of self-harm among LGBT+ people, particularly young people. This was supported by the interviews and group discussions in which people of all LGBT+ identities disclosed histories or current practice of self-harming. Self-harm appeared to be most common in younger years and prior to coming out or transitioning. Non-binary and trans people were among those who more frequently mentioned self-harming, and this was often linked to their gender dysphoria or hatred of their body. LGBT+ people of all identities who self-harmed also spoke of self-harm as a form of release from their feelings of anxiety, turmoil or overwhelm and was often (but not always) linked to their struggle to reconcile their identity or difficulties with relationships.

The survey findings showed that nearly three in five (58%) respondents had ever self-harmed. Of these, nearly half (46%) had done so in the last year, with 12% having done so in the last week.

Prevalence of self-harm varied considerably across LGBT+ groups, with more than four in five trans masculine and non-binary people saying they had ever deliberately harmed themselves, compared to three in ten gay men. Bisexual women had particularly high rates of self-harm (70%).

Figure 8.7: Proportion who had Ever Deliberately Harmed Themselves by LGBT+ Group



Eating Disorders

In the qualitative research, a few LGBT+ people mentioned they had history of eating disorders, and many more described a 'difficult relationship with food' rather than a recognised or diagnosed eating disorder. Many referred to either over- or under-eating when they were depressed or anxious.

Eating disorders among trans and non-binary people were sometimes linked to their gender dysphoria. Service providers spoke about trans men and women deliberately delaying puberty by not eating. Trans men and women spoke about either over or under eating in a deliberate attempt to change their body shape in a way they perceived was more in accordance with their preferred gender.

The pressures around physical appearance, particularly for men on the gay scene, were also felt to be catalysts for body dysmorphia and eating disorders.

The follow-up qualitative research in 2020 highlighted that the circumstances of the pandemic could be conducive to relapse among those with a history of eating disorders, where controlling food intake was a mechanism for exerting control at times when many aspects of life were uncontrollable.

The survey findings showed that:

- One in four (26%) respondents had ever eaten and made themselves sick;
- More than three in five (63%) had ever restricted food or binged on food;
- Nearly all those who had eaten and made themselves sick had also restricted food or binged on food (93%);
- Altogether, 64% of respondents had one of these signs of an eating disorder (either eating and making themselves sick, or restricting or binging on food).

Just under half (48%) of those who had ever eaten and made themselves sick had done so in the last year, and 9% had done so in the last week. Nearly three quarters (73%) of those who had ever restricted or binged on food had done so in the last year, and 29% had done so in the last week.

As the two following figures show, the prevalence of both eating problems was highest for bisexual women, trans masculine and non-binary people.

Figure 8.8: Proportion who had Ever Eaten and Made Themselves Sick by LGBT+ Group

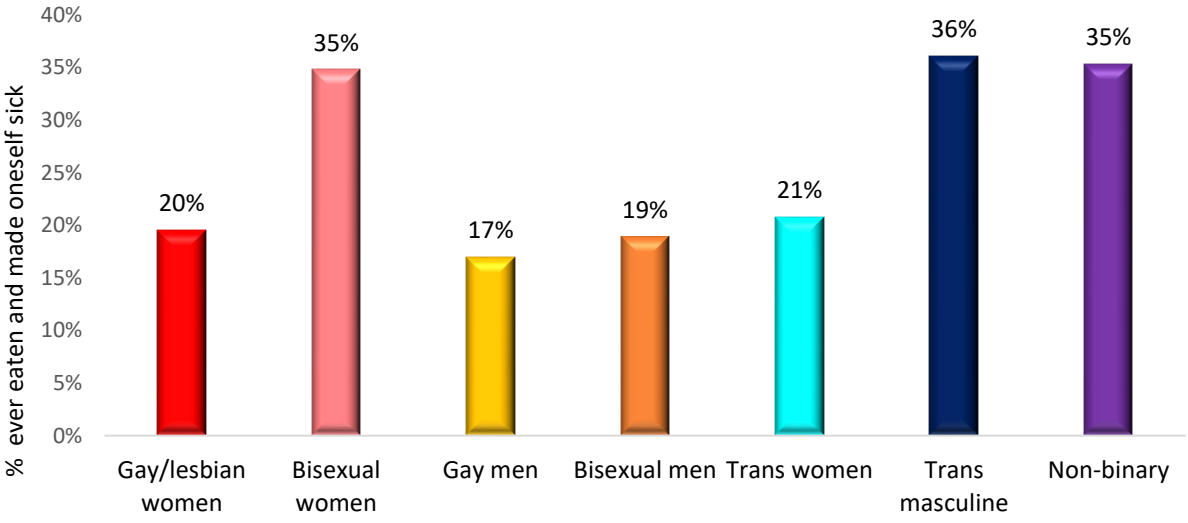
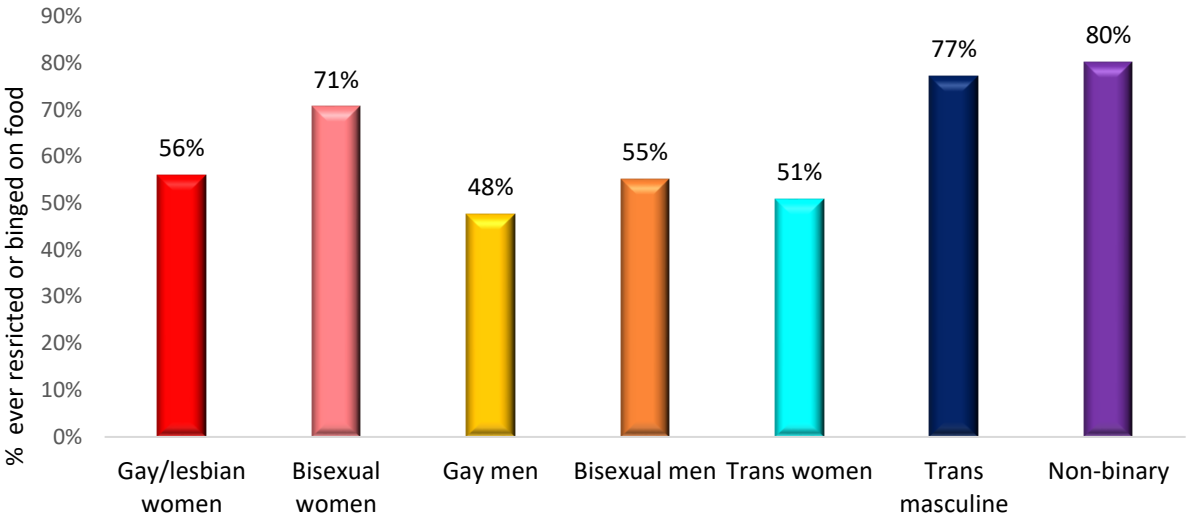


Figure 8.9: Proportion who had Ever Restricted Food or Binged on Food by LGBT+ Group



Suicidal Thoughts and Behaviours

The literature review included many sources which demonstrate a high prevalence of suicidal thoughts and behaviours among LGBT+ people. Indeed, many of those who engaged with the qualitative research had contemplated or attempted suicide. Trans and non-binary people were particularly likely to speak about suicidal thoughts, although these tended to subside after transition.

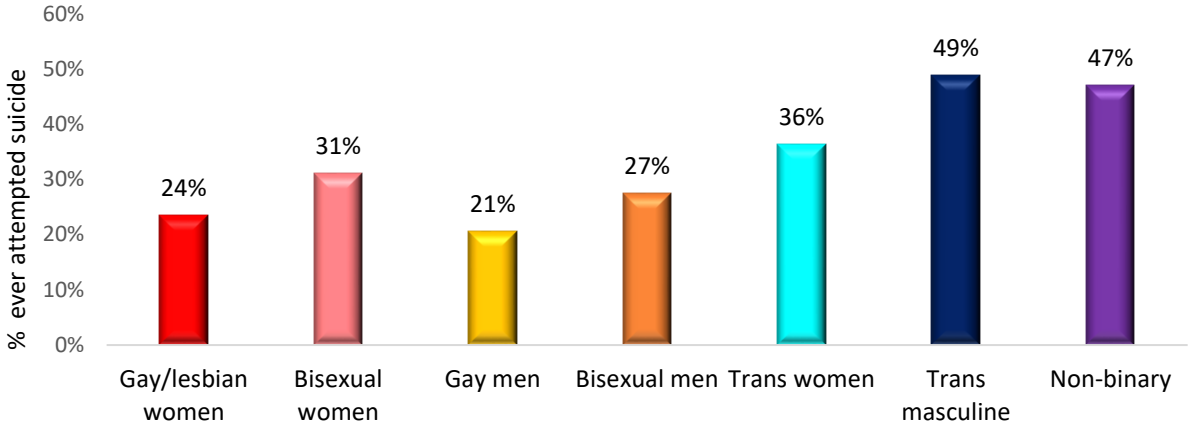
> *"When I was just starting to transition I still had a short back and sides, and I wasn't totally comfortable wearing women's clothing yet and I didn't really know how to put a male body into women's clothes and stuff. That was turbulent in terms of my mental health. My thoughts were very dark and I was thinking get out, end it all".*
>
> Trans woman

For all LGBT+ groups, those who appeared most susceptible to suicidal thoughts included those growing up in cultural or religious groups who were not accepting of LGBT+ identities, those who felt particularly isolated or did not have supportive family or friends, and victims of abuse. Asylum seekers (a group largely unreached by the survey, but included in the qualitative research) were particularly likely to have attempted suicide. Gay and bisexual men gave second-hand accounts of men married to women who were also having sex with men, and these men were also at particular risk of suicide.

Of those who answered the question in the survey (N=2,182), nearly one in three (31%) said that they had ever made an attempt to end their life. Of those who had attempted suicide, 28% said that they had made an attempt in the last year.

Although the prevalence of suicide attempts was high across all LGBT+ groups, it was highest among trans masculine and non-binary people, with nearly half of respondents in these groups saying they had made a suicide attempt.

Figure 8.10: Proportion who had Ever Attempted Suicide by LGBT+ Group



What helps mental health?

The qualitative research showed that having supportive family and friends was seen as one of the most important factors contributing to good mental health. Support from the LGBT+ community and having LGBT+ friends ("finding my tribe") was also seen as crucial by some, and this made a huge difference to the mental health of those who had previously felt depressed, anxious and/or isolated.

Some had struggled for some time to work out how they identified, and a key facilitator of improved mental health was the point at which they were able to identify and name the sexual and/or gender identity which described them ("finding my label"):

> *"I think getting to a point of being able to identify as asexual rather than a weird straight person helped a lot. Actually being able to say this is the thing that I am was really helpful, having the word. That other people feel like this and it's got a word, this is what I am".*
>
> Asexual woman

Although there were huge frustrations at the long waiting times for mental health services and concerns about the appropriateness of some mental health services, appropriate counselling and medication were also felt to be very beneficial for improved mental health.

A comment from a survey respondent (answering about the impact of the wait for GIC services) showed the dramatic improvement on mental health for a non-binary person after accessing appropriate transition services:

> *"I grew increasingly more depressed until the end of 2019 where I attempted suicide. I was offered my first appointment to the GIC in February 2020 and began (transitioning) in September 2020. Waiting such a long time for something that I feel is a life saving service, really brought me to such a low point. Since getting my first appointment back in 2020, my mental health has completely changed by 180 degrees. Just that communication gave me hope and since starting (transition), I have been in the best mental place in my entire life. I can see myself 30+ years in the future, where before getting that appointment, and the never ending waiting list, I couldn't see myself 24-48 hours into the future".*
>
> Non-binary survey respondent

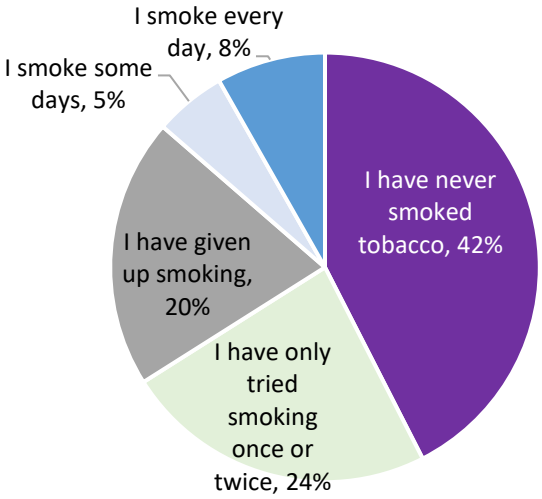
9. Behaviours Impacting Wellbeing

Smoking

The literature review showed many sources which showed that smoking rates were higher for LGBT+ people than for straight cis people. Many of those who engaged with the qualitative research were smokers. Some linked this to mental health (e.g. using smoking as stress relief), and it was felt that depression and other mental health problems were not conducive to a successful attempt to stop smoking. Many felt that smoking cessation was not a top priority for them when they had other problems to deal with such as mental health problems, relationships with family or partners, etc.

One in seven (14%) respondents to the survey were current smokers – smoking every day (8%) or some days (5%). Nearly three in five (58%) had some history of smoking – having tried it, given up or were currently smoking. The prevalence of smoking did not vary by LGBT+ group.

Figure 9.1: Smoking Status



Base: N=1,996

The survey suggests that smoking prevalence may indeed be higher for LGBT+ people than others. The Scottish Health Survey in 2020 showed that 9% of adults in Scotland were current smokers.

Those who were current smokers were asked whether they intend to stop smoking. Half (52%) said yes, 26% said no and 22% said they did not know.

Alcohol

The literature review cited numerous sources which show that LGBT+ people are more likely to drink alcohol at high or problematic levels. This was substantiated by the qualitative research, with many interviews and group discussions involving much discussion around alcohol as an issue for many LGBT+ people. Some used alcohol at problematic levels, and some had a history of addiction to alcohol.

One of the common reasons for using alcohol excessively was 'self medication' and as a coping mechanism to deal with depression, anxiety and stress. One non-binary person described how they used alcohol not only to cope with depression but also to facilitate self-harm:

> *"I drink to drown my sorrows. I don't have non-binary friends that I can go to, to hang out with – I don't have that social connection, so I drink on my own, and self-harm comes into it, because alcohol numbs the skin for when you go to self-harm – it makes it easier".*
>
> Non-binary

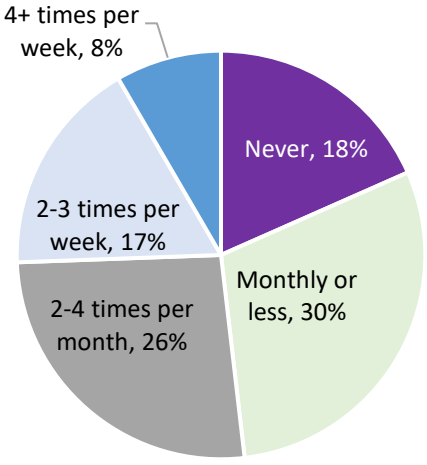
A common theme in the qualitative research was the fact that the gay scene and other LGBT+ social spaces were almost exclusively focussed on alcohol or in places where alcohol was served. Some felt that the only way to socialise with other LGBT+ people or to meet potential partners was to go to bars and clubs and this could lead them to drink more alcohol than they would otherwise.

Alcohol was also used by many as a means of losing social and sexual inhibitions. LGBT+ people commonly said that they only felt able to be themselves and be out about their identity in social settings when they had drunk alcohol. Many also acknowledged that they were much more likely to have sex if they had been drinking alcohol and were also less likely to practice safe sex.

> *"Because of social anxiety stuff, alcohol tends to calm that down because I'm just not thinking any more. I don't think I've ever come out to anyone sober, thinking about it, because the anxiety is just too much. When I realised alcohol reduced anxiety, I realised it was helpful".*
>
> Non-binary

Most (82%) survey respondents said that they drink alcohol, at least sometimes. One in four (26%) said they drink alcohol twice a week or more.

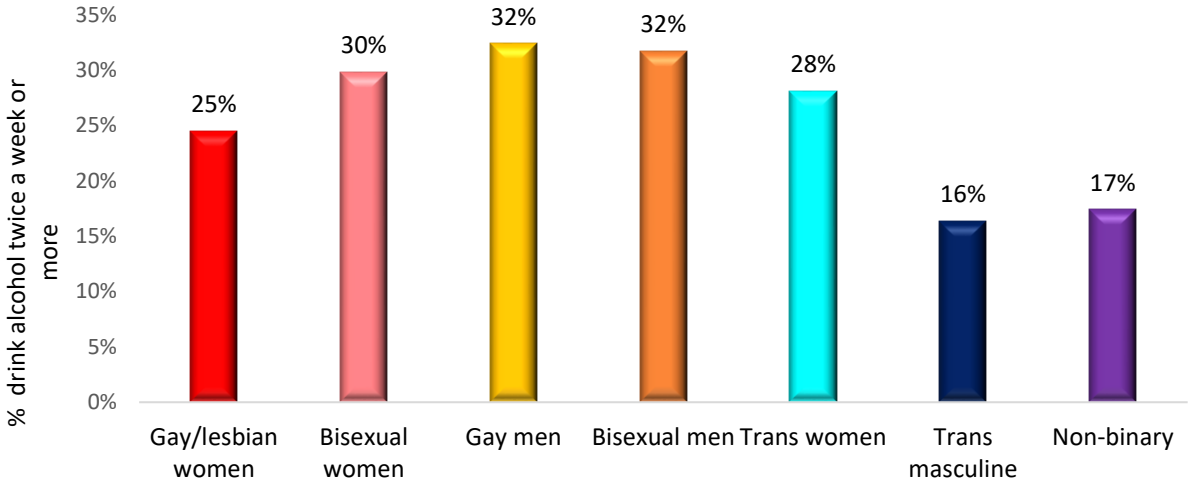
Figure 9.2: How often do you have a drink containing alcohol?



Base: N=1,996

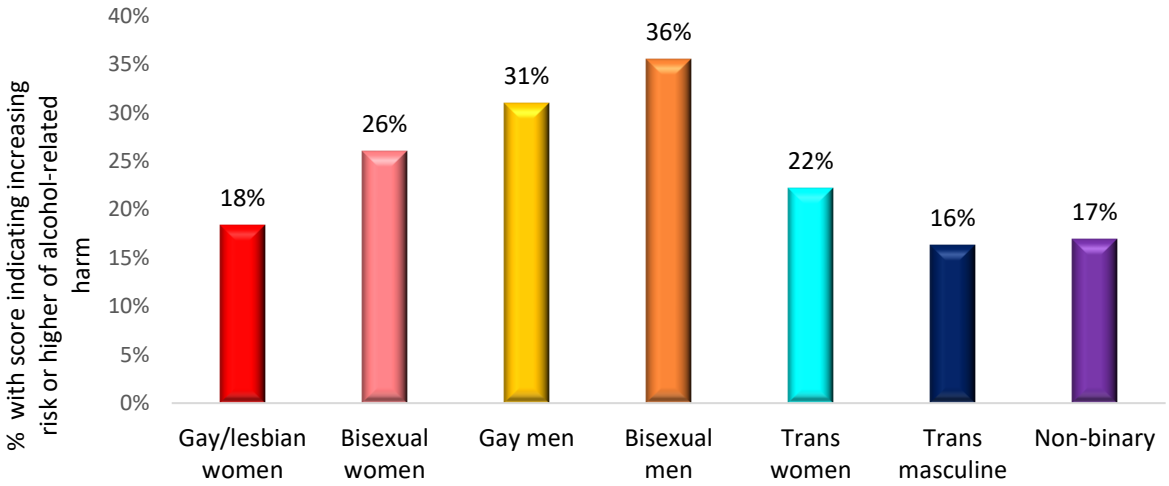
Trans masculine and non-binary people were the least likely to drink alcohol twice a week or more. Nearly one in three (32%) gay and bisexual men drank alcohol twice a week or more.

Figure 9.3: Proportion who Drink Alcohol Twice Per Week or More by LGBT+ Group



The survey included the AUDIT tool[8], developed by the World Health Organisation and widely used to measure levels of risk of alcohol related harm. Of the survey respondents who answered all questions enabling an AUDIT score to be calculated (N=1,694), 77% had a score indicating low risk, 21% were at 'increasing risk', 1% were at higher risk and 1% had a score indicating possible dependence. Gay and bisexual men were the most likely to have scores indicating a level of risk ('increasing' risk or higher) of alcohol-related harm.

Figure 9.4: Proportion who had an AUDIT Score Indicating Increasing Risk or Higher for Alcohol Related Harm by LGBT+ Group



8 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/684823/Alcohol_use_disorders_identification_test__AUDIT_.pdf

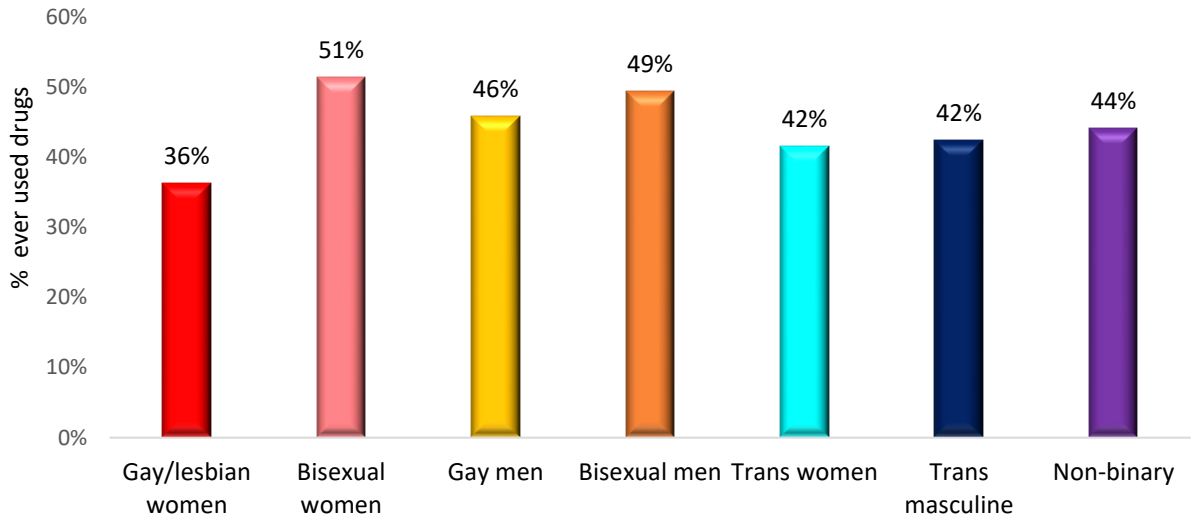
Drugs

Among gay and bisexual men in particular, a recurrent theme in discussions was the prevalence and normalisation of drug use on the gay scene in both Edinburgh and Glasgow, with drugs readily available and drugs being consumed routinely by patrons in gay bars and clubs, and among social groups of gay men. Many different types of drugs were mentioned including Cannabis, MDMA, Ketamine, Cocaine and G (GHB/GBL).

Some MSM also used drugs for chemsex, and this could be problematic as it was often associated with risky sex or men finding themselves in vulnerable situations. For some, chemsex was addictive and they felt that sex without drugs subsequently became unsatisfying.

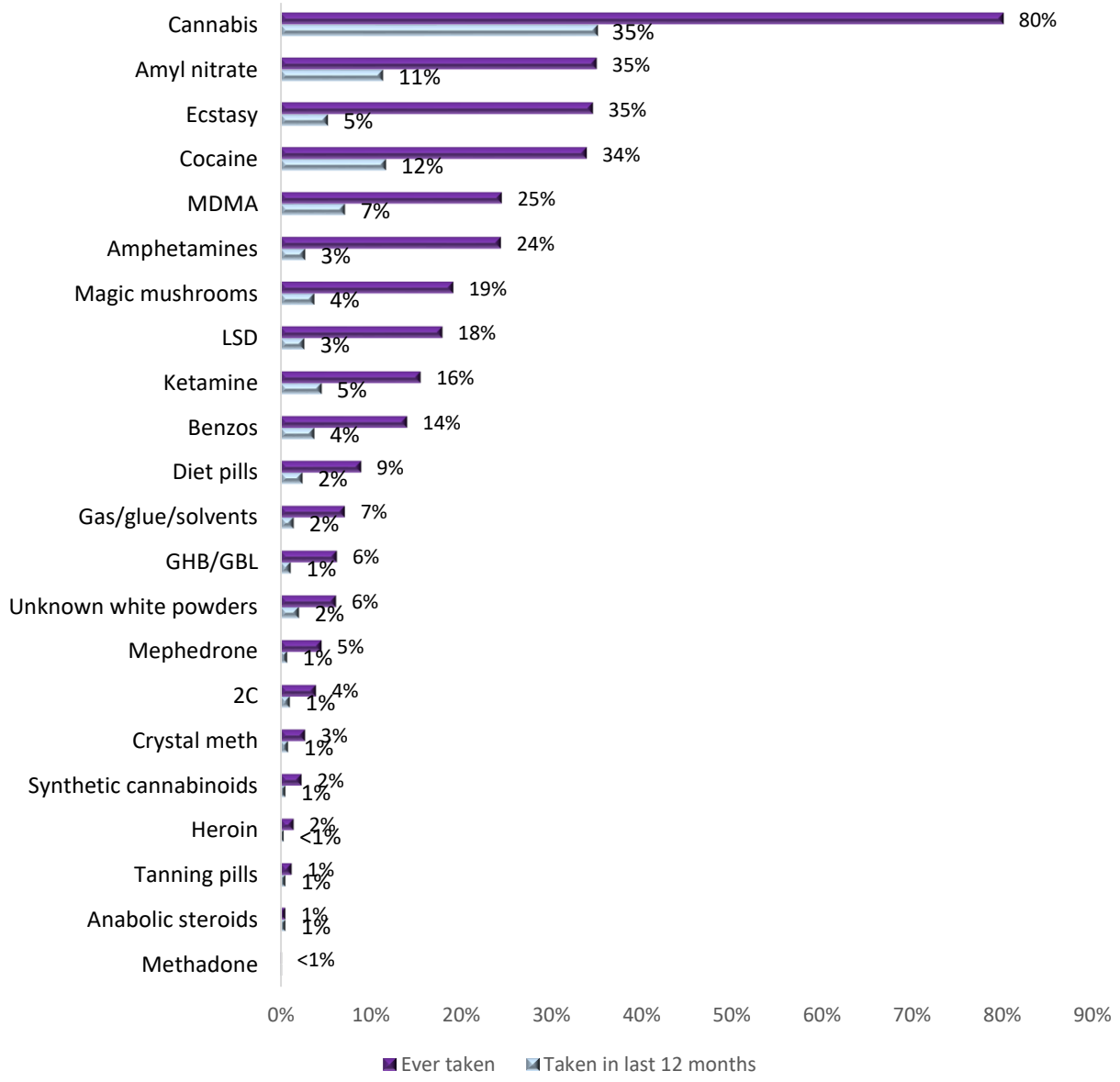
The survey findings show that just under half (44%) of all respondents who answered the question (N=1,939) said they had used drugs. Prevalence of drug use was highest among bisexual women and men.

Figure 9.5: Proportion who had Ever Used Drugs by LGBT+ Group



Those who had ever taken drugs were asked which drugs they had ever taken, and which they had taken in the last 12 months. Of the 845 respondents who had taken drugs and who answered the question, the most common drug was cannabis (80% had used it, and 35% had used it in the last year). The other more common drugs were amyl nitrate, ecstasy and cocaine, as shown in the following figure.

Figure 9.6: Types of Drugs Used Ever and in the Last 12 Months (of those who had ever taken drugs)



Base: All those who had ever used drugs, and who specified which drugs had been used: N=845

Among those who had ever taken drugs:

- Gay men were the most likely to have taken ecstasy (44% gay men; 39% gay/lesbian women; 33% bisexual men; 32% trans masculine; 32% trans women; 30% bisexual women; 25% non-binary).
- Gay men were much more likely than other groups who had used drugs to have used amyl nitrate (54% gay men; 36% trans masculine; 31% bisexual men; 30% bisexual women; 26% non-binary; 26% gay/lesbian women).
- Most of those who had ever used GHB/GBL or crystal meth were gay men.

In the qualitative research, there was a range of views about how people who took drugs felt about their drug use. Some were unconcerned about it, some felt addicted, but a more common position was having concerns about how they were using drugs and wanting to cut down or stop:

> *"I'm using drugs when I want to, so I wouldn't say I'm compelled or addicted, but I think socialising on the gay scene makes using drugs kind of inevitable and predictable and I would say I am concerned a bit about my drug and alcohol intake. I think a lot of it is choosing who I socialise with. I need to sort of step back and just have a bit of a reality check and think is this the sort of behaviour I want to continue? I can already see how much hurt I've caused myself".*
>
> Gay man

Some LGBT+ people felt they relied on drugs to the point of being addicted, but like those addicted to nicotine, addressing their drug addiction was not necessarily a priority for them as they were dealing with other problems:

> *"I definitely am addicted to weed. I tried a couple of weeks ago to go a full week without smoking weed and I couldn't. I feel like it's not a high priority for me – there are a lot bigger fish to fry in terms of what's making my life worse, so weed makes it easier in the short to mid-term. It will be a medical problem at some point probably, and it's obviously not great at improving my mental health. It maybe limits me in getting better, but it also stops me from getting really bad. So it's a stabiliser almost. I just don't feel my addiction is that significant a problem next to everything else".*
>
> Non-binary

In the survey, those who used drugs were asked whether they would like to cut down or stop their substance use. Of those who answered (N=760), just 16% said they wanted to cut down or stop, 76% said they did not and 7% said they did not know. Gay men who used drugs were the most likely to say they wanted to cut down or stop (22%).

Sex/Safe Sex

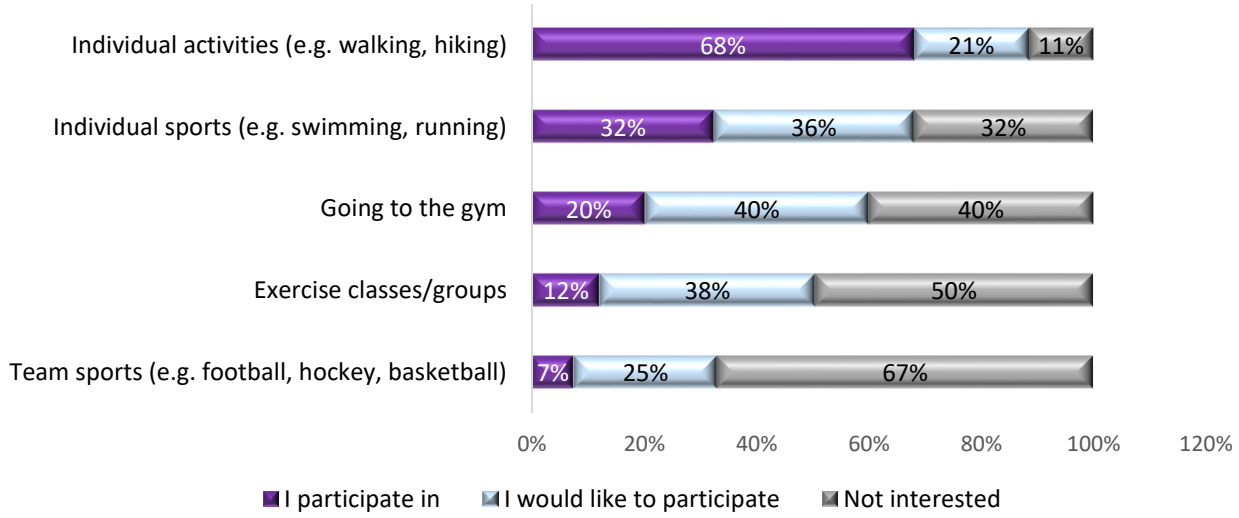
The survey did not include questions about sex/safe sex. However, the qualitative research report includes findings relating to sexual health information/education and services, and an exploration of the reasons for risky sexual behaviour (see from Page 30 in the qualitative research report).

Physical Activity

The qualitative research highlighted a large degree of variation in the extent to which people were physically active, ranging from those who were completely inactive to those for whom sport/physical activity was an important part of their daily lives. Some pointed to a clear link between physical activity and mental health, noting that when they were depressed they did not feel like being active, but also that being active boosted their mental wellbeing.

The survey gauged participation and interest in five types of activity. The findings are shown in Figure 9.7. The most common activities participated in were individual activities such as walking or hiking (68%). For each type of activity, there were large proportions (between 21% and 40%) of respondents who said they would like to participate but currently did not. Overall, respondents were much more likely to say they would like to participate than actually participate in going to the gym, exercise classes or team sports.

Figure 9.7: Which of the following activities do you generally participate in or would like to participate in?



The following table shows how participation and desire to participate in each type of activity varied for each of the LGBT+ groups.

Table 9.1: Proportion who Participate In, and Would Like to Participate In, Activities by LGBT+ Group

		Gay/ lesbian women	Bi-sexual women	Gay men	Bi-sexual men	Trans women	Trans masculine	Non-binary
Individual activities	Participate	74%	75%	71%	63%	57%	63%	56%
	Would like to participate	15%	16%	20%	17%	30%	21%	28%
Individual sports	Participate	35%	40%	36%	37%	24%	23%	24%
	Would like to particate	36%	35%	33%	30%	32%	42%	40%
Team sports	Participate	7%	8%	6%	12%	4%	8%	10%
	Would like to participate	34%	24%	23%	21%	18%	27%	27%
Exercise classes/ groups	Participate	15%	17%	13%	10%	6%	5%	9%
	Would like to participate	36%	38%	43%	28%	39%	30%	37%
Going to the gym	Participate	21%	18%	28%	27%	5%	23%	17%
	Would like to participate	32%	43%	38%	35%	37%	40%	44%

Barriers to Physical Activity

The qualitative research highlighted a number of barriers to participation in sport and exercise for LGBT+ people:

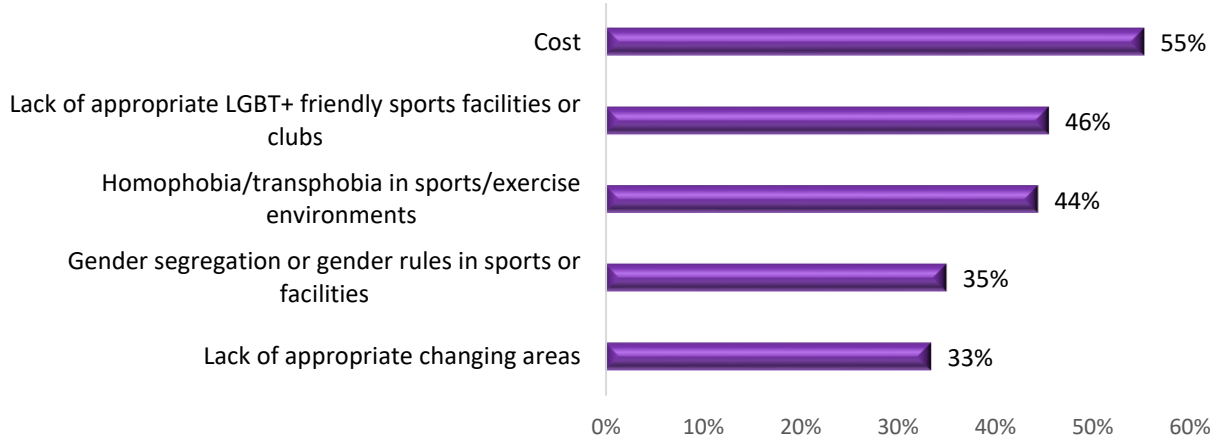
- Gay men in particular felt excluded from the 'laddish culture' in many sports. Some also spoke about anxieties around communal changing and showering with straight men in sports facilities. The importance of physical appearance for many gay men, also led to some reporting that they felt too self-conscious or too unhappy about their body to use gyms.

- Trans and non-binary people had practical and emotional barriers to participation in sports and physical activity, including communal or gender-segregated changing rooms at gyms and other sports venues which caused high levels of anxiety or were deemed completely inappropriate. There were also very practical considerations around what to wear for sports and exercise, particularly for those who had not surgically transitioned, and many trans people said they would feel too self-conscious exercising in any way with other people around. Many trans and non-binary people spoke about doing exercises such as yoga alone at home rather than in a class setting because they did not feel they could participate with others. One trans woman described how she went to the gym at 2am because the gym was almost empty at that time and she was also able to use the disabled changing cubicle. A trans man said he could only use the gym if he changed at home.

- Some trans people spoke about sports which they felt they had had to give up after transition. For example, some trans men and trans women had given up swimming due to not feeling comfortable presenting in a swimming costume. Some trans women spoke about having given up sports which they did not feel were in keeping with their feminine identity. Gender segregation in sports and strict rules around gender were also barriers to trans and non-binary people who were interested in participating competitively.

Survey respondents were asked whether any of five factors (other than COVID) prevented them or put them off taking part in physical activity. Responses are shown in the figure below. While cost was the most common barrier, each of the other barriers were identified by at least a third of respondents.

Figure 9.8: Proportion who Identified Each Factor as Preventing Them or Putting Them Off Participating in Physical Activity



Barriers to participating in physical activity varied for LGBT+ groups, with trans and non-binary people much more likely than LGB respondents to face barriers to participating in physical activity, as shown in Table 9.2.

Table 9.2: Proportion who Identified Barriers to Participating in Physical Activity by LGBT+ Group

	Gay/ lesbian women	Bi-sexual women	Gay men	Bi-sexual men	Trans women	Trans masculine	Non-binary
Cost	49%	66%	41%	40%	50%	66%	69%
Lack of appropriate LGBT+ friendly sports facilities or clubs	36%	22%	45%	36%	66%	74%	66%
Homophobia/ transphobia in sports/ exercise environments	26%	25%	41%	44%	74%	76%	68%
Gender segregation or gender rules in sports or facilities	16%	20%	15%	27%	65%	77%	73%
Lack of appropriate changing areas	17%	18%	18%	28%	63%	73%	64%

The qualitative research did, however, highlight some examples of good practice and inclusivity including a number of LGBT+ sports clubs and teams. Most of these were felt to be inclusive of all LGBT+ identities, and for those interested in the sports, these clubs offered a much sought-after opportunity to connect and socialise with other LGBT+ people away from 'the scene'. Roller derby was also mentioned several times as an inclusive mainstream sport.

Impact of COVID on Physical Activity

The follow-up qualitative research in 2020 found variation across individuals regarding the impact of the pandemic on levels of physical activity – with some reporting increased physical activity and others reporting a decrease.

For some, reasons for increased physical activity during the pandemic included:

- Making the most of the few permittable reasons for leaving the house including physical activity
- Having more time to devote to exercise and physical activity
- Finding accessible opportunities for fitness classes online

A number of participants spoke of taking up cycling or rediscovering cycling as a form of exercise in lockdown. The reduction of traffic on the roads also facilitated this.

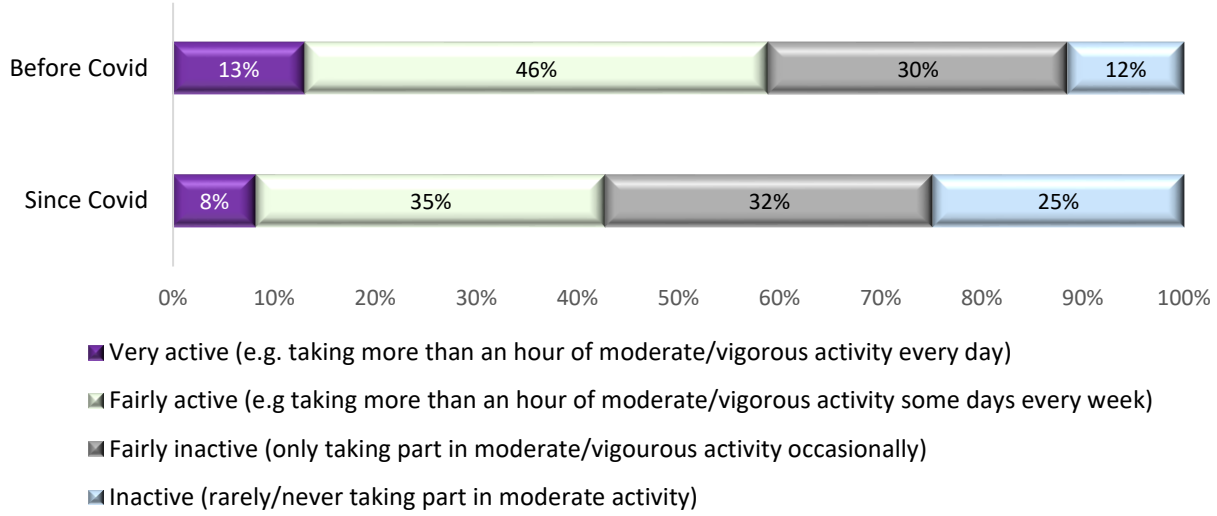
However, others spoke about their physical activity levels declining due to the closure of gyms, exercise classes and sports facilities.

> *"Personally, I've been really struggling with physical activity because I kind of feel like I need the environment of a gym, and even when they opened up again recently.. I've not (gone) because I don't feel that it is safe enough yet, it doesn't feel like it's worth the risk. The gym used to be part of my routine. It wasn't even like a fitness thing, it was more of a self-care thing. It was kind of meditative – like listening to music and working out. And that's not really there any more".*
>
> Bisexual man

> *"I think, like a lot of trans guys, I like going to the gym, because it makes me feel good about myself and helps me a lot with managing dysphoria. When the gyms closed and I couldn't access a gym for six months, it was really hard on me. And like everyone else, I tried doing the home workout thing, but it wasn't feeling like it did when I went to the gym- I like using heavy weights and exhausting things, so when I go home I feel exhausted but really good about myself. So not having had that for a really long time had a profound impact on my mental health and I think my physical health as well, in terms of how fit I am and how good my circulation is and all that stuff".*
>
> Trans masculine

The survey asked respondents how active they were before COVID, and how active they had been since COVID. Overall, levels of activity fell, with the proportion describing themselves as inactive doubling from one in eight (12%) to one in four (25%), as the following chart shows.

Figure 9.9: How active would you say you were before COVID and Since COVID?



Overall, 44% of respondents gave responses which showed they had become less active since COVID, but 37% showed no change and 19% had become more active since COVID.

Online Activity

Evidence from the Qualitative Research (Pre-COVID)

The qualitative research in 2019 highlighted that some trans and particularly non-binary people often used online gaming as a means of interacting in a non-gendered way, or trying out genders in a virtual environment. Among those who did this, this was largely felt to be positive on their mental health. Online gaming allowed people to experiment playing as characters of different genders, characters with no gender, or adopt avatars that presented in ways they identified (before beginning their own transition). Online gaming was also felt to be an activity which could relieve stress and was seen as a much more positive alternative to destructive options such as drug use or self-harming. However, it was recognised that gaming could become addictive or people could be compelled to spend longer on these types of activities than they felt they should. As a result, some had taken action to try to limit their online gaming activity.

Among GIC professionals, there was some concern that people were accessing the service who spent much of their time online gaming and that they had not spent sufficient time socialising in the real world in their preferred gender.

Social media was largely viewed as a very good way for people to connect to other LGBT+ people, particularly those in more rural areas and those with minority identities. Social media was used to connect to people, make friends, access online groups and online support. Social media and digital dating apps were also used to connect to potential partners. However, it was also recognised that social media could be very detrimental to mental health and self-confidence where negative messages and attitudes relating to LGBT+ people were prevalent. There was much discussion from all LGBT+ groups about the current discourse on social media against trans people, particularly trans women.

Some LGBT+ people took action to ensure they were not too exposed to negative online content, including blocking people, limiting the time they spent on social media and ensuring they only linked to their friends on some platforms rather than having sight of wider activity.

Social media was also felt by some to have a negative effect on mental health because of people posting and promoting distorted images and messages of their 'perfect lives', leaving people feeling inadequate. For gay men in particular, social media and dating apps were felt to perpetuate the unrealistic pressures on gay men regarding their appearance.

Digital Lives Since COVID

The 2020 research showed that as the pandemic period forced people to spend more time connecting to others online when they could not meet in person, the harmful aspects of online activity could become magnified. 'Doom scrolling' was a term used by several participants to describe their behaviour of browsing through social media, and becoming overwhelmed by the stream of either bad news relating to the pandemic, or hateful comments directed at LGBT+ communities. It was recognised that 'doom scrolling' was harmful to their mental health.

The trans community had been particularly affected during the pandemic period by the high level of social media activity centred around the consultation on the Gender Recognition Reform (Scotland) Bill. While the 2019 research had already highlighted the effects of negative discourse on trans women on social media, this became heightened in 2020 when people were feeling particularly vulnerable and isolated and the social media rhetoric intensified. Some found it impossible to escape from this, particularly when it was repeated and discussed in mainstream media:

> *"I can't not be online, because I need to be for my job. (Anti-trans social media content would be) repeated across 25 different mainstream news articles – all the reactions from all the other websites. You just can't get away from social media. All the bigots were in lockdown too and had time on their hands. I feel that I need to be online for my job but by going online I'm practicing self-harm – it really does feel like that, and I don't know what I can do about it".*
>
> Transgender woman

> *"Before coronavirus I'd stopped looking at the BBC, because they kept having articles that were really transphobic, and it's really traumatic to me to come across. I had stopped looking because it was constantly overwhelming. But now I've had to go back to looking there, because I'm not sure where else to get information- like what the current rules are for the virus. So every time I want information about coronavirus, at the same time I run the risk of getting triggered or reading stuff that's really upsetting".*
>
> Non-binary

Some had taken steps to cut back on their exposure to harmful social media contact particularly in the lockdown period.

However, several participants spoke about the positive aspects of social media, particularly connecting with people with similar identities or people with similar interests.

"My online activity has exploded outwards, but I've found through online communities that I've built a nice network of people that I might not otherwise have got to know, which has been really helpful. Mostly because- well, you can't see friends, so what are you gonna do? Make more friends! Which has been surprisingly fun, perhaps because we're all in the same boat, so we all share the same sort of feeling for the outside world right now, and so we collectively understand each other, which is rather nice".

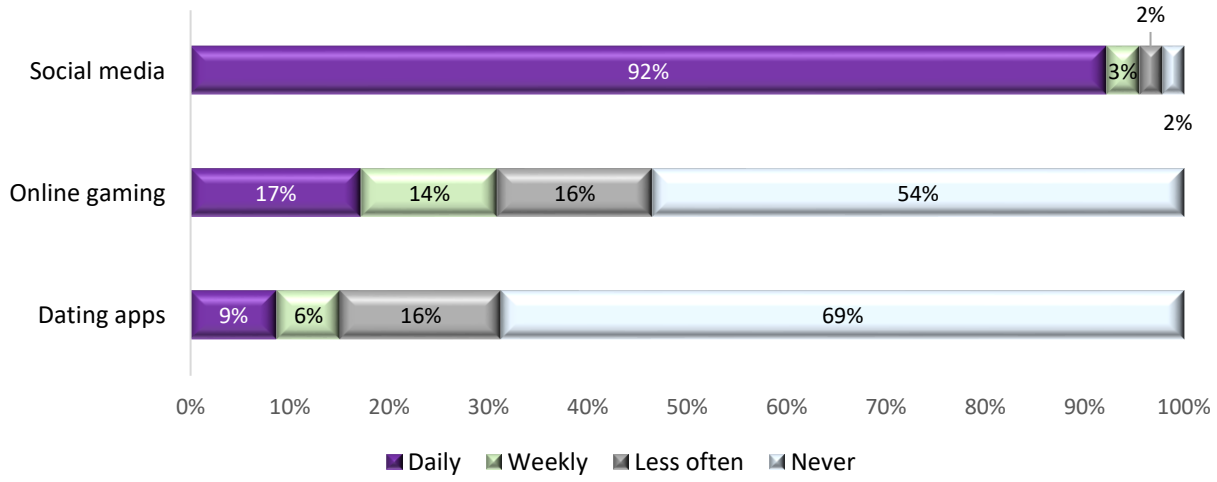
Non-binary

There were sections, particularly among non-binary people, who preferred online interactions to 'real world' socialising and engagement with services, and they welcomed the move to much more widespread online interactions, and were in fact anxious about returning to 'normal' when more face-to-face interactions might be expected of them.

Survey Findings

Survey respondents were asked how often they used social media, online gaming and dating apps. Responses are shown in the figure below. Nearly all (92%) used social media daily[9]. Around half (46%) participated in online gaming at least some times, and 31% used dating apps.

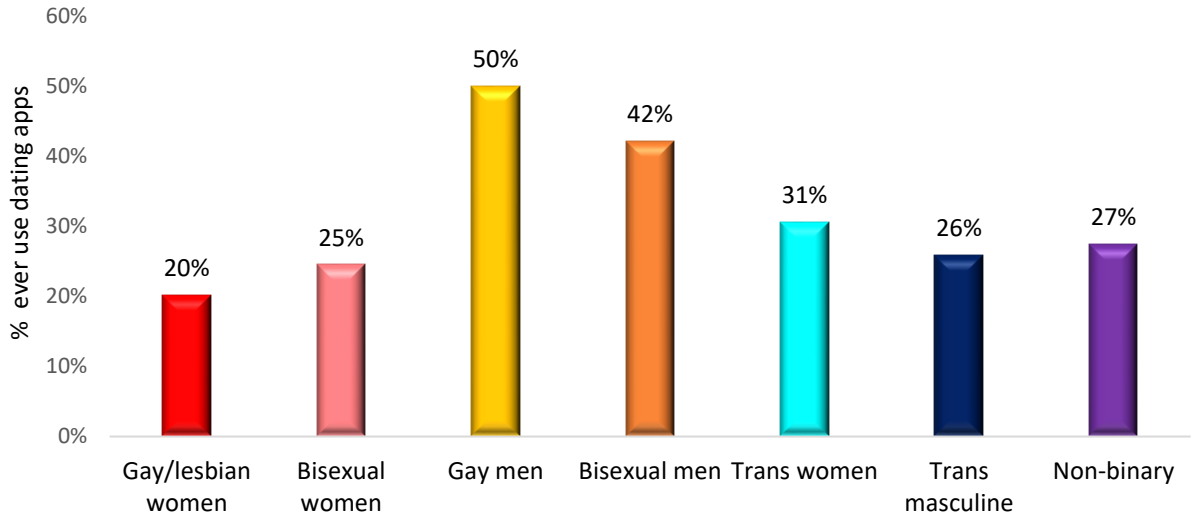
Figure 9.10: How often do you use the following things online?



Gay and bisexual men were the most likely to use dating apps. Half (50%) of gay men ever used dating apps and 23% did so daily.

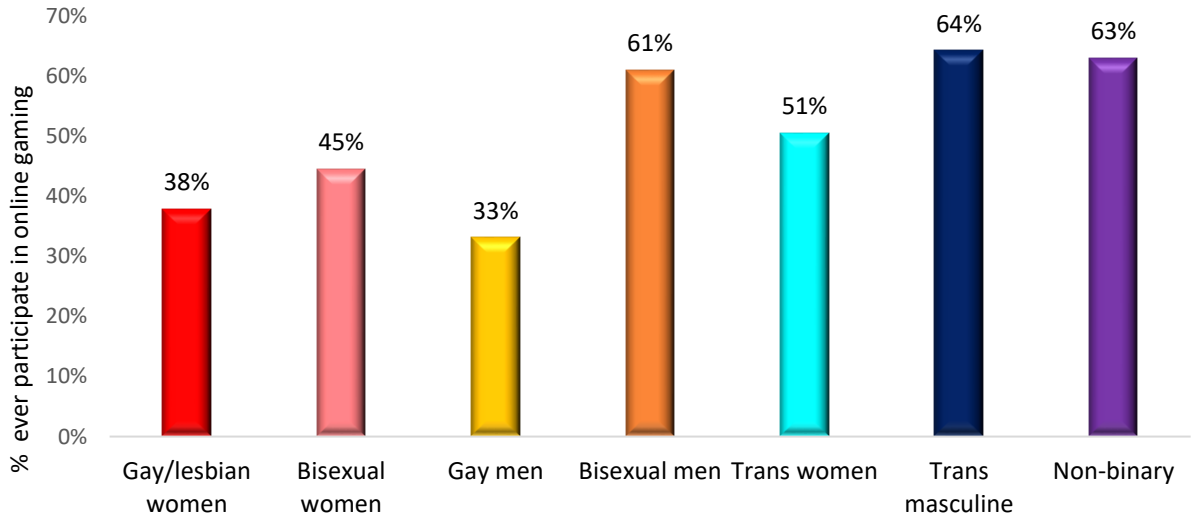
[9] The survey link was shared widely on social media, being the main method of survey recruitment.

Figure 9.11: Proportion who Ever Use Dating Apps by LGBT+ Group



Trans masculine, non-binary and bisexual men were the groups most likely to participate in online gaming, as shown below.

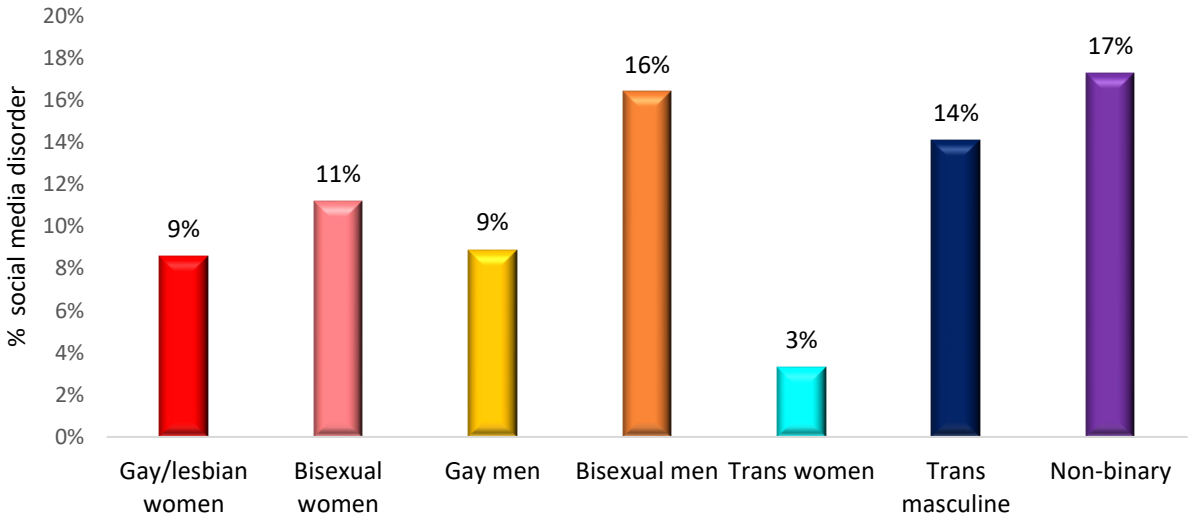
Figure 9.12: Proportion who Ever Participate in Online Gaming by LGBT+ Group



The survey included a set of questions which comprise the Social Media Disorder Scale[10] which is used to diagnose a disorder of social media use. Overall, one in nine (11%) of respondents who answered all questions for the scale (N=1,546) had scores which indicated a social media disorder. Scores indicating a social media disorder were most common among non-binary people and bisexual men.

[10] https://www.psytoolkit.org/survey-library/social-media-disorder-scale.html

Figure 9.13: Proportion who have a Social Media Disorder Scale Score Indicating a Disorder by LGBT+ Group



Respondents were asked how they thought their online use affects their life. Responses were mixed. Half (47%) said it was equally positive and negative; 29% said it was more positive than negative; 24% said it was more negative than positive. Patterns of response did not vary significantly by LGBT+ group.

10. Financial Wellbeing and Homelessness

Financial Wellbeing

The literature review highlighted evidence that LGB people were more likely than heterosexual people to have difficulty meeting living expenses, experience food insecurity and live in areas of multiple deprivation.

The qualitative research revealed significant financial impacts which were directly or indirectly related to LGBT+ identities:

- Due to either lack of access or long waiting times for NHS treatment, many LGBT+ people felt forced or compelled to access private treatment, particularly for counselling, but also fertility services and private treatments for gender transition.

> *"I'm still on the waiting list for the* (GIC). *I've still not got a date for my initial appointment and I've waited 22 months, so I'm temporarily seeing a private specialist and got my diagnosis of gender dysphoria and prescribed hormones. That is having a huge financial impact, and that's been one of my biggest worries. I had some savings and they've been depleted to zero. I think I can continue to have the private treatment until the end of the year, but if I haven't transferred to the NHS by then I'll have to sell my flat".*
>
> Trans woman

- All NHS GRS is performed in England and although travel expenses are reimbursed, they have to be paid upfront by patients and this caused financial difficulties for some.

- Some young people did not feel able to come out to parents until the point they were leaving or had left the parental home. In some cases, this led to young people moving out of the parental home before they may be otherwise ready either emotionally or financially, and they could struggle to meet living costs.

- The difficulties faced by LGBT+ people living in rural areas and small towns compelled LGBT+ people to migrate to cities where living costs could be higher and where they did not have financial support from family. Also, moving to a new city (e.g. as a student) often represented a 'new beginning' for LGBT+ people where they lived openly in their identity for the first time, but this also meant they were less likely to return to their family home or place of origin to live after their studies, and this could also have a financial impact.

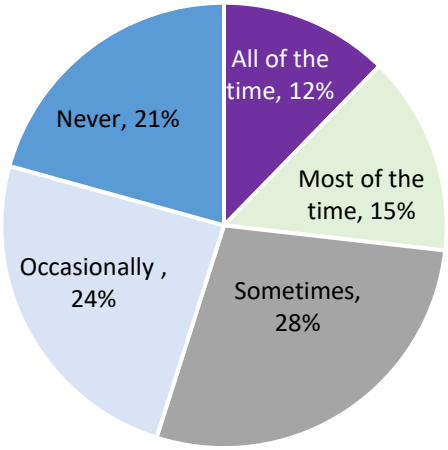
- The cost of travel to use health services, third sector support services and LGBT+ social groups was a financial burden for those in rural or outlying areas.

- There was also a significant financial impact of addictions or use of drugs, alcohol and cigarettes.

Financial Worries

Survey respondents were asked whether they currently had any financial worries. Only one in five (21%) said they never had any financial worries. More than one in four (27%) said they had financial worries all or most of the time.

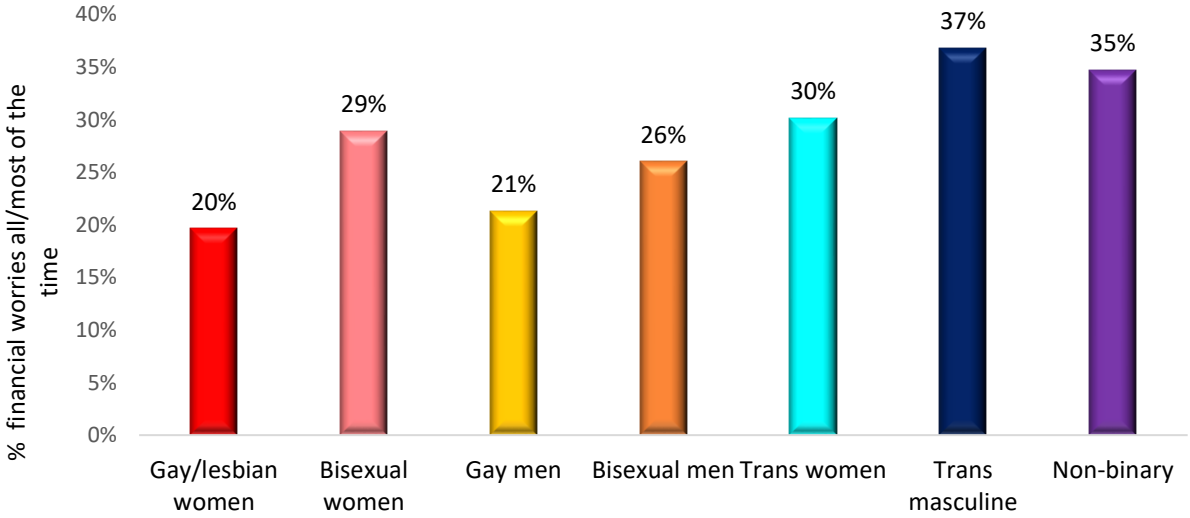
Figure 10.1: Do you currently have any financial worries?



Base: N=1,856.

Across LGBT+ groups, the proportion who had financial worries all or most of the time ranged from 20% of gay/lesbian women to 37% of trans masculine people.

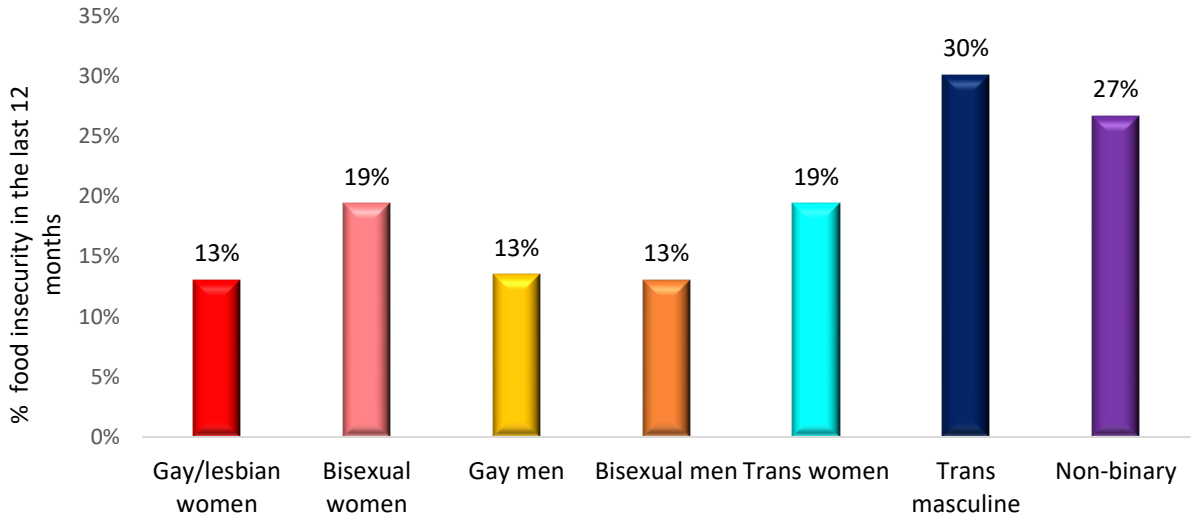
Figure 10.2: Proportion who had Financial Worries All or Most of the Time by LGBT+ Group



Food Insecurity

More than one in six (18%) LGBT+ respondents said that during the last 12 months there was a time when they were worried they would run out of food because of a lack of money or other resources. The prevalence of food insecurity was highest among trans masculine and non-binary respondents, as shown in Figure 10.3.

Figure 10.3: Proportion who had Experienced Food Insecurity in the Last 12 Months by LGBT+ Group

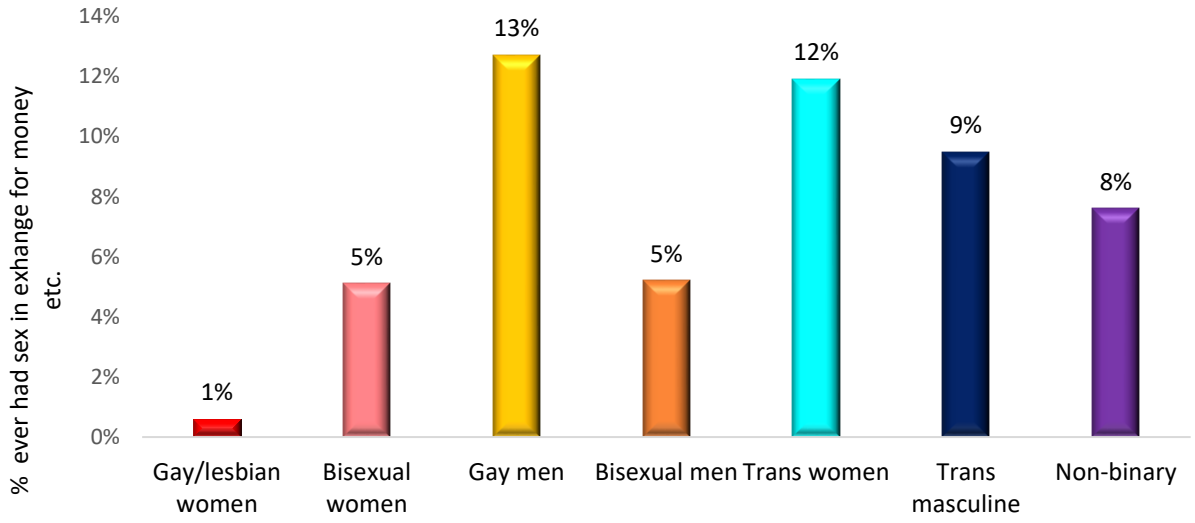


Overall, 20% of LGBT+ people aged under 50 had experienced food insecurity in the last 12 months. The closest comparable data is from the 2020 Scottish Health Survey which asked the identical question and found that 12% of those aged under 45 had experienced food insecurity in the last 12 months.

Selling Sex

Overall, one in fourteen (7%) LGBT+ people in the survey said that they had ever had sex in exchange for money, goods, food, drugs or somewhere to stay. This was most common among gay men and trans women and least common among gay/lesbian women.

Figure 10.4: Proportion who had Exchanged Sex for Money in the Last 12 Months by LGBT+ Group

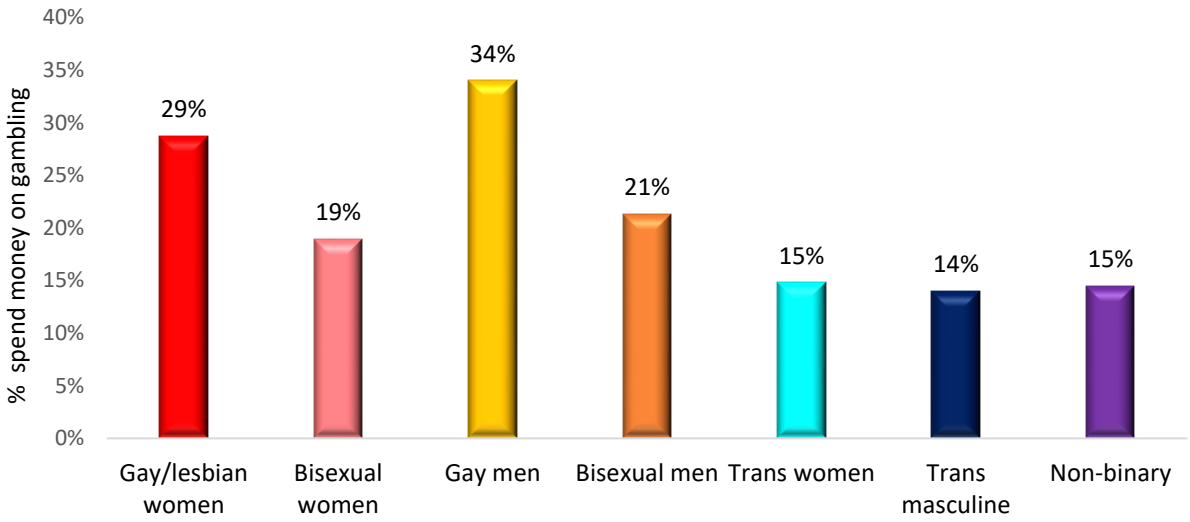


Gambling

There was evidence highlighted in the literature review suggested that LGB people were less likely to spend money on gambling than heterosexual people. However, nearly one in four (23%) survey respondents said they ever spend money on gambling – most commonly monthly or less (18%), but 4% did so two to four times per month, and 2% did so twice a week or more.

Gay men and gay/lesbian women were more likely than other LGBT+ groups to spend money on gambling.

Figure 10.5: Proportion who Ever Spent Money on Gambling by LGBT+ Group



The survey included questions to calculate scores on the Problem Gambling Severity Index (PGSI)[11] (Mini version). Among the 446 respondents who ever gambled and who answered the PGSI questions:

- 80% were non-problem gamblers
- 11% were low-risk gamblers
- 6% were moderate-risk gamblers
- 3% were problem gamblers.

Homelessness

The literature review pointed to a disproportionately high number of homeless people having LGBT+ identities. A number of those who engaged with the qualitative research had experienced homelessness, and reasons included:

[11] https://www.gamblingcommission.gov.uk/statistics-and-research/publication/problem-gambling-screens

- Breakdown of family relationships after coming out, forcing young people away from the parental home, or preventing return in times of hardship
- Escaping an abusive relationship
- Migration from rural areas to cities, where people would sofa-surf
- Addictions including alcoholism and gambling addiction which led to eviction

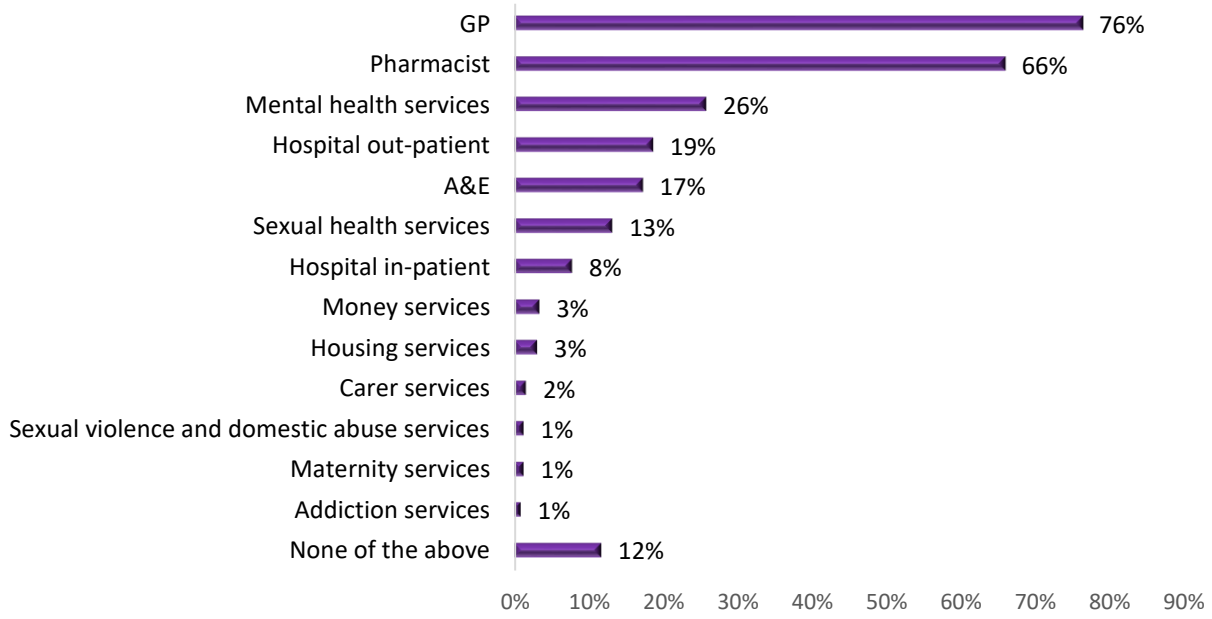
One in eight (13%) survey respondents said they had ever been homeless. Experience of homelessness did not vary significantly across LGBT+ groups.

11. Experience of Health Services and Other Services

Use of Services

Survey respondents were asked whether they had used particular services in the last 12 months. The services most commonly used were GP (76%) and pharmacist (66%). All responses are shown in Figure 10.1.

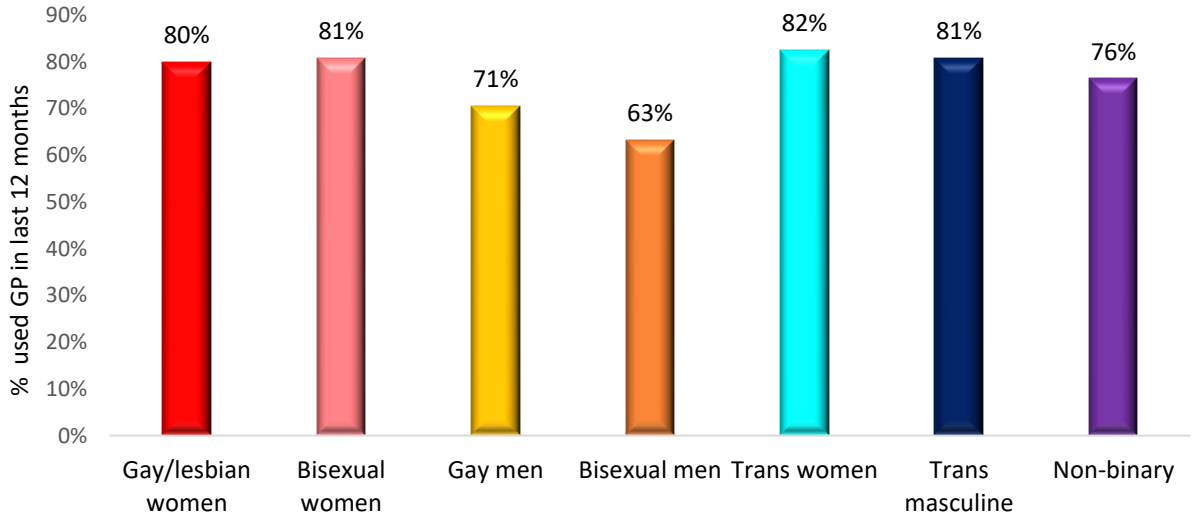
Figure 11.1: Proportion who had Used Each Service in the Last 12 Months



GP Services

Bisexual men were the group least likely to have used their GP in the last year.

Figure 11.2: Proportion who had Used the GP in the Last 12 Months by LGBT+ Group



The qualitative research found that overall, most were happy with the care they received from their GP and most of those who were out to their GP had positive experiences. However, there were also issues around heteronormative assumptions, examples of GPs misdiagnosing people through assumptions made about their sexuality or gender identity, inadequate knowledge about some identities, and some concerns around confidentiality.

In the survey, of those able to answer about the most recent time they used their GP:

- 72% were out to their GP (from N=1,302)
- 88% said it was a positive experience (from N=1,113)
- 65% said the staff showed an appropriate understanding of LGBT+ uses (from N=527)
- 5% said they were treated unfairly due to their LGBT+ status (from N=1,098).

Gay men and trans masculine were the most likely to have been out to their GP at their last engagement (89% gay men; 87% trans masculine; 87% trans women; 80% gay/lesbian women; 58% non-binary; 54% bisexual men; 50% bisexual women).

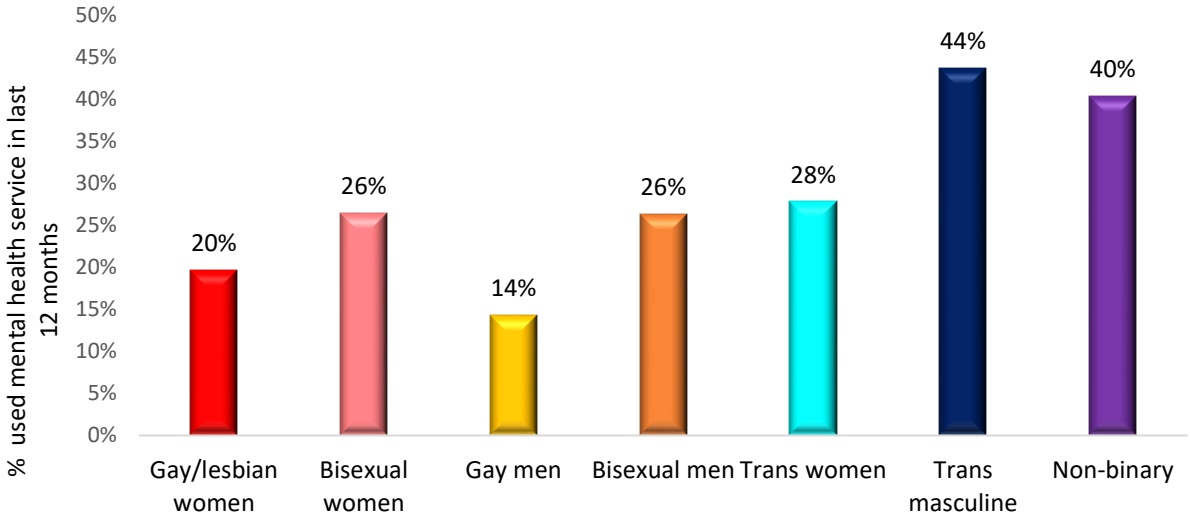
Gay men were the most likely to describe their last use of GP services as positive, and trans masculine people were the least likely (94% gay men; 91% bisexual women; 89% gay/lesbian women; 82% non-binary; 82% bisexual men; 78% trans masculine).

Just over one in seven (15%) trans women and trans masculine people felt that they had been treated unfairly due to their LGBT+ status the last time they used their GP service, compared to less than 5% of all other groups.

Mental Health Services

Use of mental health services varied considerably across LGBT+ groups. Trans masculine and non-binary people were the most likely to have used mental health services in the last year, and gay men were the least likely.

Figure 11.3: Proportion who had Used Mental Health Services in the Last 12 Months by LGBT+ Group



In the qualitative research, there was huge frustration at the long waiting lists of mental health services, with waiting times themselves seen as hugely detrimental to mental health.

The lack of early-intervention services for mental health was also decried. Across all LGBT+ groups there was much reliance on third sector providers for counselling and support, many of which were dedicated LGBT+ services. Also, many had used private mental health services.

Some people spoke about accessing mental health services, but not being out to their mental health practitioners, even where they recognised that their LGBT+ identity was relevant to their mental health. In other cases, it took a number of sessions with a practitioner before patients felt able to be open about their identity. Some felt that their LGBT+ identity was not understood by mental health practitioners.

An LGBT+ service provider spoke about the shortcomings of mainstream mental health service provision for LGBT+ people:

> *"What people tell us – there is a huge desire for specialist services, not because people particularly want to focus on their LGBT identity, but they want that to be understood. What people tell us is that when they go to mainstream services that often one of two things happen– either the service provider will really focus in on their LGBT identity as somehow being the cause of their mental health issues (that's particularly true for trans people, but not only so), or there will be an attitude of 'this is not an issue for this service' and they'll skirt over it rather than saying ok, you're LGBT what does that mean for your relationships with your family, what does that mean for your intimate relationships, what does that mean for your employment, your relationship with your neighbours, are you the victim of hate crime – all of these things that we absolutely talk about daily and understand within the LGBT context".*
>
> Service provider

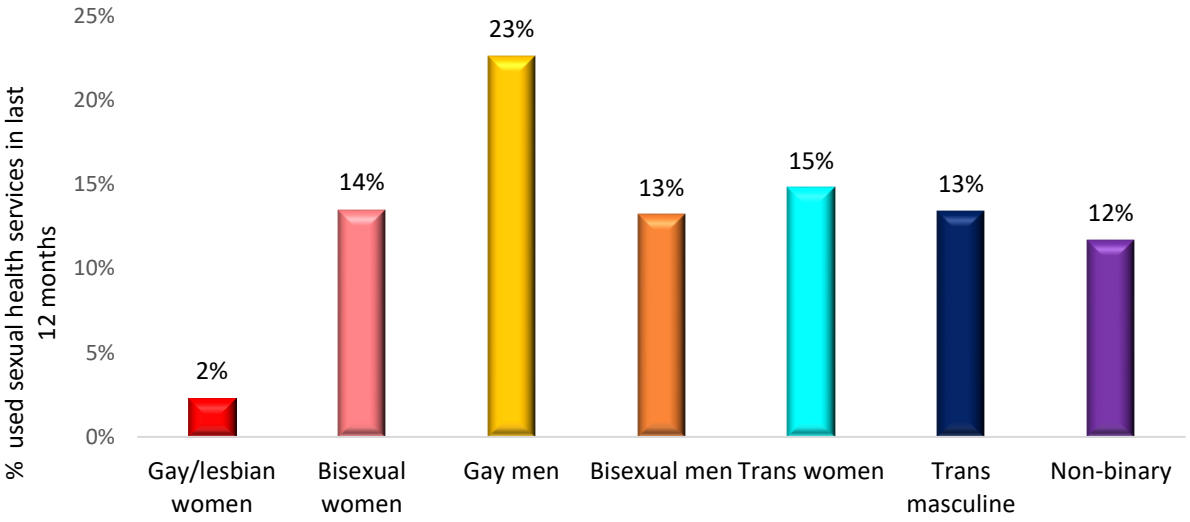
In the survey, of those able to answer about the most recent time they used mental health services:

- 79% were out to mental health service staff (from N=459)
- 71% said it was a positive experience (from N=390)
- 64% said staff showed an appropriate understanding of LGBT+ issues (from N=301)
- 12% said they were treated unfairly due to their LGBT+ status (from N=373).

Sexual Health Services

Use of sexual health services was most common among gay men and least common among gay/lesbian women.

Figure 11.4: Proportion who had Used Sexual Health Services in the Last 12 Months by LGBT+ Group



A common theme in the qualitative research with gay/lesbian and bisexual women was the lack of dedicated sexual health services for WSW. When using sexual health services, gay/lesbian women sometimes felt that health professionals saw them as a low risk and were reluctant to do full STI screening. Some bisexual women felt that staff in sexual health clinics exhibited biphobic assumptions that bisexual women were promiscuous and engaged in risky sex.

Gay and bisexual men often expressed praise for dedicated sexual health services for MSM which they felt offered a good service where they got good information, advice and treatment and where they were treated respectfully and non-judgementally.

Trans men and women and non-binary people often expressed confusion about which sexual health services they would use, and felt that generally there was not enough information and advice around trans sexual health.

Screening

Cervical Screening

The qualitative research found that most lesbian and bisexual women who were within the age range to have routine cervical screening said that they did attend, but many felt that the screening protocols were not appropriate for them and found the heteronormative questions off-putting.

> *"The last several times I've been for my smear test the practice nurse has always used it as a chance to talk about contraceptive needs. You find yourself in the situation of saying 'no, I don't use contraception' and she says 'are you not sexually active' and I have to say 'yes, but I'm married to a woman'…and then you have to get your smear done. It's all a bit embarrassing".*
>
> Gay/lesbian woman

For all transgender people who engaged with the qualitative research, it was very important to them that their CHI number and gender marker was changed on their NHS records. However, this meant that NHS systems could initiate invitations to attend screening appointments based on their gender identity but not their anatomy (e.g. trans women being invited for cervical screening). Moreover, trans men and women were not always being invited to attend screening appropriate to their anatomy, and the perception was that the onus was on the patient to remember to specifically ask for it. Trans men and women recognised the importance of having screening tests, but were concerned they would not remember to ask for them, and also had anxiety about having tests/procedures which were discordant to their gender identity.

> *"Having smears is always a bit stressful. I have them at my GP surgery- the nurse practitioner does them. I have to remember when I last had one, because I don't get screening letters anymore because of being registered as male. It's easy to forget. They've always been good about it and done their best to make sure it's ok. But I'm very self-conscious about my genitals being different, and I wonder what they think really".*
>
> Trans masculine

There were 604 survey respondents who said they had been invited for cervical screening and who answered the questions about it. Of these, 71% said they had a screen and 29% had not. These included 21 transgender women (19 of whom did not attend the appointment). A third of trans masculine and non-binary people who said they had been invited for cervical screening did not attend. Non-attendance rates for gay/lesbian women were 27% and for bisexual women were 17%.

Among the 460 people invited for cervical screening and who attended and answered questions about it, 59% said they were out at their screening appointment. The proportion who were out about their identity at the cervical screening appointment was:

- 76% of gay/lesbian women
- 64% of trans masculine
- 44% of non-binary
- 44% of bisexual women

Of the 388 people who answered, 9% felt they had been treated unfairly at their cervical screening appointment due to their LGBT+ status.

Other Screening Tests

There were smaller numbers of survey respondents who had been invited to other types of screening tests, preventing detailed analysis by group. However,

- Of the 169 people invited to breast screening, 31% did not attend. Fewer than three in five (58%) were out at their breast screening appointment.
- Of the 230 people invited to bowel screening, 25% did not participate.
- Of the 64 people invited to abdominal aortic aneurysm (AAA) screening, 78% did not participate.

Fertility and Pregnancy Services

A few of the bisexual and gay/lesbian women who engaged with the qualitative research had experience of accessing fertility and pregnancy services. Experiences were mixed. Some felt that the process of accessing fertility services was lengthy and complicated but they did not feel they were discriminated in any way on the basis of their sexual identity. Others pointed to procedures, forms and questions being inappropriate for same-sex couples:

> *"My partner and I went through a few rounds of IVF. All the encounters we had with people were really positive – it's not that unusual for same-sex female couples to be seeking IVF. But still the paperwork – I'm having to sign away that they can use my sperm for testing! It's just not applicable. Surely it can't be that difficult to come up with a separate set of paperwork".*
>
> Gay/lesbian woman

Further evidence of this issue was provided in the survey from a respondent who used the 'other' option for suggestions for improving LGBT+ people's lives to illustrate experiences of using NHS fertility treatment and maternity services:

> *"While going for fertility treatment, the paperwork sections were for Mother and Father. Also, once pregnant, my female partner was given a 'future father' booklet as they did not have booklets for same sex couples. Post-birth, a midwife, in front of my partner, stated that she had to go through contraception advice with me, a gay woman – basically making me feel I was not committed to my partner and our now family of three".*
>
> Gay/lesbian woman (from survey)

Gender Identity Clinics

Waiting Times

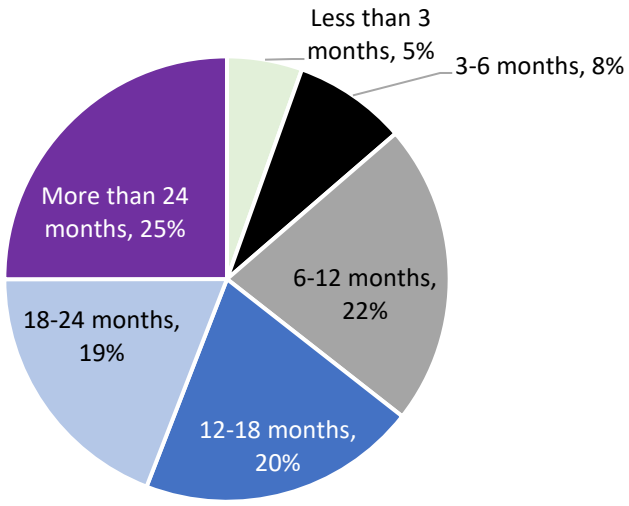
The qualitative research in 2019 highlighted huge frustration and dissatisfaction with the GIC in both Glasgow and Edinburgh. Waiting times for an initial appointment at that time were around 18 months. For those who had made the decision to medically transition, this was a long and difficult wait during which they largely felt unsupported. Many opted to seek private treatment for hormones or buy hormones on the internet. GIC staff also spoke about the problems caused by demand for their service greatly exceeding their capacity. Provision of services at the GIC was further constrained by a lack of specialists in gender dysphoria meaning that if any member of staff left or was on extended leave for any reason, there was a significant impact.

By the time of the 2021 survey, waiting times for the GIC had increased to approximately three years.

There were 275 survey respondents who said they had ever been referred or self-referred to the Gender Identity Clinic (GIC). Of those who had ever been referred or self-referred, 46% were on the waiting list, 33% were currently attending the GIC, 17% were no longer using the service and 4% said their appointment had been cancelled due to COVID. Of those who had ever been referred, 28% had been referred more than 5 years ago, 51% had been referred within the last five years and 21% had been referred within the last year.

Of the 256 respondents who said how long they waited or have been waiting for a first appointment, nearly two in three (64%) said they waited or had been waiting for over a year, as shown below.

Figure 11.5 : How long did you wait or have been waiting to get a first appointment at the GIC?



Base: N=256

Those who had been waiting six months or more were asked to describe the impact this had on them. Descriptions echoed the accounts from the qualitative research, with mental health impacts by far the most commonly described. Many spoke of anxiety, depression and anguish caused by the prolonged wait and continued dysphoria. Some mentioned suicidal thoughts and self-harm. Examples are:

- *I feel bad, I feel I'm in limbo with my life. I feel unsupported. I feel let down by the system. Gender dysphoria / incongruence has got worse. Depression / low moods are more frequent. Anxiety levels have increased so much. I feel I am not getting access to advice I need - I am self medicating on estradiol and may be damaging my optimal chances of positive feminisation, but I could not wait on the snail pace of the NHS. ..My loneliness and isolation have got worse as I feel I cannot go out dressed as a woman as I need medical intervention. Sometimes I feel my life is not worth living. Having taken decades to act on life long feelings being a woman internally, then deciding to act on it, only to be let down by hellishly long waiting lists... it takes a toll on your mental health and sense of purpose.*

- *I constantly feel like I'm in limbo, it's very harrowing to feel myself ageing but not able to progress in my life. Every single day I regret not referring myself to a GIC when I first felt a discord between my physical body and gender as a young teen. But I couldn't have because I didn't know they existed until I was in my 20's. I see other trans people flying through their transitions, both here and abroad, and I'm still stuck in stasis. It's literal torture. I know where I need to be but the services operate at such a slow pace that it feels like I will never ever get there.*

- *It's been really tough. It took me enough time to fully understand myself, and now I face a long time to access the care I need. I am a person who menstruates, and every menstruation causes significant mental distress, often to the point of experiencing suicidal ideation as a result.*

Other impacts included the severe financial impacts of seeking private treatment:

- *I essentially bankrupted myself paying for private treatment to keep me alive while I waited.*

- *I paid privately for surgery, which reduced my savings and has meant I am unable to put down a deposit on a home.*

- *I'm about £2,000 into private health services to make up for the absolute failure of the GIC. I absolutely cannot afford this and it is pushing me into debt. It makes me feel like I'm subhuman.*

- *I'm doing my best on my own but it's costing me thousands of pounds for hair removal and counselling. My savings are gone and I'm having to consider selling possessions because access to GICs is so poor, not to mention how poor my mental health is as a result of gender dysphoria.*

There were also some physical health impacts:

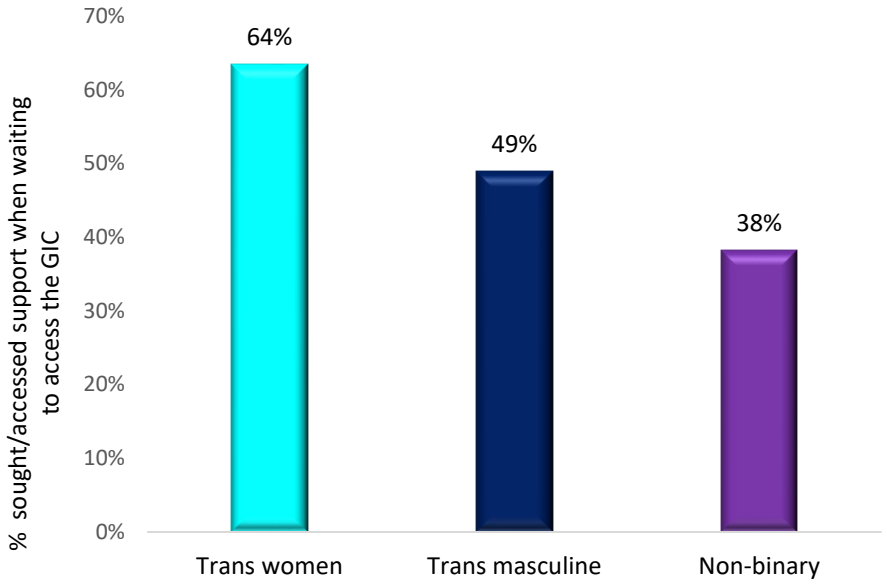
- *Physically, my binders are causing me pain but I can't stop wearing them because foregoing them feels even worse mentally and emotionally. I need top surgery but it's possible I have another 10 year wait, by which time, my ribs will probably be permanently misshapen.*

Accessing Support when Waiting for GIC Access

The qualitative research in 2019 showed that waiting time for specialist counselling service at the GIC was even longer than the wait for an initial appointment, and this too caused considerable distress and many trans people sought private counselling.

In the survey, half (50%) of those referred to the GIC said that they sought or accessed support from any organisations or services when waiting to access the GIC. Trans women were the most likely to have sought or accessed support and non-binary people were the least likely.

Figure 11.6: Proportion Who Sought/Accesses Support When Waiting to Access the GIC by LGBT+ Group



The most common places where people sought/accessed support when waiting to access the GIC were LGBT Health and Wellbeing, LGBT Youth Scotland, private gender clinics and mental health services.

Accessing Cross-Sex Hormones

The qualitative research found that trans people waiting to use GIC services had often sought alternative means to access hormones while they awaited NHS treatment.

Among those who had ever been referred/self-referred to the GIC:

- 15% had accessed cross-sex hormones online (not prescribed);
- 18% had accessed cross-sex hormones via a private prescription from a health professional.

Withholding Information from the GIC

The qualitative research found that among those who had accessed the GIC, there were often accounts of trans people hiding relevant information for fear that it would prevent access to hormone therapy and/or surgery. Most commonly, this included mental health problems, including depression, anxiety, self-harming and suicidal thoughts or attempts. Not only did trans people hide mental health problems from professionals at the GIC, they often did not seek help elsewhere because they expected or feared that the information would be shared with the GIC.

> *"I got diagnosed with an anxiety disorder, but I was seeing a uni therapist and he said that if I got diagnosed with depression or something like that, then that would mess up my transition because then the NHS could turn round and say that you're not in your right mind to be able to decide to go through the process. So even people I know who really need help, they*

don't reach out for it in case they get a diagnosis and then later on the gender clinic says you can't go through the process because of the diagnosis, and then you'll wait years and years longer again, to try and prove that you are trans."

Trans masculine

"Two of my three near misses with suicide occurred when I was under the care of the gender clinic. These are not things you can tell the gender clinic. I was terrified if I mentioned it they would refuse surgery".

Non-binary

Non-binary people who had accessed the GIC also hid their non-binary identity. The GIC service has stated that they are accepting of, and will facilitate transitions for, people with non-binary identities, but the perception of non-binary people themselves was that they had to present as if wishing to fully transition to another gender.

"I have never said anything about being anything other than a binary trans woman to the GIC or to anyone else in the NHS. I've been seeing a non-NHS therapist and I wouldn't say anything to her either. It's just the paranoia of it getting back to the (GIC)*. It's easier to pretend I'm binary".*

Non-binary

In the survey, among those who had used the GIC, some had withheld information from GIC staff about:

- Self-harm (22%)
- Mental health issues (20%)
- Suicide attempts (17%)
- Their sexual orientation (11%)
- Their preferred gender identity (9% - nearly all of whom were trans masculine or non-binary).

Views of GIC Services

The qualitative research in 2019 showed that not only was there a long waiting time for initial consultation, but also additional frustration and distress caused by:

- Very long waits between appointments
- Long waits for appointments notes to be transcribed and letters sent
- Long waits for referrals, or referrals not being made
- Correspondence being addressed to previous name/gender identity, even after repeated corrections
- Being given inaccurate information/expectations of waiting times
- Various other clerical inefficiencies and errors

Some trans women were dissatisfied with the extent to which the GIC was able to provide services such as hair removal and wigs. It was felt that the courses of electrolysis available on the NHS were insufficient, and many had supplemented these with private treatment. Some trans women also felt that it was unfair that wigs were not available on the NHS for those who had male pattern baldness.

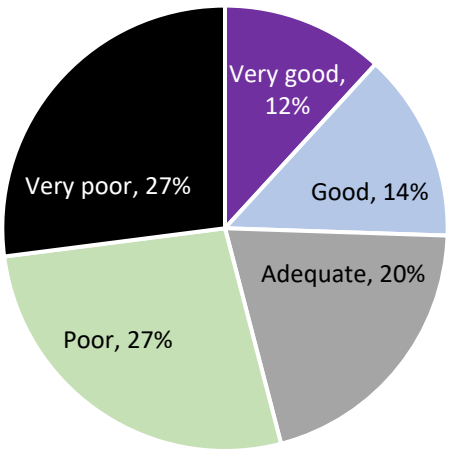
A further issue of concern which was raised by service providers as well as trans people was the perception that rules around Body Mass Index (BMI) imposed by the GIC were unfair and unnecessary, where the GIC would prevent GRS if BMI was above a certain threshold. There was a suspicion that this was 'gatekeeping' and a means of cutting down the number of GRS patients.

Geographical constraints of GIC services were also an issue, with those living in rural areas having to travel large distances to use the GIC. There was a perception of inequality in service provision between Glasgow and Edinburgh, with those in Edinburgh feeling that the GIC in Glasgow offered a wider range of services. The lack of any GRS in Scotland meant that trans people had to travel to England not only for surgery but also for pre- and post-operative consultations.

The follow-up research in 2020 found that many trans and non-binary people had been impacted by the halt to the GIC services during the initial lockdown and some had had GRS cancelled or postponed, causing severe anxiety and uncertainty. A particular frustration was the lack of communication and the lack of clarity around expected timescales for accessing GIC services. When the GIC services began offering video appointments, service users felt this worked well.

The survey asked those who had been referred to the GIC how they would rate their experience at the GIC. Just one in four (26%) rated their experience as good or very good.

Figure 11.7: How would you rate your experience at the GIC?



Further Learning on Experience of Health Services (Qualitative Research)

Further learning on the experience of using health services can be found in Chapter 6 of the qualitative research report including the prevalence of heteronormative assumptions, the conflation of LGBT+ identities and diagnosing other disorders, the experiences of trans people as hospital inpatients and the perceived need for a more holistic approach to service provision.

12. Intersections

The report on the 2019 qualitative research findings provides a discussion on the experiences of LGBT+ people in the following groups:

- People of faith
- Disabled people
- Asylum seekers
- Rural/urban differences
- Experiences relating to perceived social class

This can be found in Chapter 7 of the qualitative research report.

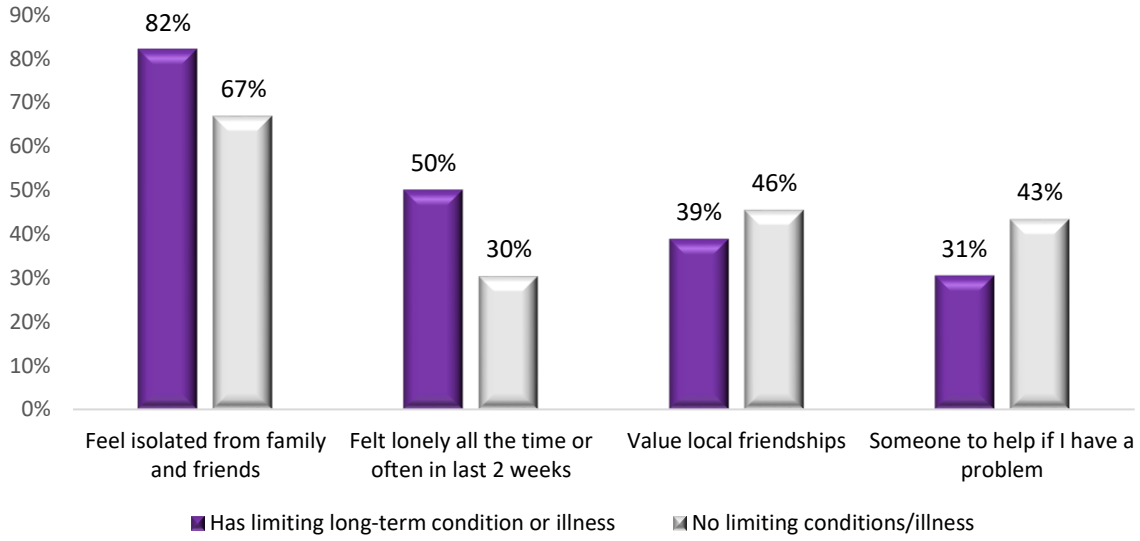
This chapter sets out the key findings from the survey together with the learning from the qualitative research for people with limiting conditions/illnesses, those with autism or ADHD, rural/urban differences, deprivation groups.

People with Limiting Conditions and Illnesses

Loneliness, Isolation and Friendships

The qualitative research showed that feelings of isolation were common among disabled people. As Figure 12.1 shows, survey respondents who had a limiting long-term condition or illness were more likely to feel isolated and lonely, and were less likely to value local friendships or feel that someone was there to help them if they had a problem.

Figure 12.1: Indicators of Isolation, Loneliness and Friendship by Whether Respondents had a Limiting Condition/Illness



The qualitative research highlighted that those with limiting conditions may have isolation/loneliness compounded by the LGBT+ community being considered not inclusive for disabled people because:

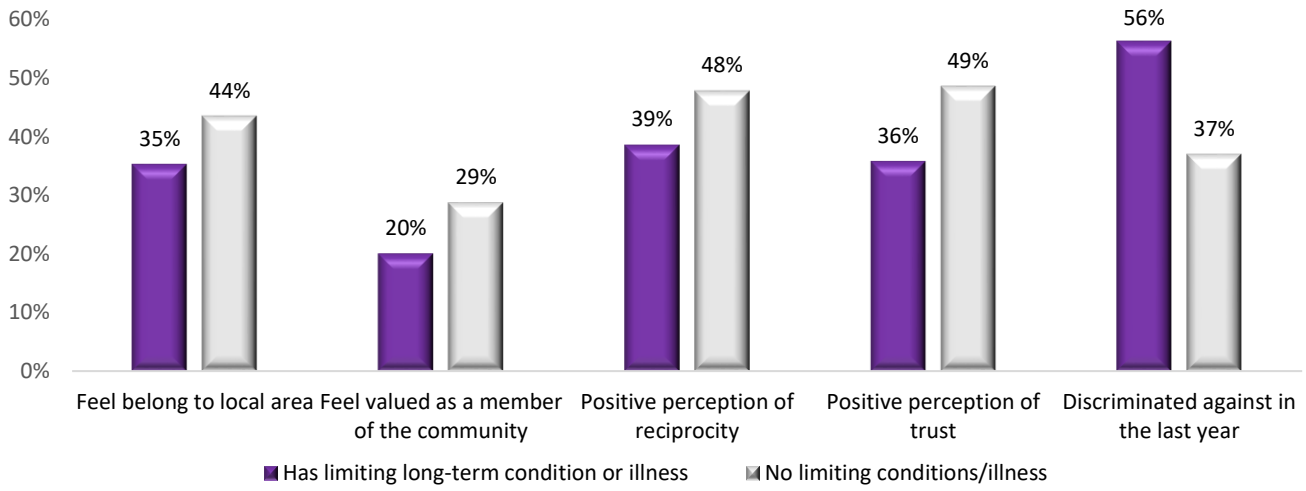
- LGBT+ service provision and social spaces are not accessible
- LGBT+ social spaces focus on alcohol, and many disabled people can not drink alcohol due to medication or factors relating to their disability

- Disabled people frequently encountered negative attitudes towards disabled people among other LGBT+ people
- Disabled people were often disregarded as potential partners by many in the LGBT+ community.

Other Indicators of Social Health

As the Figure 12.2 shows, those with a limiting condition or illness were less likely to have positive perceptions of their community and their place in it, and were also more likely to have experienced discrimination in the last year.

Figure 12.2: Indicators of Social Health by Whether Respondents had a Limiting Condition/Illness

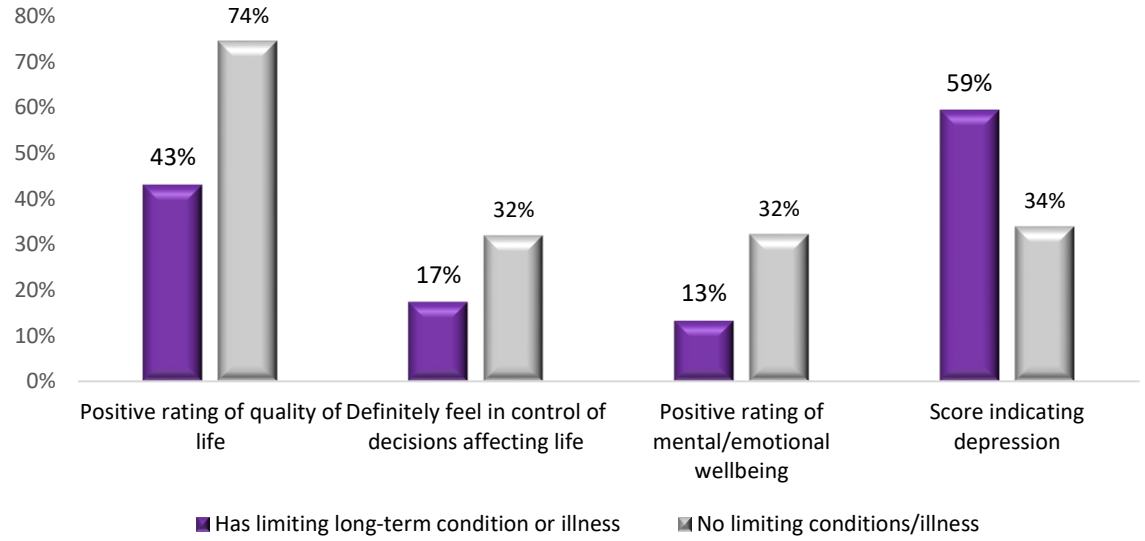


The qualitative research showed that disabled LGBT+ people felt the effects of 'double discrimination', feeling they were discriminated against on the basis of both their disability and their LGBT+ identity, and feeling they did not usually fit in with either LGBT+ or disability support or social groups. This included Deaf participants in 2021 who felt they had two distinct identities as both LGBT+ and Deaf and had to choose which community to engage with.

Mental and Emotional Wellbeing

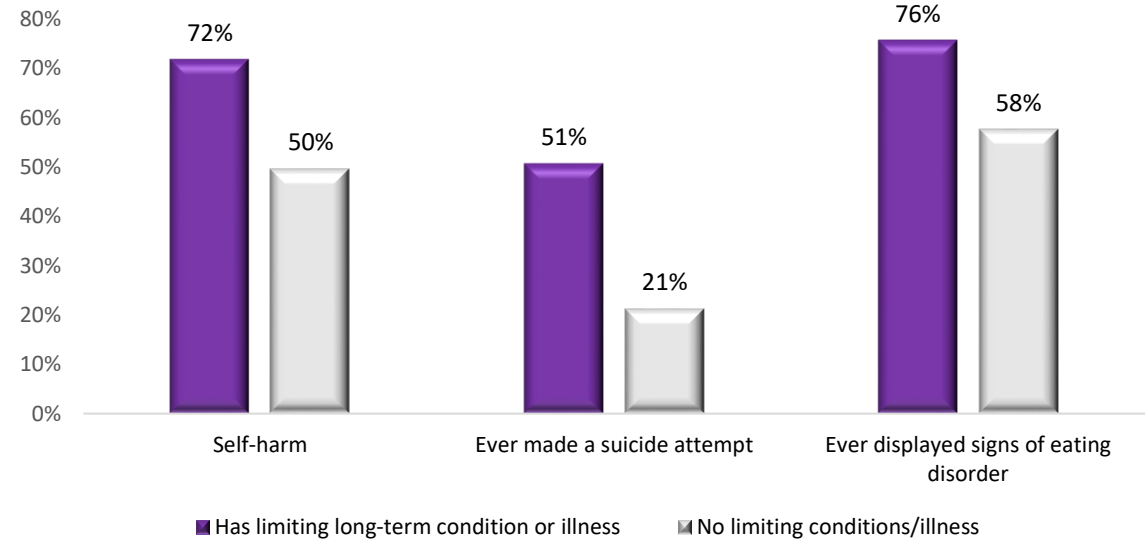
Those who said they had long term condition or illness that limited what they could do were much less likely to have a positive rating of their quality of life, less likely to feel in control of the decisions affecting their life, less likely to rate their mental/emotional wellbeing positively and more likely to have PHQ scores indicating depression.

Figure 12.3: Indicators of Mental and Emotional Wellbeing by Whether Respondents had a Limiting Condition/Illness



Those with a limiting condition or illness were also much more likely than others to have displayed behaviours of self-harm, suicide attempts and signs of eating disorders (eating and making themselves sick or binging or restricting food).

Figure 12.4: Experience of Self-harm, Suicide Attempts and Eating Disorders by Whether Respondents had a Limiting Condition/Illness



Relationships

Many of the disabled LGBT+ people who engaged with the qualitative research felt that they were often 'desexualised', with people often assuming they did not have a sex life or could not have a sexual identity. Also, they said that when they were open about their sexual identity or alluded to having a sex life, they were often asked inappropriate, invasive questions

about the details of their sex lives. The tendency to be desexualised meant that where LGBT+ disabled people had a partner, the partner was often not recognised or legitimised.

As noted in Chapter 5, the qualitative research highlighted that disabled LGBT+ people could be particularly vulnerable to abusive or unhealthy relationships. The survey also showed that those who had a limiting condition or illness were more likely than others to have experienced an abusive relationship (49% compared to 31%).

Those who themselves had a long-term limiting condition or illness were more likely than other survey respondents to be caring for someone (23% compared to 15%).

Drug Use

The qualitative research showed that LGBT+ people coping with physical pain could be susceptible to dependency to opioid pain relief. Some alluded to using them, or being tempted to use them for emotional relief:

> *"I only take prescribed drugs, but there are times when I've used prescribed painkillers that border on addictive - times when I've taken painkillers not to not feel pain, but to not feel anything. That's a dangerous place to be, because there's no-one I can talk to about that – if I go to the doctor and say I'm experiencing addictive behaviour with my pain meds, they'll just take the pain meds away and then I'll be left with the pain. So there's nowhere I can address this problem – I just have to manage it on my own".*
>
> Disabled bisexual man

The survey findings show that those with a limiting condition or illness were more likely than others to have used drugs (51% compared to 40%).

Neurodiversity

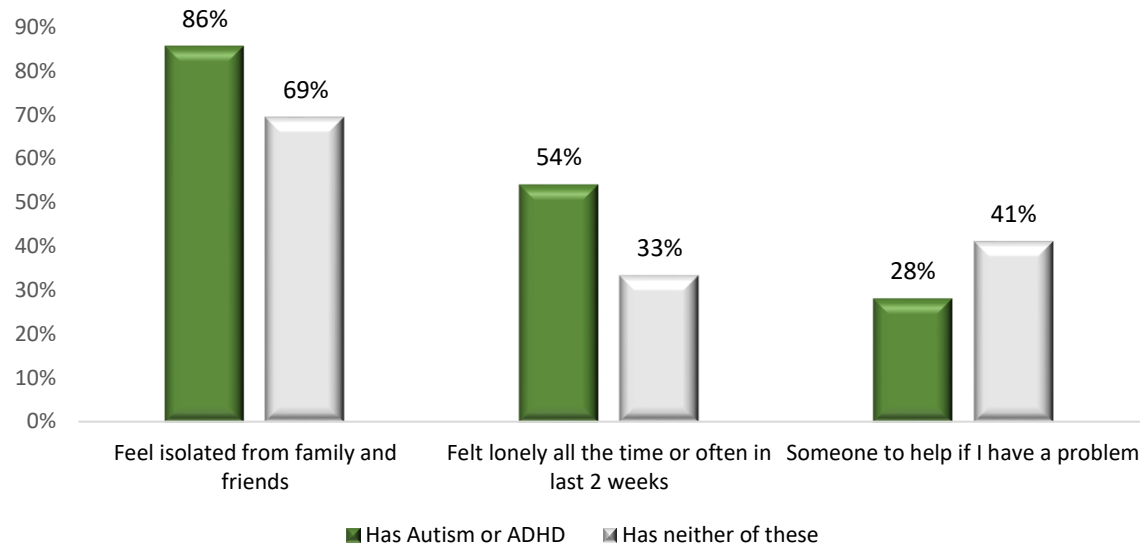
This section presents key indicators which differed for those who had autism[12] or ADHD compared to those who had neither of these conditions. Some of the issues identified with neurodiversity from the qualitative research and the survey findings on prevalence of neurodiverse conditions are reported in Chapter 7.

Loneliness, Isolation and Friendships

Those with autism or ADHD were more likely to feel lonely and isolated and less likely to feel that there was always someone to help them if they had a problem.

[12] 'Autism' includes ASD and Asperger's

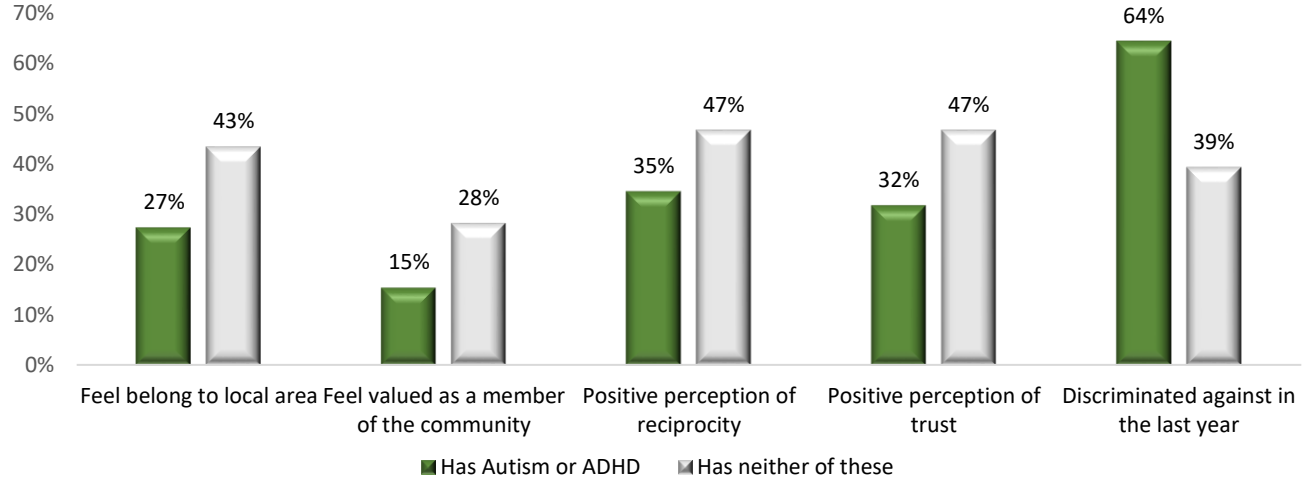
Figure 12.5: Indicators of Isolation, Loneliness and Friendship by Whether Respondents had Autism/ADHD



Other Indicators of Social Health

Figure 12.6 shows that those with autism or ADHD were less likely to have positive perceptions of their community and their place in it, and were also much more likely to have experienced discrimination in the last year.

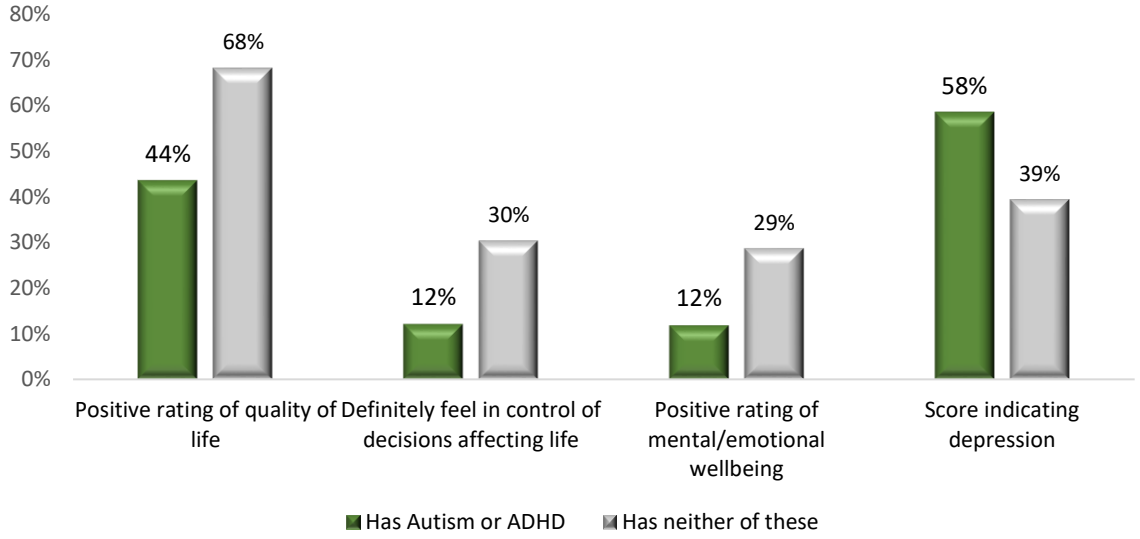
Figure 12.6: Indicators of Social Health by Whether Respondents had Autism/ADHD



Mental and Emotional Wellbeing

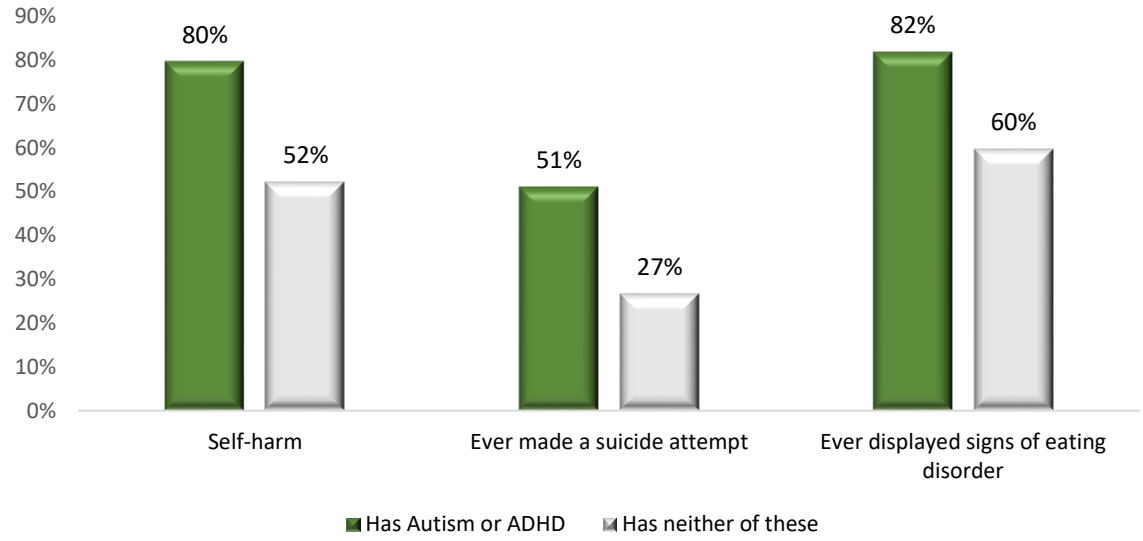
Those with autism or ADHD were much less likely than others to rate their quality of life positively, feel in control of their life or have a positive rating of their mental/emotional wellbeing. They were more likely than others to have a score indicating depression.

Figure 12.7: Indicators of Mental/Emotional Wellbeing by Whether Respondents had Autism/ADHD



Those with autism or ADHD were much more likely than others to have a history of self-harm, suicide attempts and indicators of eating disorders.

Figure 12.8: Experience of Self-harm, Suicide Attempts and Eating Disorders by Whether Respondents had Autism/ADHD



Relationships

As noted in Chapter 5, people with autism were among those in the qualitative research who identified as being more vulnerable to abusive relationships. Indeed, the survey findings showed that 48% of people with autism or ADHD had experienced an abusive relationship compared to 35% of other LGBT+ people.

Rural/Urban Differences

In the qualitative research, many pointed to the differences in experiences of LGBT+ people in rural areas or small towns compared to large cities like Glasgow and Edinburgh. It was considered much harder to be an LGBT+ person in a rural area for many reasons:

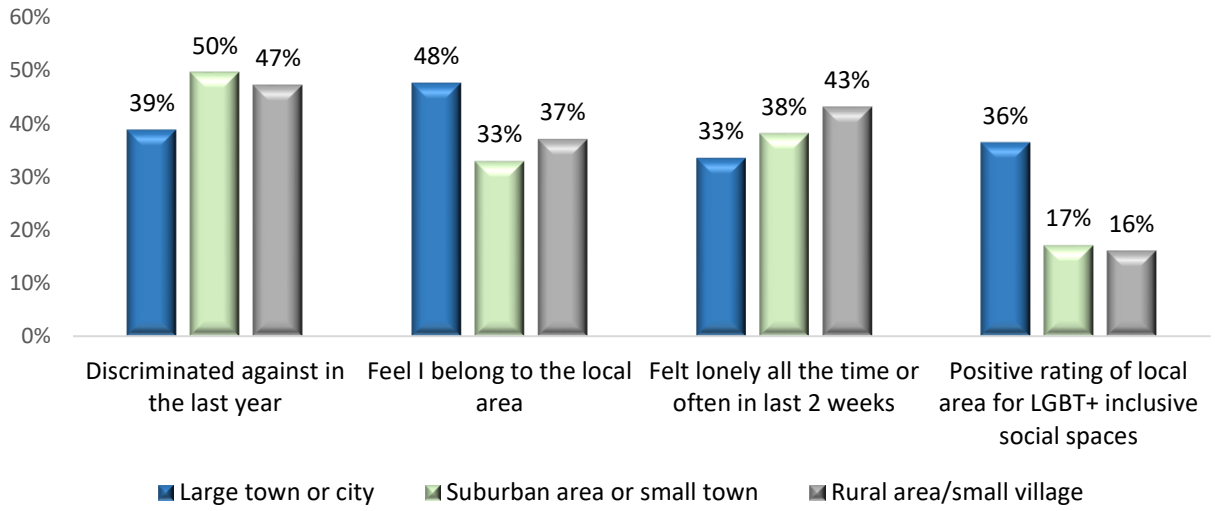
- LGBT+ people said that generally, people in rural areas and small towns were more likely to have negative attitudes towards people with LGBT+ identities
- There was a lack of visibility and understanding of LGBT+ issues in rural areas
- LGBT+ people felt 'exposed' in rural areas and small towns, and often craved the anonymity of living in a large city. The cliché of being 'the only gay in the village' was often referred to, but was a stark and very uncomfortable reality for some.
- There was a lack of services for LGBT+ people and a lack of an LGBT+ community in rural areas
- GPs and other health services in rural areas may be less knowledgeable about LGBT+ issues, are more likely to be known to family members (therefore heightening concerns about confidentiality), and there is less choice in GP practices, meaning LGBT+ people were unable to transfer to another practice if they were unhappy with the attitude or level of knowledge of their GP
- Transgender people in rural parts of Scotland had to travel significant differences to attend GICs in cities.

> *"I've dealt with isolation, loneliness, discrimination, exclusion and hate crime – all of that due to growing up in a village. With me being the only gay in the village it got quite difficult. I moved away and came back and it was just as bad – people crossing the road so they didn't have to walk by me, shouting stuff, etc. Small villages are a tough crowd".*
>
> Gay/lesbian woman

Often, LGBT+ people had moved from rural areas to Edinburgh or Glasgow where they were able to connect with an LGBT+ community, the gay scene and LGBT+ service provision.

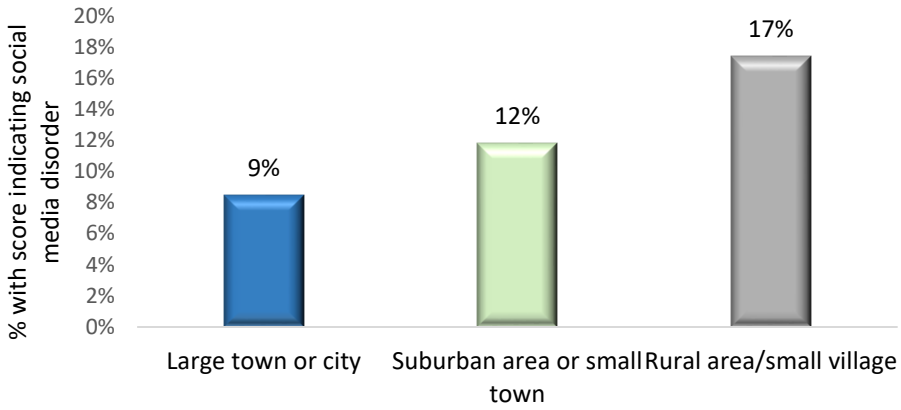
The survey findings also highlight the different experiences for LGBT+ people living in large towns or cities compared to more rural areas. As Figure 12.9 shows, those living in large towns and cities were less likely to have experienced discrimination, more likely to feel they belong to the local area, less likely to feel lonely and much more likely to have a positive rating for LGBT+ inclusive spaces in their area.

Figure 12.9: Indicators of Social Wellbeing by Urban/Rural Categories



The survey findings also show that those in rural areas were more likely than those in urban areas to have a score indicating a social media disorder, as Figure 12.10 shows.

Figure 12.10: Proportion with a Score Indicating a Social Media Disorder by Urban/Rural Categories



Those in large towns and cities were less likely than those in other types of settlement to have displayed signs of an eating disorder (60% large town/city; 69% suburban area/small town; 68% rural area/small village).

However, LGBT+ people living in large towns/cities were more likely than others to have used drugs (50% large town/city; 36% suburban area/small town; 35% rural area/small village).

Deprivation

An opinion expressed in the qualitative research was that people in more deprived areas were generally less open-minded or accepting of LGBT+ people. A number pointed to the difficulties of growing up in a 'working class' area or family, or going to school in a deprived area where they perceived bullying of LGBT+ people to be more prevalent. In describing their background

as 'working class', it was evident that this term had connotations of 'traditional', with stronger expectations relating to gender roles and sexual orientation:

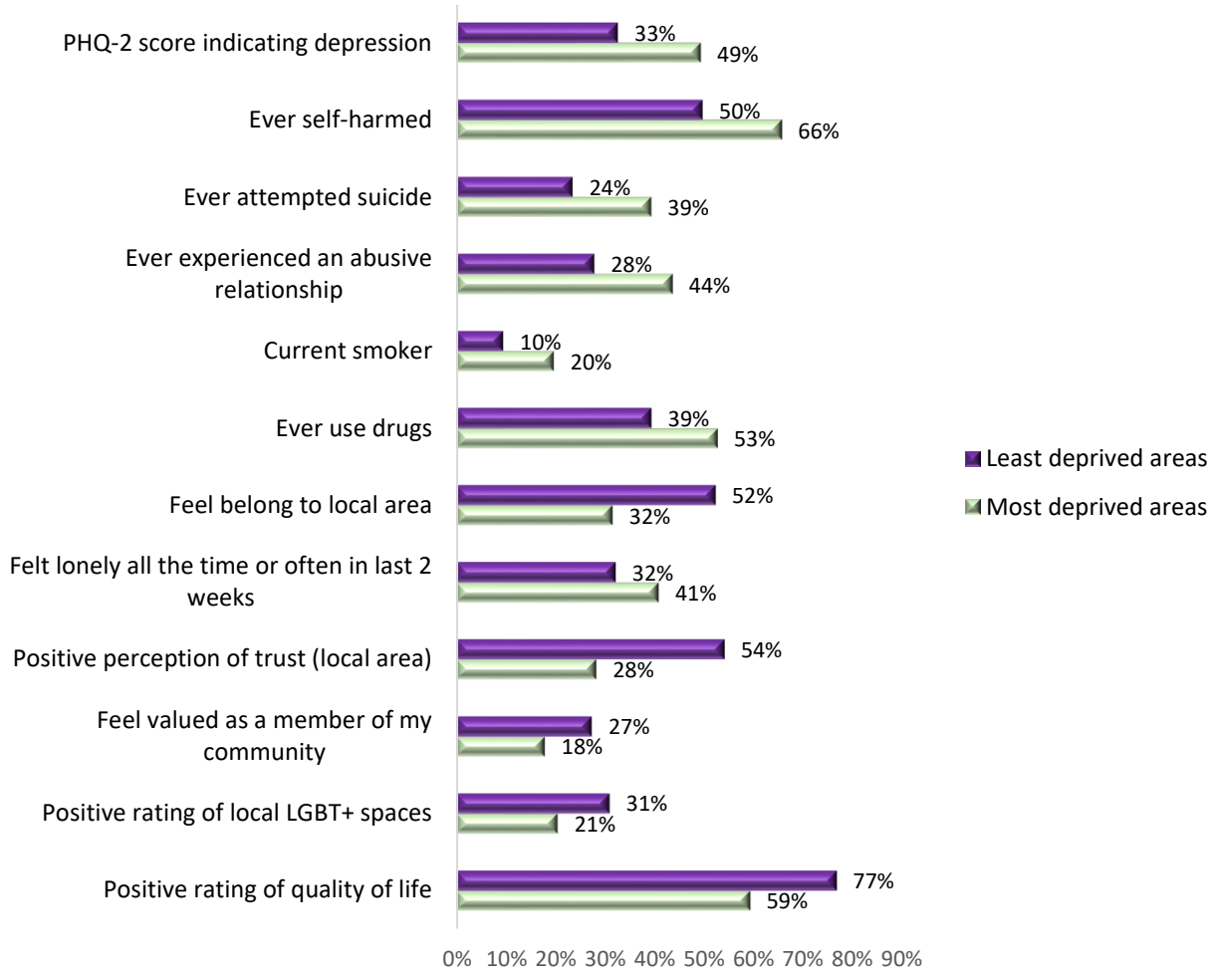
> *"I was bullied quite a lot at school for being gay. It was in a working class part of Glasgow. I think if you were a girl you wanted to be a hairdresser, if you were a guy you wanted to be a footballer – that was the two career choices. I had no interest in sport whatsoever. I was bullied for being gay – they seemed to know before I did".*
>
> Gay man

Some spoke about a more deprived background as having a very negative effect on them in terms of their inability to be out about the identity, internalised homophobia/trans phobia and experiences or being bullied at school. This was also recognised from those who grew up in less deprived areas - some pointed to not feeling comfortable or safe being visibly LGBT+ in deprived areas or around 'working class' people. One young trans woman described how she was supported by one side of her family but estranged from the other side, which she at least partly attributed to their working class background fostering traditional views:

> *"When I wanted to transition, (my dad) wasn't supportive of that and I haven't spoken to him since. So I'm not in contact with my dad or his side of his family…his side are more traditional and conservative, and more working class than my mum's side of the family. Not that that's a black and white thing, but I do think in some communities there's less visibility, or less opportunity for LGBT to gain visibility within working class communities. I don't know how much that played into it, but that may have had an impact on their opinions. Before I came out, I did know there was a fair probability there would be an issue there, just because my (paternal grandfather) was quite vocally homophobic when it comes to those issues. That might be through the social situation and the area they're in. Exposure in day to day life is less common than in economically privileged areas".*
>
> Trans woman

As Figure 12.11 shows, the survey found that those living in the most deprived areas (first SIMD quintile), had poorer wellbeing indicators than those in the least deprived areas (fifth SIMD quintile). These included mental wellbeing indicators such as depression, self-harm and suicide attempts.

Figure 12.11: Key Wellbeing Indicators by Least and Most Deprived Areas



13. Wish List, Discussion and Recommendations

Limitations and Gaps

It was acknowledged that the qualitative research in 2019 had low numbers of older LGBT+ people participating. Just 14% of respondents to the 2021 survey were 50+ (including only 4% 60+). The online nature of the survey, and the promotion of this primarily through social media would have been a real barrier for many older LGBT+ people. Among the most critical issues the pandemic has brought to the fore is the digital exclusion experienced by many older LGBT+ people, as well the impacts of loneliness, isolation and loss of connection with LGBT+ peers.

This lack of reach, particularly in relation to those 60+, means that crucial challenges of later life for LGBT+ people have not been captured, e.g. issues around health, social care, housing, finances and caring responsibilities. **The health needs of older LGBT+ people is an area where further research is needed**.

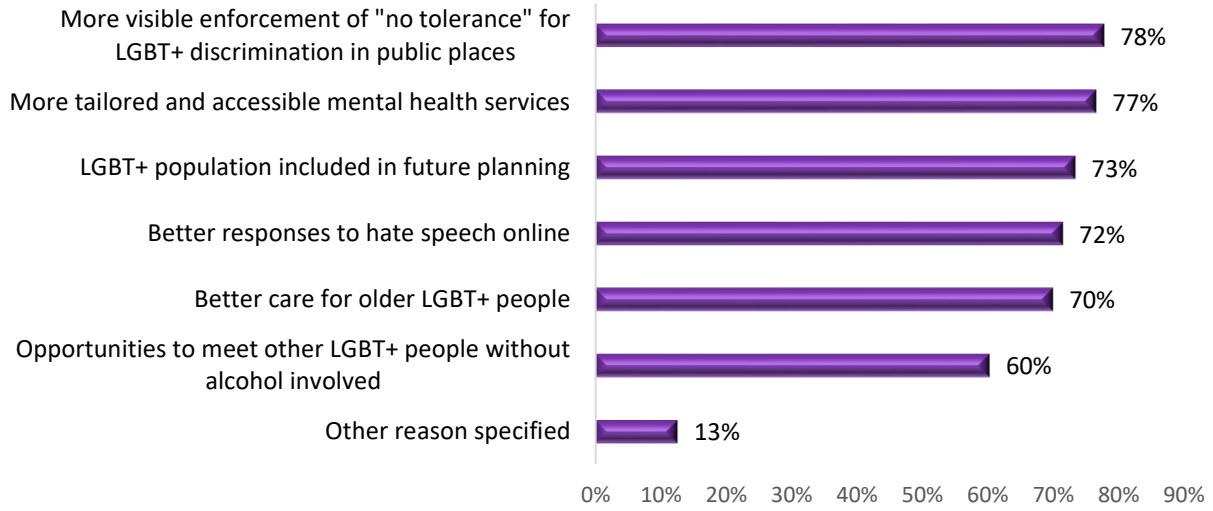
LGBT+ People's Wish List

The qualitative findings report from 2019 included a final chapter 'Wish List and Discussion' which brought together the most frequent suggestions made regarding what would improve life for LGBT+, together with a discussion on how the suggestions related to the broader findings from the qualitative research.

This chapter presents again the wish list as it was reported in 2019, but brings in the additional related evidence from the 2020 qualitative research and the survey findings. Recommendations are provided which are informed by the research findings and the discussions and recommendations formed at the stakeholder event in March 2022 (see chapter 1).

The survey asked respondents what they would like to see for LGBT+ people as society recovers from COVID – with a list of six options (and the opportunity to select multiple/all options). Responses are shown in Figure 13.1.

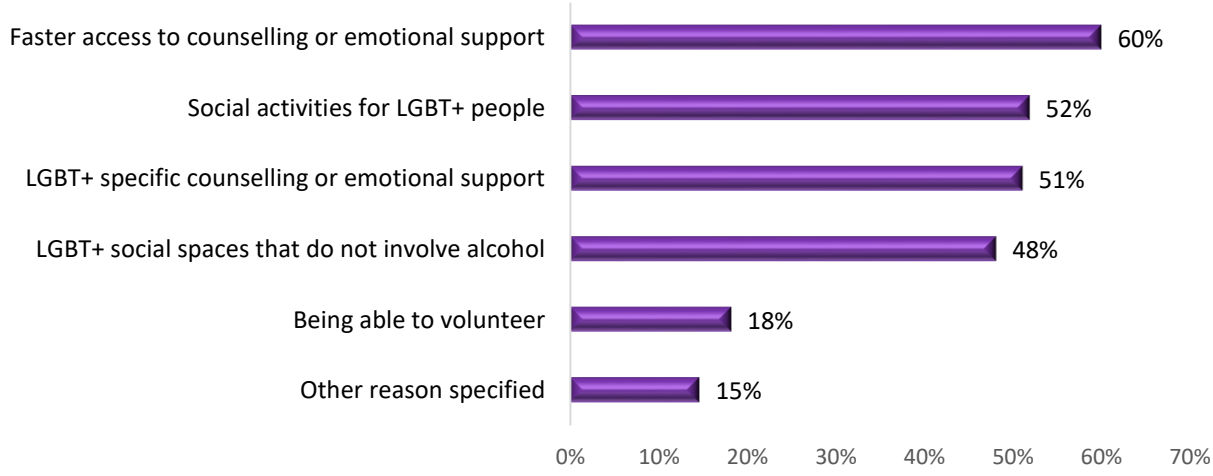
Figure 13.1: What would you like to see for LGBT+ people as society recovers from COVID?



Of the 296 respondents who specified something other than the listed options, the most common were easier or better access to GIC/hormones/surgery (27%), tackling transphobia/homophobia (11%) and providing single-sex social spaces or services for LGB people (7%).

Survey respondents were also asked what would make a difference to their mental and emotional wellbeing, from a list of options. Responses are shown in Figure 13.2.

Figure 13.2: What would make a difference to your mental and emotional wellbeing?



Of the 344 respondents who gave an 'other' answer and specified what would help their mental/emotional wellbeing, the most common answers were access to GIC/hormones/trans surgery (20%), lifting COVID restrictions/return to normality (11%) and improvements to healthcare (9%).

The nine 'wish list' items set out in the qualitative research report were:

1. LGBT+ spaces for socialising without a focus on alcohol
2. LGBT+ education in schools
3. Training for health and other staff
4. Mental health waiting lists and appropriate services
5. Improvements to the GIC
6. More services being visually LGBT+ inclusive
7. Support for LGBT+ victims of domestic abuse and sexual violence
8. Provision of inclusive facilities and opportunities for sport and physical activity
9. Provision for asylum seekers

Each of the nine wish list items are discussed below together with recommendations.

1. LGBT+ Spaces for Socialising without a Focus on Alcohol

Research evidence

In 2019, the provision of LGBT+ social spaces was a priority across all LGBT+ identities. Many in Glasgow lamented the loss of the LGBT Centre which closed in 2009. This was felt to have been a hugely valuable, inclusive and safe space which gave LGBT+ people an opportunity to come together away from the alcohol-focused alternative places. Informants to the research said the centre was accessible for disabled people and inclusive of all LGBT+ identities and age groups. Across Lothian and GGC, there was a great appetite for a similar venue to be provided.

The 2020 research included the repeated call for alcohol-free cafes or social spaces for LGBT+ people.

Although this was a strong message from the qualitative research, the survey findings show that this was not a top relative priority as society recovers from COVID (but still advocated by 60% of respondents) – as shown in Figure 12.1 above.

Discussion

The qualitative research highlighted the importance, for many people, of the LGBT+ community. It was vital for many to be able to connect to others in the LGBT+ community and develop friendship groups with similar people. Those who were unable to do so felt particularly isolated; having LGBT+ friendship groups and being part of the community was felt to contribute to improved mental health. A key priority for many people across all LGBT+ identities was having appropriate, accessible social spaces to come together with other LGBT+ people away from the gay scene.

There were pockets of good practice and some niche LGBT+ clubs and groups focusing on specific interests (e.g. sports and singing). The community-based groups supported by LGBT Health and Wellbeing were also helpful for some. However, the apparent unmet need was for **a safe social space for LGBT+ people, or groups of friends to meet and socialise more organically and without specific agendas, but without alcohol or drugs**.

Such venues may contribute not only to reduced isolation and improved mental health but also less engagement with behaviours such as excessive alcohol, drug use and risky sexual behaviour. At the time of the 2020 research, the 'tiers' system to mitigate COVID risks included periods where bars and clubs were closed but cafes etc were open – this experience may have heightened the awareness of venues serving alcohol as more risky, and may have heighted the appetite for safe social LGBT+ spaces outside of alcohol-focused venues.

Recommendations:

1. **A mapping exercise should be conducted to map existing provision of groups and activities for LGBT+ people, identifying good practice and gaps in provision in terms of geography and identity groups.**
2. **Every local authority in Scotland should provide or fund at least some groups or activities specifically for LGBT+ people.** It is recognised that remote and rural areas are unlikely to have large and diverse LGBT+ populations. Provision of groups and activities must be to scale of population. Where demographics allow, provision of groups and activities must encompass cultural, sport and physical activity, social interest groups as well as targeting specific identity groups.
3. **An inclusive LGBT+ social space (hub or café) should be established at least in the largest cities in Scotland (e.g. Glasgow, Edinburgh, Dundee, Aberdeen, Inverness).** These should be welcoming, inclusive and safe spaces for people from all LGBT+ groups.
4. **The development of LGBT+ social spaces and opportunities should be community-led.** To do this well, local areas will need to ensure local 3rd sector organisations are sufficiently resourced.

These recommendations will be of most relevance to **Local Authorities, Public Health, Community Planning, LGBT+ stakeholders.**

2. LGBT+ Education in Schools

Research evidence

A further priority mentioned by many people across all LGBT+ identities in 2019 was education about LGBT+ issues in schools. A very common complaint across all LGBT+ groups (including young people still in, or having recently completed, school) was that they had not received Sexual Health and Relationship Education (SHRE) or RSHP (Relationships, Sexual Health and Parenthood education) in schools which adequately related to their LGBT+ identity, leaving them without the required information about forming relationships and safe sex, and it was suggested by many that such education should be more inclusive of all identities. Moreover, many felt that education about LGBT+ identities in schools was needed to ensure that all people are aware of LGBT+ issues in order to ensure that LGBT+ issues are normalised/destigmatised, which, it would be hoped, would increase understanding and reduce discrimination.

Although the survey did not specifically ask about LGBT+ education in schools, some respondents used free-text boxes to raise this issue. When asked what would make a difference to their mental and emotional wellbeing, one respondent said:

"All I could ask for our gay youth, is just to be properly included in the PSE curriculum. All I ever wanted was to be taught about my own sexuality like every other straight person in the class did. Not in a 'LGBT pride week' way or shown off to make the school look good. Just to be treated normal (for example being taught gay sex whilst we learned about straight sex). Even hanging up a gay flag in the school can help people a lot and I think the power of these things underestimated".

Another said:

"In schools…educating the correct people whether they are lgbtqia+ themselves or not can make children and students feel more accepted/understood".

Discussion

LGBT+ education in schools was advocated by many people in the qualitative research. Indeed, suitable LGBT+ education may be effective in:

- normalising LGBT+ identities, improving acceptance and understanding among the general population;
- helping young LGBT+ people struggling with their identities to understand how they may be identifying;
- allowing young LGBT+ people in schools to feel included and accepted;
- alleviating any shame or internalised homophobia on the part of LGBT+ young people;
- providing LGBT+ with the information they need about making choices relating to healthy relationships and safe sex.

These measures may therefore be instrumental in improving many of the aspects of social and mental health highlighted by the research.

A further consideration relates to domestic abuse and sexual violence (see wish list item 7). It was recognised that domestic abuse and sexual violence was not widely recognised outside the scenario of male perpetrators and female victims and school education may be an opportunity for dispelling this narrow perception of the range of relationships and gender roles which may be involved in such abuse.

It is recognised that since the qualitative research was conducted in 2019, much has been done nationally to commit to LGBT+ education in schools. Scotland has become the first country in the world to make provision of LGBT inclusive education a government commitment and an LGBT Inclusion Education Toolkit and guidance for supporting transgender young people in schools has been published.

Recommendations

5. **Investigate the extent to which LGBT+ inclusive aspects of Relationship, Sexual Health and Parenthood education (RSHP) and other curricular areas are being used and applied in schools.**
6. **Ensure staff training and continual professional development provides staff with the confidence to deliver inclusive education.**
7. **Schools should strive to achieve a charter mark or other formal recognition of inclusivity.**
8. **School based approaches to reducing abuse/sexual violence (e.g. *Equally Safe)* should be reviewed for LGBT+ inclusiveness.**

These recommendations will be of most relevance to **Education Scotland** and **Directors of Education and Health** and **Wellbeing Leads in each Local Authority.**

3. Training for Health and Other Staff

Research evidence

Many participants in the qualitative research suggested that there was a clear need to train staff, particularly in NHS services, in order to provide awareness of LGBT+ identities and ensure that service provision was inclusive, non-judgemental and appropriate. Some pointed out that training should be essential for receptionists and administrative staff who had contact with patients as well as nurses, doctors and counsellors. Some stressed the importance of such training to be mandatory rather than optional, and some felt that such training should be embedded into medicine and nursing courses.

Discussion

The research suggests that a key aim of NHS staff training should be to ensure that heteronormative assumptions, prevalent across all healthcare settings could be replaced with open and inclusive conversations and protocols. Healthcare providers could make significant steps to offering a more comfortable and inclusive experience for LGBT+ patients when their language, forms and protocols did not make presumptions about gender identity or sexual orientation.

Some other areas for improvements in healthcare may include:

- a better awareness and understanding of trans and non-binary issues in primary health care
- more information and provision around sexual health services for gay and bisexual women, transgender and non-binary people
- a more holistic approach to healthcare including the consideration of the relationship between physical health, mental health, and engagement with harmful behaviours; also more awareness and consideration of how certain conditions can specifically impact the lifestyles of LGBT+ people.

Recommendations

9. **LGBT+ awareness and inclusivity training should be mandatory and organisations should be accountable for keeping up to date with LGBT+ training needs.** Such training would be applicable across all public services and open to all 3rd sector and private sector.
10. **LGBT+ training should be reviewed and updated and capacity should be built to deliver training.** This will require financial investment. Third sector organisations may be best place to deliver such training. LGBT+ communities should be involved in the development.
11. **NES should work with NHS Boards and LGBT+ communities to produce a new LGBT+ Awareness e-learning module for NHS staff across Scotland.**
12. **General LGBT+ inclusivity training should be delivered to all staff in all positions within organisations. Speciality training should also be developed for specific roles to address specific inclusive practice (e.g. for mental health care; sexual and reproductive health care; trauma informed practice development, etc).**
13. **LGBT+ issues and inclusiveness should be incorporated into undergraduate and post graduate education across disciplines including medicine, nursing, social work, education, etc.**

These recommendations will be of most relevance to **all service providers.**

4. Mental Health Waiting Lists and Appropriate Services

Research evidence

The long waiting lists and lack of availability of appropriate mental health services meant that improvements to mental health provision was a key priority suggested by many LGBT+ people in 2019. The importance of early-intervention mental health services was stressed by many, and generally cutting down the excessive waiting times for mental health services was seen as essential. It was recognised that all mainstream mental health services should be LGBT+ inclusive, and counsellors and other mental health practitioners should have adequate training on LGBT issues. However, it was also felt that specialist services for LGBT+ people, particularly the availability of LGBT+ counsellors would best meet the needs for many LGBT+ people. For trans people, mental health support while they were waiting to transition was also a key priority.

The COVID pandemic has had a very significant detrimental effect on mental health for many. In 2020, the additional qualitative research asked what would make a positive difference to mental health, and responses repeated the findings from 2019, with a call for:

- Easier access/reduced waiting time for counselling and other mental health services
- A dedicated LGBT+ mental health service.

As Figure 12.1 showed, 77% of survey respondents identified a need for more tailored and accessible mental health services as society recovers from COVID (one of the top priorities).

Discussion

The qualitative research and the survey have shown that mental health problems are highly prevalent among all LGBT+ identities, but that service provision is inadequate to support and treat those with mental health problems. Investment is needed to ensure that those in need are provided with timely interventions and that support is available which is inclusive, with mental health professionals having an appreciation of LGBT+ issues.

Recommendations

14. **Investment should be made in mainstream NHS mental health services to ensure shorter waiting lists for counselling and other therapies.**
15. **Training for mainstream mental health professionals (see recommendations 9-13) should ensure that they have the awareness, knowledge and skills to treat LGBT+ people appropriately.**
16. **Provide more funding to 3rd sector organisations to expand services in dedicated LGBT+ counselling and non-therapeutic early intervention.** This should include dedicated referral routes for those waiting to use Gender Identity services and for asylum seekers.

These recommendations will be of most relevance to **NHS and 3rd sector mental health providers.**

5. Improvements to the GIC

Research evidence

Among trans men and women, improvements to the GIC service were the most frequently mentioned priority in 2019. The types of improvement desired were:

- Shorter waiting times for initial appointments
- Shorter times between appointments
- Improvements to efficiencies in, for example, dictating notes, issuing letters and making referrals
- Support for those on the waiting list
- More opportunities for shared care with GPs, which would relieve pressure on the GIC
- More access to services to assist transition including wigs and hair removal
- Provision of GIC services in areas other than Edinburgh and Glasgow[13]
- Access to GRS in Scotland, or more pre- or post- op care available in Scotland.

The 2020 qualitative research and the 2021 survey have highlighted the often devastating effects of a much increased backlog and demand for GIC services, with the COVID pandemic very significantly exacerbating the problems with a service which was already unable to meet

[13] The 2019 research included only people in Lothian and Greater Glasgow and Clyde. In Scotland, GICs are also available in Inverness and Aberdeen.

demand. The process of trying to access treatment was frequently described as 'dehumanising' and GIC services were perceived as 'gatekeeping'.

Discussion

Demand for the GIC service in Edinburgh and Glasgow clearly outstrips capacity and the evidence suggests that the long waiting times and inefficiencies of the service are hugely frustrating to the trans and/or non-binary people who use them. A further issue was patients not disclosing all relevant information to the GIC for fear that it would prevent or delay their transition. Some of the impacts of the waiting times, inefficiencies and mistrust of the GIC were:

- detriment to mental health while waiting to be seen, prolonging the period of dysphoria without access to treatment for transition
- significant financial impact of private treatment
- dangers or damage caused by buying hormones without prescription
- risk of suicide or other impacts from not seeking mental health treatment or disclosing mental health problems.

The findings suggest that investment is needed in the GIC to improve capacity and service provision. The experience of trans people varied with regard to the degree to which GPs were involved in their care, but training GPs regarding trans care and having more universal protocols for shared care and prescription of hormones would be a way of alleviating the pressures on the GIC and also providing more a more convenient service for trans people.

The 2020 research found high levels of satisfaction with the video consultations offered by the GICs in response to the pandemic, and if these were evaluated as being effective, they might prove to be a more efficient means of providing services. Moreover, if the GIC provided remote consultations by means of video, it would also address the issue of trans and non-binary people from more remote areas having to travel long distances to attend the GIC.

The Scottish Government has recently published the NHS Gender Identity Services Framework 2022-2024 as part of their commitment to improving Gender Identity Services in Scotland.

Recommendations

17. **Consistent and universal protocols should be developed and applied, supported by relevant training, to ensure that primary care services are involved in transgender and non-binary health care. This would include bridging hormones for those on the waiting list and shared care agreements and shared pathways.**
18. **Online video consultations, initiated during the pandemic, should continue and be offered as part of the core service delivery model for the Gender Identity Clinics (GIC).**
19. **Considerable investment is needed to increase capacity and reduce waiting times within the GIC.**
20. **To increase capacity, more clinicians need to be encouraged into the speciality. Training programmes or the development of a specialist post-graduate programme in trans healthcare with a Scottish university may be instrumental in this.**
21. **Redesign services to be more person-centred and patient-led in order to reduce the extent to which GIC clinicians are perceived to act as 'gatekeepers' to accessing care.**
22. **Improve communication through investment in GIC admin and support, including:**
    a. Increasing the number of administrative staff allocated to support GIC services
    b. Streamline admin processes to ensure there are no delays for letters and reports, and investigate how enquiries can be responded to more quickly
    c. Investigate the possibility of a 'care navigator' system which would mean those referred to the GIC would have a named person they could contact who would support them through the process and system.
23. **Reform to GIC and trans health care should be informed by former service users.**

(see also Recommendation 16 on mental health provision for those on the GIC waiting list).

These recommendations will be of most relevance to **Scottish Government, GIC service leads, NHS Board level Chief Executives.**

6. More Services being Visibly LGBT+ Inclusive

Research evidence

Many in the 2019 qualitative research suggested that a key development would be more services, including health services, being *visibly* LGBT+ inclusive, and many pointed to rainbow lanyards, badges and flags worn or displayed by staff in workplaces as a very positive development, meaning that LGBT+ people felt more comfortable and welcome using services

and felt they would be more confident being out about their identity and less likely to fear discrimination. However, some stressed that where services and staff used these types of branding, it would be vital to ensure that this was backed up by appropriate equality and diversity training. There were mixed opinions regarding formal accreditation such as the LGBT Charter mark. Some LGBT+ people felt that this was useful in knowing that services had a real commitment to inclusivity, and some LGBT+ service providers felt that if a service had the LGBT Charter mark they could refer people there with confidence. However, some LGBT+ people felt that the amount of work required to achieve accreditation could be off-putting and could foster resentment among some people.

A confounding issue expressed in the 2020 research and also mentioned by some survey respondents in free-text boxes, was that the pandemic has seen the rainbow used as a symbol for support for NHS workers, and there was concern that the use of rainbow signage and symbols to support the LGBT+ community could be confused with this.

Discussion

The evidence from the research suggests that visible signs of LGBT+ inclusivity in services such as posters, rainbow lanyards/branding etc may help to inspire confidence in LGBT+ people in accessing and using services and being open about their identity. A newly emerging consideration is how to distinguish LGBT+ rainbow branding from those used to support NHS workers. It would, of course, be important that visible signs of inclusivity were backed up by appropriate staff training to ensure that LGBT+ service users did indeed receive the level of service the branding suggested. The LGBT Charter mark or similar schemes offering formal accreditaion may be valuable particularly for third sector services having confidence when referring LGBT+ people to services.

Recommendations

24. **Organisations should be clear that their services are inclusive and should work with LGBT+ people to design and monitor provision. They should ensure that their website(s) and their physical environment where services are run (including services delivered in people's homes), clearly demonstrate that all people are welcome to use their service.** This should be backed up with appropriate training.
25. **NHS Scotland/NHS Boards should ensure all generated letters clearly demonstrate that all NHS services are inclusive.**
26. **Pro-active engagement with LGBT+ people should seek to maximise uptake of NHS screening services.**
27. **Complaints processes and complaints logging should be structured in a way that it is possible to search for complaints which relate to discrimination relating to protected characteristics including sexual orientation and trans or non-binary status. Complaints processes should be transparent.**
28. **NHS and other public services should engage in formal accreditation or external assessments to demonstrate inclusivity and increase confidence in service users.**

These recommendations will be of most relevance to **NHS Scotland, all NHS Boards** and **all service providers.**

7. Support for LGBT+ Victims of Domestic Abuse[14] and Sexual Violence

Research evidence

Across LGBT+ groups, several people in 2019 suggested that there needs to be provision of services to support people from the LGBT+ community who had been victims of domestic abuse and/or sexual violence, including services to support those who had been the victims within same-sex relationships.

Discussion

Many of the research informants had been the victim of domestic abuse and/or sexual violence, and the survey findings confirm the high prevalence of abusive relationships. However, there was a perceived lack of services to support or advise victims, leaving them further isolated and vulnerable. There was also a lack of understanding and awareness among service providers and the general public that sexual violence and domestic abuse can occur outside of scenarios involving male perpetrators and female victims. This could also mean that LGBT+ victims did not always recognise that their experience constituted abuse.

It is noted that at the time of interview in June 2019, funding was being sought for a service, led by Rape Crisis and LGBT Health and Wellbeing to support LGBT+ victims of sexual violence. The research suggests that this is a much needed service, and, once available, it would be important that this was widely advertised to ensure that LGBT+ victims were aware of it. A more general campaign raising awareness of domestic abuse and sexual violence in LGBT+ relationships may help victims to recognise incidents and seek help, and also boost awareness among the general population.

Recommendations

29. **All services which provide for victims of domestic abuse and sexual violence should be demonstrably LGBT+ inclusive.** This may include staff training (see recommendation numbers 9 to 13) and ensuring visible inclusivity (see recommendation numbers 23 to 26). Health professionals and others must be made aware of inclusive support services in order to appropriately signpost.
30. **Establish a dedicated service for LGBT+ victims of domestic abuse and sexual violence,** and this must be publicised and promoted to LGBT+ communities and professionals.
31. **There is a need for a campaign raising awareness of partner abuse and sexual violence in LGBT+ relationships**, in order to help victims recognise incidents and seek help, and boost awareness among professionals and the general population.
32. **Development of services and an awareness raising campaign should involve the LGBT+ community, including those with lived experience of domestic abuse/sexual violence.**

These recommendations will be of most relevance to **Scottish Government, statutory and 3rd sector support services for victims, NHS Boards.**

[14] 'Domestic abuse' is the term here used to describe all abuse between partners (whether living together or not).

8. Provision of Inclusive Facilities and Opportunities for Sport and Physical Activity

Research Evidence

In 2019, many, particularly trans men and women and non-binary people, suggested that they would be able to be more physically active if there were affordable (e.g. council-run) sports facilities which provided gender neutral changing facilities with private cubicles. Some suggested more LGBT+ inclusive sports clubs and facilities. Some said they would be interested in taking part in dedicated sessions for trans people (e.g. yoga or swimming sessions), while others were against this and felt it would be more important to make regular sessions more inclusive.

Discussion

While some trans and non-binary people indicated that they participated in sports and physical activity, descriptions of their activities were very often solo activities, and often behind closed doors. The survey findings highlight that significant proportions of LGBT+ people – particularly trans and non-binary people would like to participate in different types of sports and physical activity but were not currently doing so.

Improving the provision of appropriate community sports venues with non-gendered changing rooms and offering inclusive sports sessions are likely to increase participation in sports and physical activity for trans and non-binary people and may have impacts such as:

- Improving overall equality of access
- Reducing isolation
- Improving physical wellbeing, encouraging healthy weight
- Improving mental wellbeing

Recommendations

33. **A clear framework of inclusivity should be established for sports and leisure providers to use as a tool for implementing a plan of proactive LGBT+ access and participation.**
34. **Relevant stakeholders should develop clear national strategic guidance for providers that supports access to facilities.**
35. **Consideration must be given to both dedicated physical activity opportunities for LGBT+ people and equitable access to regular facilities, clubs and sessions.** This should involve consultation with the LGBT+ community.
36. **Provision of dedicated LGBT+ opportunities for sports and physical activity should be considered in light of the findings from the mapping exercise advocated in Recommendation No 1.**
37. **A working group should be tasked to explore and consider the opportunities and possibilities of an LGBT+ thematic community sports hub in large population centres** (e.g. in the way disability sport is a thematic approach to provision).

These recommendations will be of most relevance to **sportscotland, local authorities, leisure trusts, sports charities and providers, NHS.**

9. Provision for Asylum Seekers

Research Evidence
The qualitative research in 2019 included focus groups with asylum seekers. For asylum seekers, the key priorities were:

- Provide dedicated counselling services for LGBT+ asylum claimants, and have emergency services available to those whose claims are initially rejected

- Employ LGBT+ people to conduct Home Office interviews for asylum claimants as they would have a better understanding of the issues faced by LGBT+ claimants

Discussion

The mental health needs of asylum seekers were particularly acute. These were often the result of very traumatic experiences in their home countries, separation from family and culture, internalised homophobia/shame, and the huge anxieties associated with going through their asylum claim and not knowing whether they will be returned to the country from which they had fled.

The research suggests that mental health service for LGBT+ asylum seekers, offering support from a service which understands the unique set of pressures and issues faced by LGBT+ asylum seekers would be of great benefit. Moreover, it would appear that work is needed to ensure that asylum seekers are aware of any and all relevant existing services and, critically, that they are aware that they can access NHS services after an asylum claim is denied. Asylum seekers appear to be at particular risk of suicide and the point at which claimants are denied refugee status is potentially the most perilous. It is therefore most important that appropriate emergency mental health services are available.

At the time of the 2019 qualitative research, LGBT Health & Wellbeing was already supporting a high number of LGBT asylum seekers. In March 2020 they launched a dedicated Glasgow-based LGBT Refugee Project. From 2021-22 they provided one-to-one support to 176 individuals, from 28 different countries of origin, through this project. Much of the support centres around people's asylum claim, as well as mental health support and referrals to health, welfare, educational and other support agencies. They have seen demand continue to grow.

Recommendations

38. **LGBT+ asylum applicants should be offered supported access to a range of health and wellbeing services including counselling and mental health services delivered in partnership between trusted 3rd sector organisations with supported referral to NHS services where required.** Organisations providing support must recognise the sensitivities and needs of those who are both asylum seekers and LGBT+ people.
39. **Asylum applicants should have an opportunity, through sensitive enquiry by the Home Office, to disclose their LGBT+ identities and be supported by link workers aligned to the asylum application process (and latterly within named accommodation centres) to engage with local support structures. When submitting an application in Scotland, applicants should – as a minimum – be given information in their own language on NHS services and the Scottish Refugee Council. Consideration should be given to routine referral to the Scottish Refugee Council.**
40. **Asylum applicants should have unrestricted access to relevant health and social care information, developed in partnership between public sector and 3rd sector bodies. This information should be available from a range of safe and trusted public spaces and should seek to reassure rights to support.**

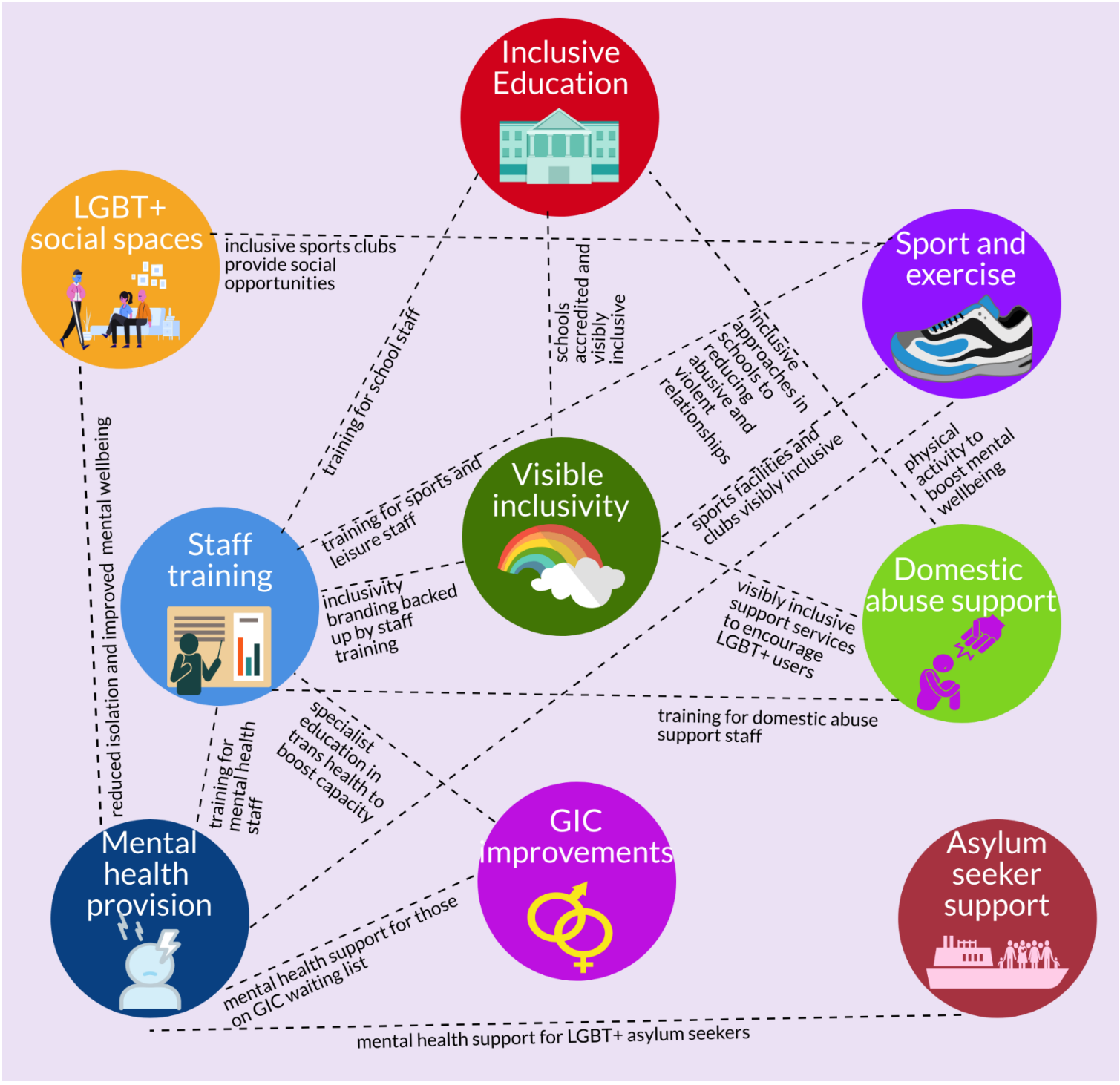
These recommendations will be of most relevance to **The Home Office, Scottish Refugee Council, mental health care providers, NHS Inform, relevant 3rd sector organisations.**

Final Over-arching Recommendation

41. **Directors of Public Health and Public Health Scotland are asked to champion the recommendations from this report within their local health boards, and nationally with COSLA and Scottish Government.**

Inter-relating Recommendations

It is clear that many of the nine wish list items and their associated recommendations are inter-related, with many over-lapping areas for improvement. The graphic on the next page highlights some of the ways in which the areas for improvement are related.


Inclusive Education
LGBT+ social spaces
Sport and exercise
Staff training
Visible inclusivity
Domestic abuse support
Mental health provision
GIC improvements
Asylum seeker support
inclusive sports clubs provide social opportunities
training for school staff
schools accredited and visibly inclusive
inclusive approaches in schools to reducing abusive and violent relationships
physical activity to boost mental wellbeing
reduced isolation and improved mental wellbeing
training for sports and leisure staff
sports facilities and clubs visibly inclusive
inclusivity branding backed up by staff training
visibly inclusive support services to encourage LGBT+ users
training for domestic abuse support staff
specialist education in trans health to boost capacity
training for mental health staff
mental health support for those on GIC waiting list
mental health support for LGBT+ asylum seekers

Appendix A: Survey Questionnaire

LGBT+ Health & Wellbeing Survey 2021

Public Health Scotland

NHS Greater Glasgow and Clyde

NHS Lothian

LGBT+ Health & Wellbeing Survey 2021

Information About the Survey

We want to hear from people with LGBT+ identities.
This survey is being done to find out more about the health and wellbeing of people who identify as lesbian, gay, bisexual, transgender or non-binary and live in Scotland. The survey is being undertaken by several NHS Boards working together.

To make sure the health service in Scotland is able to meet the health and wellbeing needs of LGBT+ people, provide inclusive health services, prevent ill health and promote positive health, we need to understand more about the health of LGBT+ people.

Over the last 18 months we have spoken to over 180 LGBT+ people and 18 organisations to hear about their experiences of health and wellbeing. We have used their feedback to develop this survey which we hope LGBT+ people throughout Scotland will complete.

Since we started this work COVID 19 has changed all our lives and this survey will also help us identify how LGBT+ would like to see the health service change to better meet their needs as COVID 19 recovery progresses.

To take part in the survey, please read the information provided below and then tick either the yes or no box at the end to say if you agree to take part in the survey.

Below are a series of questions and answers that provide information about the survey and should help you to make a decision.

What do I have to do?

We would like you to fill in an online questionnaire about your health (such as physical activity, eating, smoking, drinking etc.), relationships, and how you feel about yourself, the neighbourhood you live in, the services you might use, and how you feel about your wellbeing generally.

For most questions, you'll be asked to select an option that best fits your answer Others will require selecting all that apply Some will ask you to provide more information, which can be typed into a text box A few questions use drop down boxes Most questions will require an answer before moving on to the next question or section, unless otherwise indicated Each question will include a 'Don't know' or 'Prefer not to say' option

The survey will take approximately 30 minutes to complete and you will be able to pause the questionnaire at any stage and complete at a later time. We will send you an email reminder to complete, but we will only use the results from completed questionnaires, so we would be grateful if you can complete the questionnaire as soon as possible.

You will have an opportunity at the end of the survey to enter into a prize draw to win one of four vouchers for £250 for your choice of Amazon, John Lewis, Ikea, or Apple.

Who will see my answers?

The people on the research team from NHS Greater Glasgow & Clyde, NHS Lothian and Public Health Scotland will see your answers. All the information you supply will be aggregated with answers from other respondents for analysis and publication of results. You will not be identified in any analyses or publications.

The survey findings will be published late 2021.
The resarch team can be contacted by email here

NHSGG&C privacy notice
Prize draw tems and conditions

Before proceeding to the survey, please read the statement below and let us know whether or not you are willing to take part in the survey by ticking either yes or no.

I have read and understood the information provided to me about the LGBT+ Health & Wellbeing Survey. I understand that any data I provide will be anonymous and confidential , and used solely for research and analysis purposes.

I am happy to take part in the LGBT+ Health & Wellbeing survey
*****

- [ ] Yes
- [ ] No

ABOUT YOU

Firstly, we would like to ask some questions about your gender, whether you are trans or have a trans history, your sexual orientation and age.

2. Which of the following best describes your gender? *

- [ ] Female
- [ ] Male
- [ ] Non binary
- [ ] Prefer not to say
- [ ] Other (please specify): _____

3. Are you a trans person or do you have a trans history? *

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

4. Which of the following best describes your sexual orientation? *

- [ ] Heterosexual or Straight
- [ ] Gay
- [ ] Lesbian
- [ ] Bisexual
- [ ] Pansexual
- [ ] Prefer not to say
- [ ] Other (e.g. Queer BI+ Questioning Asexual Ally): _____

5. What age are you? *

- [ ] 16-19
- [ ] 20-24
- [ ] 25-29
- [ ] 30-39
- [ ] 40-49
- [ ] 50-59
- [ ] 60-69
- [ ] 70 or over
- [ ] Prefer not to say

GENERAL HEALTH AND QUALITY OF LIFE

We would like to ask you some questions about your health in general and quality of life, whether you have any long term conditions or illness, what type of condition/illness, and any conditions you are currently being treated for. We would also like to know if you have had COVID and if you have been shielding.

6. How is your health in general? *

- [ ] Very good
- [ ] Good
- [ ] Fair
- [ ] Bad
- [ ] Very bad
- [ ] Don't know
- [ ] Prefer not to say

7. Has your general health been affected in any way by COVID? *

- [ ] Yes
- [ ] No
- [ ] Don’t Know
- [ ] Prefer not to say

8. Have you had COVID? *

- [ ] Yes, diagnosed and recovered
- [ ] Yes, diagnosed and still ill
- [ ] Not diagnosed but suspected
- [ ] No
- [ ] Don't know
- [ ] Prefer not to say

9. Are you on the shielding list or living in a shielding household? *

- [ ] Yes, I am on the shielding list
- [ ] No, I am not shielding but live in a shielding household
- [ ] No, I am not shielding or living in a shielding household
- [ ] Prefer not to say

10. Do you have any long-term conditions or illnesses that substantially interfere with your day to day activities? *

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

11. Would you describe yourself as having?

TICK ALL THAT APPLY

- [ ] A physical disability
- [ ] A mental or emotional health problem
- [ ] A long-term illness
- [ ] Don’t know
- [ ] Prefer not to say

12. Do you have any of the following conditions?

TICK ALL THAT APPLY *

- [ ] ADHD
- [ ] Accident / injury related condition
- [ ] Alcohol or drug-related conditions (e.g. dependence, liver disease, cirrhosis , pancreatitis, cellulitis)
- [ ] Autism/Asperger's/ASD
- [ ] Cancer
- [ ] Chronic pain
- [ ] Diabetes
- [ ] Dyslexia
- [ ] Epilepsy
- [ ] Gastro-intestinal problems e.g. peptic ulcer disease, irritable bowel syndrome
- [ ] HIV
- [ ] Heart disease
- [ ] High blood pressure
- [ ] Mental Health problems e.g. depression/stress/anxiety
- [ ] Musculoskeletal problems e.g. arthritis; rheumatism; painful joints
- [ ] Respiratory problems - asthma, bronchitis, or persistent cough
- [ ] Severe eyesight problems
- [ ] Severe hearing problems
- [ ] Stroke
- [ ] None of the above
- [ ] Prefer not to say
- [ ] Other (please specify):

13. How would you describe your overall quality of life? *

- [ ] Very good
- [ ] Good
- [ ] Fair
- [ ] Bad
- [ ] Very bad
- [ ] Don't know
- [ ] Prefer not to say

14. Has your quality of life changed during COVID? *

- [ ] Improved a lot
- [ ] Improved a little
- [ ] Much the same
- [ ] Deteriorated a little
- [ ] Deteriorated a lot
- [ ] Don’t know
- [ ] Prefer not to say

MENTAL AND EMOTIONAL WELLBEING

The following questions ask about your mental and emotional wellbeing, whether you feel in control of decisions which affect your life, what you think can be done to make a difference to these and how they may have changed due to COVID.

Some questions in this section touch upon sensitive issues. If these questions raise any concerns there is a link to a document listing advice and support organisations by topic at the end of the survey.

15. How would you describe your general mental and emotional wellbeing? *

- [ ] Very good
- [ ] Good
- [ ] Fair
- [ ] Bad
- [ ] Very bad
- [ ] Don't know
- [ ] Prefer not to say

16. Has your mental or emotional wellbeing changed due to COVID? *

- [ ] Improved a lot
- [ ] Improved a little
- [ ] Much the same
- [ ] Deteriorated a little
- [ ] Deteriorated a lot
- [ ] Don’t know
- [ ] Prefer not to say

17. Do you feel in control of decisions that affect your life, such as planning your budget, moving house or changing job? *

- [ ] Definitely
- [ ] To some extent
- [ ] No
- [ ] Don’t know
- [ ] Prefer not to say

18. Has your feeling of control of these decisions changed due to COVID? *

- [ ] Improved a lot
- [ ] Improved a little
- [ ] Much the same
- [ ] Deteriorated a little
- [ ] Deteriorated a lot
- [ ] Don’t know
- [ ] Prefer not to say

19. Over the last 2 weeks, how often have you been bothered by the following problems?

Source: PHQ-2 *

	Not at all	Several days	More than half the days	Nearly every day	Don’t know	Prefer not to say
Little interest or pleasure in doing things	☐	☐	☐	☐	☐	☐
Feeling down, depressed or hopeless	☐	☐	☐	☐	☐	☐
Been unable to sleep, felt restless	☐	☐	☐	☐	☐	☐

20. What would make a difference to your mental and emotional wellbeing?

TICK ALL THAT APPLY *

- [ ] Being able to volunteer
- [ ] Faster access to counselling or emotional support
- [ ] LGBT+ specific counselling or emotional support
- [ ] Social activities for LGBT+ people
- [ ] LGBT+ social spaces that do not involve alcohol
- [ ] Don't know
- [ ] Prefer not to say
- [ ] Other (please specify):

SUICIDAL THOUGHTS AND SELF HARM

There may be times in everyone's life when they become very unhappy and depressed. Some people who experience these feelings might think about, or take actions, to end their life.

Some questions in this section touch upon sensitive issues. If these questions raise any concerns there is a link to a document listing advice and support organisations by topic at the end of the survey.

21. Have you ever made an attempt to end your life? *

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

22. Can you tell us tell us when this was?

- [ ] In the last week
- [ ] In the last six months
- [ ] In the last year
- [ ] Some other time
- [ ] Prefer not to say

23. Have you ever deliberately harmed yourself in any way? *

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

24. Can you tell us tell us when this was?

- [ ] In the last week
- [ ] In the last six months
- [ ] In the last year
- [ ] Some other time
- [ ] Prefer not to say

EATING PROBLEMS

Eating problems such as eating and making yourself sick, restricting and binging food can affect and be affected by our mental and emotional wellbeing. They can also have significant effects on our general health and physical wellbeing.

Can you tell us if you have experienced any of these issues?

Some questions in this section touch upon sensitive issues. If the questions raise any concerns there is a link to a document listing advice and support organisations at the end of the survey.

25. Have you ever eaten and made yourself sick? *

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

26. Can you tell us tell us when this was?

- [ ] In the last week
- [ ] In the last six months
- [ ] In the last year
- [ ] Some other time
- [ ] Prefer not to say

27. Have you ever restricted food or binged on food? *

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

28. Can you tell us tell us when this was?

- [ ] In the last week
- [ ] In the last six months
- [ ] In the last year
- [ ] Some other time
- [ ] Prefer not to say

MORE ABOUT YOU - COMING OUT

We would like you to tell us how 'out' you are.

29. How 'out' are you? *

- [ ] I'm not out
- [ ] I'm only out to friends
- [ ] I'm out to friends and family
- [ ] I'm out to most people (e.g. friends, family, health care and other providers)
- [ ] I'm out to everyone
- [ ] Prefer not to say

30. Which of the following knows your sexual orientation? *

	Yes	No	Don't know	Prefer not to say	Not applicable
GP	☐	☐	☐	☐	☐
Employer	☐	☐	☐	☐	☐
Education provider	☐	☐	☐	☐	☐
Housing provider	☐	☐	☐	☐	☐
Care provider	☐	☐	☐	☐	☐

31. If you are trans or non-binary how 'out' are you about your trans or noin-binary status? *

- [ ] I'm not out
- [ ] I'm only out to friends
- [ ] I'm out to friends and family
- [ ] I'm out to most people (e.g. friends, family, health care and other providers)
- [ ] I'm out to everyone
- [ ] Prefer not to say
- [ ] Not applicable - not trans or non-binary

32. Which of the following knows your trans or non-binary status?

	Yes	No	Don't know	Prefer not to say
GP	☐	☐	☐	☐
Employer	☐	☐	☐	☐
Education provider	☐	☐	☐	☐
Housing provider	☐	☐	☐	☐
Care provider	☐	☐	☐	☐

SOCIAL HEALTH AND SOCIAL CAPITAL

We would like to ask you how you feel about the neighbourhood you live in and your relationships with others in that area.

Social Health focuses on your feelings of belonging, value, isolation and loneliness and experience of crime and discrimination. We also would like to ask about any caring responsibilities you have.

Social Capital is often described as the glue which holds communities* together e.g. being able to rely on and trust others, exchange favours, work together to affect change and volunteering.

Both play a significant role in our feelings of health and wellbeing.

Some questions in this section touch upon sensitive issues. If these questions raise any concerns there is a link to a document listing advice and support organisations at the end of the survey.

* communities in this section refer to the local area people live in rather than one based on a shared identity.

33. Do you ever feel isolated from family and friends? *

- [ ] Yes
- [ ] No
- [ ] Don't know
- [ ] Prefer not to say

34. Has this changed due to COVID? *

- [ ] Yes, changed for the better
- [ ] Yes, changed for the worse
- [ ] No change
- [ ] Don't know
- [ ] Prefer not to say

35. How often have you felt lonely in the past two weeks? *

- [ ] All of the time
- [ ] Often
- [ ] Some of the time
- [ ] Rarely/Never
- [ ] Don't know
- [ ] Prefer not to say

36. How much do you agree or disagree with the following statements about living in this local area? *

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know	Prefer not to say
I feel I belong to this local area	☐	☐	☐	☐	☐	☐	☐
I feel valued as a member of my community	☐	☐	☐	☐	☐	☐	☐

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know	Prefer not to say
By working together, people in my neighbourhood can influence decisions that affect my neighbourhood	☐	☐	☐	☐	☐	☐	☐

37. How much do you agree or disagree with the following statements about living in this local area? *

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Don't know	Prefer not to say
This is a neighbourhood where neighbours look out for each other	☐	☐	☐	☐	☐	☐	☐
Generally speaking, I can trust people in my local area	☐	☐	☐	☐	☐	☐	☐
The friendships and associations I have with other people in my local area mean a lot to me	☐	☐	☐	☐	☐	☐	☐
If I have a problem, there is always someone to help me	☐	☐	☐	☐	☐	☐	☐

38. Do you look after, or give any regular help or support to family members, friends, neighbours or others because of long-term physical or mental ill-health or disability, or problems related to old age? (exclude any caring that is done as part of any paid employment or formal volunteering) *

- ☐ Yes. I care for someone
- ☐ Yes. I was a carer but had to stop due to COVID.
- ☐ No. I am not a carer
- ☐ Prefer not to say.

39. Have your caring responsibilities changed due to COVID?

- [ ] Yes, increased a lot
- [ ] Yes, increased a little
- [ ] Much the same
- [ ] Yes, decreased a little
- [ ] Yes, decreased a lot
- [ ] Don't know
- [ ] Prefer not to say
- [ ] Not applicable

40. How has this affected your mental and emotional wellbeing?

- [ ] More positive than negative
- [ ] More negative than positive
- [ ] Equally positive and negative
- [ ] Don’t know
- [ ] Prefer not to say
- [ ] Not applicable

41. What would you like to see for LGBT+ people as society recovers from COVID?

TICK ALL THAT APPLY *

- [ ] Better care for older LGBT+ people
- [ ] Opportunities to meet other LGBT+ people without alcohol involved
- [ ] More visible enforcement of "no tolerance" for LGBT+ discrimination in public places
- [ ] Better responses to hate speech online
- [ ] More tailored and accessible mental health services
- [ ] LGBT+ population included in future planning
- [ ] Don't know
- [ ] Prefer not to say
- [ ] Other (please specify):

42. Thinking back over the last 12 months, have you given up any time to help any clubs, charities, campaigns or organisations in an unpaid capacity? *

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

43. Do you belong to any social clubs, associations, church groups or anything similar? *

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

44. In the last 12 months, have you taken any actions in an attempt to solve a problem affecting people in your local area? E.g. contacted any media, organisation, council, councillor MSP or MP; organised a petition, etc. *

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

45. Have you felt more or less connected to your community since COVID? *

- [ ] More connected
- [ ] No difference
- [ ] Less connected
- [ ] Don't know
- [ ] Prefer not to say

46. Have you have been a victim of any of these crimes in the last year? *

	Yes	No	Prefer not to say
Anti-social behaviour	☐	☐	☐
Any type of theft or burglary	☐	☐	☐

	Yes	No	Prefer not to say
Vandalism	☐	☐	☐
Domestic violence/intimate partner violence	☐	☐	☐
Physical attack	☐	☐	☐

47. Have you been discriminated against in the last year for any reason? *

- ☐ No
- ☐ Yes, occasionally
- ☐ Yes, on several occasions
- ☐ Prefer not to say

48. Can you tell us who discriminated against you in the last year?

TICK ALL THAT APPLY

- ☐ Bank/insurance company
- ☐ Close relative
- ☐ College/school
- ☐ Employer
- ☐ Health care services
- ☐ Known person in a public place
- ☐ Landlord/housing office
- ☐ Police/judicial system
- ☐ Shops/restaurants
- ☐ Social services
- ☐ Unknown person in a public place
- ☐ Prefer not to say
- ☐ Other (please specify):

49. Can you tell us why you were discriminated against?

TICK ALL THAT APPLY

- [ ] Ethnic background
- [ ] Sex
- [ ] Trans
- [ ] Non binary
- [ ] Sexual orientation
- [ ] Age
- [ ] Disability
- [ ] Religion / faith / belief
- [ ] Because of the neighbourhood I live in
- [ ] Accent
- [ ] Don't know
- [ ] Prefer not to say
- [ ] Other (please specify):

LEISURE ACTIVITY

We would like to ask you some questions about your usual types and levels of physical activity and how this has been affected by COVID. We would also like to know what types of activity you would like to take up and any barriers (apart from COVID) preventing your participation in these activities.

50. Which of the following types of activity do you generally participate in or would like to participate in? *

	I participate in	I would like to participate	Not interested	Prefer not to say
Individual activities (e.g. walking, hiking)	☐	☐	☐	☐
Individual sports (e.g. swimming, running)	☐	☐	☐	☐
Team sports (e.g. football, hockey, basketball)	☐	☐	☐	☐

	I participate in	I would like to participate	Not interested	Prefer not to say
Exercise classes/groups	☐	☐	☐	☐
Going to the gym	☐	☐	☐	☐

51. How active would you say you were before COVID? *

- ☐ Very active (e.g. taking more than an hour of moderate/vigorous activity every day)
- ☐ Fairly active (e.g. taking more than an hour of moderate/vigorous activity some days every week)
- ☐ Fairly inactive (only taking part in moderate/vigorous activity occasionally)
- ☐ Inactive (rarely/never taking part on moderate/vigorous activity)
- ☐ Don't know
- ☐ Prefer not to say

52. How active would you say you have been since COVID? *

- ☐ Very active (e.g. taking more than an hour of moderate/vigorous activity every day)
- ☐ Fairly active (e.g. taking more than an hour of moderate/vigorous activity some days every week)
- ☐ Fairly inactive (only taking part in moderate/vigorous activity occasionally)
- ☐ Inactive (rarely/never taking part on moderate/vigorous activity)
- ☐ Don't know
- ☐ Prefer not to say

53. Other than for COVID related reasons do any of the following factors prevent you or put you off taking part in physical activity?

*

	Yes	No	Don’t know	Prefer not to say
Lack of appropriate LGBT+ friendly sports facilities or clubs	☐	☐	☐	☐
Lack of appropriate changing areas	☐	☐	☐	☐
Homophobia/transphobia in sports/exercise environments	☐	☐	☐	☐

	Yes	No	Don’t know	Prefer not to say
Gender segregation or gender rules in sports or facilities	☐	☐	☐	☐
Cost	☐	☐	☐	☐

54. How would you rate your area for LGBT+ inclusive social spaces? *

- ☐ Very good
- ☐ Good
- ☐ Poor
- ☐ Very poor
- ☐ Don't know
- ☐ Prefer not to say

LIFESTYLE BEHAVIOURS

The following questions ask about your lifestyle behaviours e.g. smoking, drinking, and drug use and also if you intend to cut down or stop any of these. We would also be interested to know if you gamble, and if so how this affects your life.

Some questions in this section touch upon sensitive issues. If these questions raise concerns there is a link to a document listing advice and support organisations by topic at the end of the survey.

55. SMOKING STATUS

Which of the following statements best describes you at present?

Please note, when answering this question please do NOT include cigarettes without tobacco or electronic cigarettes *

- ☐ I have never smoked tobacco
- ☐ I have only tried smoking once or twice
- ☐ I have given up smoking
- ☐ I smoke some days
- ☐ I smoke every day
- ☐ Prefer not to say

56. SMOKING INTENTION TO STOP

Do you intend to stop smoking?

- [ ] Yes
- [ ] No
- [ ] Don't know
- [ ] Prefer not to say

57. ALCOHOL CONSUMPTION

How often do you have a drink containing alcohol? *

- [ ] Never
- [ ] Monthly or less
- [ ] 2-4 times per month (this includes once a week)
- [ ] 2-3 times per week
- [ ] 4+ times per week
- [ ] Prefer not to say

58. ALCOHOL DAILY UNITS

How many units of alcohol do you drink on a typical day when you are drinking?

Glass of spirits = 1 unit
Bottle of lager/beer/cider = 1.7 units
Can or pint of of lager/beer/cider = 2 units
Can or pint higher strength lager/beer/cider = 3 units
Small glass of wine = 1.5 units
Standard glass of wine 2.1 units
Large glass of wine = 3 units

- [ ] 1-2
- [ ] 3-4
- [ ] 5-6
- [ ] 7-9
- [ ] 10 or more
- [ ] Don't know
- [ ] Prefer not to say

59. BINGE DRINKING

How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year

Recommendations for alcohol limits are based on biological sex assigned at birth rather than gender identity.

- [ ] Never
- [ ] Less than monthly
- [ ] Monthly
- [ ] Weekly
- [ ] Daily or almost daily
- [ ] Prefer not to say

60. How often during the last year have you . . . .

Source: AUDIT tool

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	Don't know	Prefer not to say
Found that you were not able to stop drinking once you had started?	☐	☐	☐	☐	☐	☐	☐
Failed to do what was normally expected from you because of your drinking?	☐	☐	☐	☐	☐	☐	☐
Needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	☐	☐	☐	☐	☐	☐	☐
Had a feeling of guilt or remorse after drinking?	☐	☐	☐	☐	☐	☐	☐
Been unable to remember what happened the night before because you had been drinking?	☐	☐	☐	☐	☐	☐	☐

61. Have you or somebody else been injured as a result of your drinking?

Source: AUDIT tool

- [ ] No
- [ ] Yes, but not in the last year
- [ ] Yes, during the last year
- [ ] Prefer not to say

62. Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?

Source: AUDIT Tool

- [ ] No
- [ ] Yes, but not in the last year
- [ ] Yes, during the last year
- [ ] Prefer not to say

63. DRUG USE

Have you ever used drugs? *

*** exclude prescription and over the counter medications ***

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

64. DRUG TYPES

Can you tell us if you have used any of these drugs, and if yes was it in the last 12 months?

TICK ALL THAT APPLY

Leave blank if you have not used any of these drugs

	Yes, Used	Used in Last 12 Months
Cannabis (Weed, Skunk, Green, Hash, Blow, Joints, Marijuana)	☐	☐
Gas, Glue or Other Solvents	☐	☐
Amphetamines (Speed, Whizz, Sulph, Paste)	☐	☐
Ecstasy (E, Eccies, XTC, Pills)	☐	☐
GHB/GBL (liquid ecstasy)	☐	☐
Benzos (Valium, Vallies, Blues, Whites, Yellows, Xanax)	☐	☐
Crystal methamphetamine (crystal, meth, Tina)	☐	☐
Mephedrone (4-MMC, meow, methylone, bubbles)	☐	☐
Heroin or related drugs (Smack, Kit, H, Brown, Skagpoppy straw, kompot, fentanyl)	☐	☐
Amyl nitrate (Poppers)	☐	☐
Magic Mushrooms (Shrooms)	☐	☐
Methadone (Physeptone, Meth)	☐	☐
MDMA crystals/crystals (Mandy, Molly, Madman)	☐	☐
Cocaine (Coke, Charlie, C, Proper, Council)	☐	☐
Anabolic Steroids (Roids)	☐	☐
Unknown White Powders (Gear)	☐	☐
Ketamine (Ket, K)	☐	☐
Synthetic Cannabinoids (SPICE, RedExodus, Mamba)	☐	☐
LSD (Acid, Blotters)	☐	☐
2C (2CB, 2CI, 2CE)	☐	☐
Diet Pills	☐	☐
Tanning Pills	☐	☐

65. DRUGS - CUTTING DOWN

Would you like to cut down or stop your substance use?

- [ ] Yes
- [ ] No
- [ ] Don't know
- [ ] Prefer not to say

66. USE OF CROSS SEX HORMONES

Have you ever obtained hormones for your own use?

TICK ALL THAT APPLY *

- [ ] Yes , online (not prescribed)
- [ ] Yes, with a private prescription by health professional
- [ ] Yes, with an NHS prescription
- [ ] Yes, some other way
- [ ] No, never
- [ ] Prefer not to say
- [ ] Yes, some other way (please specify):

67. GAMBLING

How often do you spend money on gambling? *

- [ ] Never
- [ ] Monthly or less
- [ ] 2 – 4 times per month (this includes once a week)
- [ ] 2 – 3 times per week
- [ ] 4+ times per week
- [ ] Prefer not to say

68. Thinking about the last 12 months...

Source: PGSI (Mini Version)

	Never	Sometimes	Most of the time	Almost always	Prefer not to say
Have you bet more than you could really afford to lose?	☐	☐	☐	☐	☐
Have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?	☐	☐	☐	☐	☐
Have you felt guilty about the way you gamble or what happens when you gamble?	☐	☐	☐	☐	☐

69. Have your levels of the following changed during COVID? *

	Increased	Much the same	Decreased	Don't know	Not applicable	Prefer not to answer
Smoking	☐	☐	☐	☐	☐	☐
Drinking	☐	☐	☐	☐	☐	☐
Drug Use	☐	☐	☐	☐	☐	☐
Gambling	☐	☐	☐	☐	☐	☐

PARENTING AND RELATIONSHIPS

We would like to know if you are a parent or carer, your current relationship status and whether you have experienced any discrimination or domestic abuse. We would also like to know what affect COVID has had on these.

This section explores sensitive issues. If these questions raise any issues for you there are links to further information and support organisations at the end of the questionnaire.

70. Are you a parent/carer for a child under the age of 16?

TICK ALL THAT APPLY *

- [ ] Yes, Biological parent
- [ ] Yes, Step Parent
- [ ] Yes, Carer
- [ ] Yes, Kinship carer
- [ ] Yes, Foster/adoptive parent
- [ ] No, not a parent/carer
- [ ] Prefer not to say

71. Has COVID changed your experience as a parent or carer due to home-schooling and working from home?

- [ ] Yes, improved it a little
- [ ] Yes, deteriorated it a little
- [ ] Yes, deteriorated it a lot
- [ ] No
- [ ] Don't know
- [ ] Prefer not to say

72. Have you, your partner or any child experienced LGBT+ related discrimination from any of the following?

TICK ALL THAT APPLY

	I have	My partner has	My child has	No experience of LGBT+ related discrimination	Prefer not to say	Not applicable
School	☐	☐	☐	☐	☐	☐
Nursery/Early Learning	☐	☐	☐	☐	☐	☐
Childcare provider	☐	☐	☐	☐	☐	☐
Foster/Adoption services	☐	☐	☐	☐	☐	☐
Social services	☐	☐	☐	☐	☐	☐
Other parents	☐	☐	☐	☐	☐	☐

	I have	My partner has	My child has	No experience of LGBT+ related discrimination	Prefer not to say	Not applicable
Other children	☐	☐	☐	☐	☐	☐
Other, please specify	☐	☐	☐	☐	☐	☐

Other, please specify

73. What is your current relationship status? *

- ☐ Single
- ☐ Boyfriend/regular male partner
- ☐ Girlfriend/regular female partner
- ☐ Regular non binary partner
- ☐ Civil Partnership / married to a man
- ☐ Civil Partnership/ married to a woman
- ☐ Civil Partnership/ married to a non binary person
- ☐ Don't know
- ☐ Prefer not to say
- ☐ Other (please specify):

74. Has your current relationship changed during to COVID?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to say

75. Has the quality of your relationship change due to COVID?

- [ ] Yes, more positive than negative
- [ ] Yes, more negative than positive
- [ ] Much the same
- [ ] Don't know
- [ ] Prefer not to say
- [ ] Not applicable

76. ABUSIVE RELATIONSHIPS

Have you ever experienced an abusive relationship? *

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

77. Please answer the following questions in relation to your current partner and any previous partners.

TICK ALL THAT APPLY

	Yes, Current Partner	Yes, Previous partners	No	Prefer not to say
Have you ever been humiliated or emotionally abused by a partner or ex-partner	☐	☐	☐	☐
Have you ever been afraid of a partner or ex-partner?	☐	☐	☐	☐
Have you been forced to have any kind of sexual activity by a partner or ex-partner?	☐	☐	☐	☐
Have you been kicked, hit, slapped or otherwise physically hurt by a partner or ex-partner?	☐	☐	☐	☐
Have you been told by a partner or ex partner who you could	☐	☐	☐	☐

	Yes, Current Partner	Yes, Previous partners	No	Prefer not to say
see and where you could go?				
Have you been put down or told you are worthless by your partner or ex-partner?	☐	☐	☐	☐
Has a partner or ex-partner persistently checked where you are?	☐	☐	☐	☐
Has a partner or ex-partner persistently commented negatively on how you dress?	☐	☐	☐	☐
Has a partner or ex-partner tried to limit the time you spent with friends?	☐	☐	☐	☐

78. Please can you tell us if these abusive aspects of your relationship changed during lockdown.

- ☐ Yes - increased
- ☐ Yes - decreased
- ☐ Much the same
- ☐ Don't know
- ☐ Prefer not to say
- ☐ Abuse did not happen during lockdown

79. Have you accessed any help or support with domestic abuse?

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

80. What would be helpful to you in relation to domestic abuse?

TICK ALL THAT APPLY

- [ ] Being asked by health and social care providers about experience of domestic abuse
- [ ] Tailored LGBT+ support for domestic abuse (e.g. dedicated helpline or specific LGBT + service)
- [ ] Don't know
- [ ] Prefer not to say
- [ ] Other (please specify):

DIGITAL LIVES

We would now like to ask you a few questions about your use of social media and the affect it has on your life.

81. How often do you use the following things online?

TICK ALL THAT APPLY *

	Daily	Weekly	Less often	Never	Prefer not to say
Social media	☐	☐	☐	☐	☐
Dating apps (e.g. Grindr, Tinder, etc.)	☐	☐	☐	☐	☐
Online gaming	☐	☐	☐	☐	☐

82.
If you use social media* during the past year have you . . .

*** The term social media refers to social network sites (e.g. Facebook, Instagram). Dating or hook-up apps (e.g. Grindr, Bumble) and instant messengers (e.g. WhatsApp, Snapchat, Skype, Facebook messenger).**

	Yes	No	Don't know	Prefer not to say
Regularly found that you can't think of anything but the moment that you will be able to use social media again?	☐	☐	☐	☐

	Yes	No	Don't know	Prefer not to say
Regularly felt dissatisfied because you wanted to spend more time on social media?	☐	☐	☐	☐
Often felt bad when you could not use social media?	☐	☐	☐	☐
Tried to spend less time on social media, but failed?	☐	☐	☐	☐
Regularly neglected other activities (e.g. hobbies, sport) because you wanted to use social media?	☐	☐	☐	☐
Regularly had arguments with others because of your social media use?	☐	☐	☐	☐
Regularly lied about the amount of time you spend on social media?	☐	☐	☐	☐
Often used social media to escape from negative feelings?	☐	☐	☐	☐
Had serious conflict with a partner or family members because of your social media use?	☐	☐	☐	☐

83. How do you think your online use affects your life?

- ☐ More negative than positive
- ☐ More positive than negative
- ☐ Equally positive and negative
- ☐ Don't know
- ☐ Prefer not to say
- ☐ Not applicable

HEALTH AND OTHER SERVICES

We would like to know about your use of a range of health and other services and your experiences when using them.

If applicable, we would also like to explore your experience of Gender Identity Clinics.

84. Which of these health and other services have you used in the last 12 months?

TICK ALL THAT APPLY *

- [ ] GP
- [ ] Pharmacist
- [ ] A&E (inc. Out of Hours and Minor Injuries Unit)
- [ ] Hospital In-patient
- [ ] Hospital Out-patient
- [ ] Mental Health Services
- [ ] Addiction Services
- [ ] Maternity Services
- [ ] Sexual Health Services
- [ ] Sexual Violence & Domestic Abuse Services
- [ ] Housing Services
- [ ] Carer Services
- [ ] Money Advice
- [ ] Prefer not to say
- [ ] None of the above
- [ ] Other Service (please specify):

85. For those services you used can you tell us

If not applicable please leave blank.

	Were you out the last time you used the service?	Was it a positive experience?	Did the staff show an appropriate understanding of LGBT+ issues?	Were you treated unfairly due to your LGBT+ status?
GP				
Pharmacist				
A&E (Inc. Out of Hours & Minor Injuries Unit)				
Hospital Out-patient				
Hospital In-patient				
Mental Health Services				
Addictions Services				
Maternity Services				
Sexual Health Services				
Sexual Violence & Domestic Abuse Services				
Housing Sercvices				
Carer Services				
Money Advice				

86. SCREENING

Have you ever been invited for any of the following screening tests? *

	Yes	No	Yes but appointment cancelled due to COVID	Yes but declined invite	Prefer not to say	Not applicable
Cervical screening	☐	☐	☐	☐	☐	☐
Breast screening	☐	☐	☐	☐	☐	☐
Bowel screening	☐	☐	☐	☐	☐	☐
Abdominal aortic aneurysm (AAA) screening	☐	☐	☐	☐	☐	☐

87. For those tests you were invited to and were not cancelled can you tell us

If not applicable please leave blank.

	Did you have a screen?	Were you out?	Did you feel you were treated unfairly due to your LGBT+ status?
Cervical Screening			
Breast Screening			
Bowel Screening			
Abdominal aortic aneurysm (AAA) screening			

88. GENDER IDENTITY CLINIC (GIC)

Have you ever been referred or self-referred to the Gender Identity Clinic (GIC)? *

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Prefer not to say

89. Are you currently?

- [ ] On the waiting list
- [ ] Attending the GIC
- [ ] No longer using the service
- [ ] Appointment cancelled due to COVID
- [ ] Prefer not to say

90. Was your initial referral to the GIC?

- [ ] Within last 12 months
- [ ] Within last 5 years
- [ ] More than 5 years ago
- [ ] Prefer not to say

91. How long did you wait or have been waiting to get first appointment?

- [ ] Less than 3 months
- [ ] 3- 6 months
- [ ] 6-12 months
- [ ] 12-18 months
- [ ] 18-24 months
- [ ] More than 24 months
- [ ] Prefer not to say

If you have been waiting six months or more

Can you tell us what has been the impact for you of waiting to access the GIC?

92. Did you seek or access any support from any organisations or services when you were waiting to access the GIC?

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

Which organisation or services did you access?

93. At any point when using the GIC did you withhold information from GIC staff about any of these things?

	Yes	No	Prefer not to say
Your preferred gender identity	☐	☐	☐
Your sexual orientation	☐	☐	☐
Mental health issues	☐	☐	☐
Suicide attempts	☐	☐	☐
Self-harm	☐	☐	☐
Other (please specify)	☐	☐	☐

Other - specify

94. How would you rate your experience at the GIC?

- [ ] Very good
- [ ] Good
- [ ] Adequate
- [ ] Poor
- [ ] Very poor
- [ ] Prefer not to say

FINANCIAL WELLBEING

Please tell us about any financial worries you have experienced.

Some questions in this section touch upon sensitive issues. If these questions raise any concerns there is a link to a document listing advice and support organisations by topic at the end of the survey.

95. Do you currently have any financial worries? *

- [ ] All of the time
- [ ] Most of the time
- [ ] Sometimes
- [ ] Occasionally
- [ ] Never
- [ ] Prefer not to say

96. During the last 12 months was there a time when you were worried you would run out of food because of a lack of money or other resources? *

- [ ] Yes
- [ ] No
- [ ] Don’t know
- [ ] Prefer not to say

97. Have you ever had sex in exchange for money, goods, food, drugs, or somewhere to stay? *

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

MORE ABOUT YOU

To finish we would like you to answer some questions about yourself e.g. where you live, your ethnic group and religion, employment status, your current living situation and the type of home you live in.

98. Which Health Board area do you live in?

PLEASE SELECT. *

Health Board

99. What Local Authority area do you live in?

PLEASE SELECT *

Local Authority

100. How would you describe the place you live in? *

- [ ] Large town or city
- [ ] Suburban area or small town
- [ ] Rural area/small village
- [ ] Don't know
- [ ] Prefer not to say

101. What is your full postcode?

We use full postcode to assign a socio-economic deprivation category to the area you live in for analysis purposes. Your postcode will not be used to identify you. All responses are anonymous.

Postcode format examples G99 9XX or EH99 9XX
(leave blank if you don't know or prefer not to say)

102. What is your ethnic group?

Source: Scottish Census 2011

This information helps public bodies meet statutory obligations relating to race equality. It is also used for resource allocation and to develop and monitor policy on improving the life-chances for disadvantaged groups, including many ethnic minority groups.

The statistics provide a better understanding of communities and are used for the government-wide race equality and community cohesion strategy, which seeks to improve race equality outcomes in areas such as housing, education, health & Criminal Justice for all groups across society.

*

Ethnic Group

If 'Other' selected, please specify

103. What is your religion/belief? *

Religion/Belief

If 'Other' selected, please specify

104. Are you seeking asylum or are you a settled refugee? *

- [ ] No
- [ ] Yes, seeking asylum
- [ ] Yes, settled refugee
- [ ] Don't know
- [ ] Prefer not to say

105. Which of these best describes the home you live in? *

- [ ] Privately owned (owned outright or with a mortgage)
- [ ] Rent from a private landlord
- [ ] Rent from council or housing association
- [ ] Prefer not to say
- [ ] Other, please specify

106. What is your current living situation? *

- [ ] I live myself
- [ ] With partner
- [ ] With my children
- [ ] With partner and children
- [ ] In student accommodation
- [ ] In a retirement / care home / with my carer(s)
- [ ] With parent/s
- [ ] With friends
- [ ] Prefer not to say
- [ ] Other, please specify

107. Have you ever been homeless? *

- [ ] Yes
- [ ] No
- [ ] Prefer not to say

108. Which of the following best describes your employment situation? *

- [ ] Employee in full-time job (35 or more hours per week)
- [ ] Employee in part-time job (less than 35 hours per week)
- [ ] Employed on a zero hours contract
- [ ] Self-employed – full or part time
- [ ] Government supported training or employment
- [ ] Unemployed and available for work
- [ ] Full-time education at school, college or university
- [ ] Part-time education at school, college or university
- [ ] Wholly retired from work
- [ ] Looking after the family/home
- [ ] Permanently sick/disabled
- [ ] Prefer not to say

- [ ] Being asked by health and social care providers about experience of domestic abuse
- [ ] Tailored LGBT+ support for domestic abuse (e.g. dedicated helpline or specific LGBT + service)
- [ ] Don't know
- [ ] Prefer not to say
- [ ] Other (please specify):