EQUAL OPPORTUNITIES COMMITTEE

Tuesday 1 June 2004
(*Morning*)

Session 2

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by The Stationery Office Ltd.

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EQUAL OPPORTUNITIES COMMITTEE
11th Meeting 2004, Session 2

CONVENER

Cathy Peattie (Falkirk East) (Lab)

DEPUTY CONVENER

*Margaret Smith (Edinburgh West) (LD)

COMMITTEE MEMBERS

*Shiona Baird (North East Scotland) (Green)
Frances Curran (West of Scotland) (SSP)
Marlyn Glen (North East Scotland) (Lab)
Marilyn Livingstone (Kirkcaldy) (Lab)
*Mrs Nanette Milne (North East Scotland) (Con)
*Elaine Smith (Coatbridge and Chryston) (Lab)
Ms Sandra White (Glasgow) (SNP)

COMMITTEE SUBSTITUTES

Jackie Baillie (Dumbarton) (Lab)
Patrick Harvie (Glasgow) (Green)
Carolyn Leckie (Central Scotland) (SSP)
Tricia Marwick (Mid Scotland and Fife) (SNP)
Mr Jamie McGrigor (Highlands and Islands) (Con)

*attended

THE FOLLOWING GAVE EVIDENCE:

Alastair Pringle (Inclusion Project)
Mr Tom McCabe (Deputy Minister for Health and Community Care)
Hector MacKenzie (Scottish Executive Health Department)

CLERK TO THE COMMITTEE

Steve Farrell

SENIOR ASSISTANT CLERK

Ruth Cooper

ASSISTANT CLERK

Roy McMahon

LOCATION

Committee Room 1

Scottish Parliament

Equal Opportunities Committee

Tuesday 1 June 2004

(*Morning*)

[THE DEPUTY CONVENER *opened the meeting at 10:04*]

Item in Private

The Deputy Convener (Margaret Smith): Good morning and welcome to this meeting of the Equal Opportunities Committee. I begin by putting on the record our condolences to our colleague Marlyn Glen, whose husband died recently. Marlyn is not with us this morning, but our thoughts are with her at a difficult time.

We are missing a few of our colleagues, but we still have a quality team lined up to ask questions. We have received apologies from Marlyn Glen, Marilyn Livingstone, Cathy Peattie and Sandra White.

Agenda item 3 is consideration of a paper on our approach to our disability inquiry. Do members agree to take that item in private?

Members *indicated agreement*.

"Towards a Healthier LGBT Scotland"

10:05

The Deputy Convener: For agenda item 2, I welcome Alastair Pringle, who is the manager of the Inclusion project. It is good to see you here. Thank you for coming, and for your written report. Would you like to make some introductory remarks before we ask questions?

Alastair Pringle (Inclusion Project): The project has been a unique and positive opportunity for Stonewall Scotland, which is known as an agency that campaigns for lesbian and gay equality, to work with a public sector health department. Such work has not been undertaken anywhere else in Europe, and it is almost unique internationally, although similar work has been undertaken in Australia and has produced evidence that is similar to that in our report, "Towards a Healthier LGBT Scotland". Given that uniqueness, and given the history of discrimination and prejudice that the lesbian, gay, bisexual and transgender community has faced in Scotland, it has been useful for the Scottish Executive Health Department to give a trusted agency such as Stonewall Scotland the opportunity to go out to engage with LGBT people and to examine the health issues that are specific to that group. The project has also been a useful opportunity for Stonewall Scotland to take an equality agenda and work with a public sector body.

As the committee will have seen in "Towards a Healthier LGBT Scotland", we tried to gather the available evidence, although it is scattered and some of it is international. We have begun to undertake new research in a range of fields, but there are still significant gaps. One of the most important pieces of work that we have undertaken this year—in partnership with the University of Glasgow and transgender support groups throughout the country—is the Scottish national transgender survey, which is an in-depth mortality and morbidity health survey that accesses transgender people through their general practitioners. It is unique in the United Kingdom to be able to achieve something like that and, internationally, it will be the biggest ever study of a transgender population. There are still significant gaps, but we are trying to plug those gaps.

A range of other issues was raised in the report, and we still have a lot of work to do. One such issue is same-sex domestic violence. The domestic violence strategy that the Executive produced last year does not include same-sex couples. We have done some research on facts and figures and we have put together a leaflet that will act as an additional resource for NHS staff and workers.

There are still significant evidence gaps on some of the other cross-cutting and socioeconomic factors that we raise in the report, including LGBT people from black and ethnic minority communities, rural issues, aging and older LGBT people, and homelessness. However, we are starting to work more closely with colleagues who work in other equalities fields, including the national resource centre for ethnic minority health and the spirituality and belief policy working group, as part of proposed plans to develop an integrated equality and diversity unit. Plans are reasonably far forward in relation to the development of a strategy to integrate the programmes so that they work together, and we recently held a meeting of the leaders of those different equalities strands to start to work out how we can work better together. I hope that some of those issues will be addressed in the future, although that is dependent on the securing of funding to take forward the unit and the strategy.

The Deputy Convener: The report focuses primarily on health, but it also highlights the difficulties of the social context in which LGBT people live in Scotland. In your submission to the committee, you mentioned the need for a commitment at the most senior level to challenge homophobia throughout Scottish society. Are you aware of any complementary activity that is being carried out by the Executive, or indeed by other public sector bodies, which would support the innovative work that is being undertaken in the health service? Are there any lessons that other departments and public sector bodies could learn from the work that you have done?

Alastair Pringle: One of the pieces of work that we undertook that created the most momentum in the national health service was an audit called "LGBT Stocktake Exercise: Analysis of Responses". I hope that members received copies of that document.

The Deputy Convener: Yes. We will ask questions about that.

Alastair Pringle: The stocktake document gave NHS boards the first opportunity to start considering whether they were doing anything not only for LGBT people, but for their staff. A lot of our contacts in the boards were initially not quite sure why that was an issue and could not relate it to the services that they were providing, but the work-force issue and the fact that employment regulations had come into force on 1 December 2003 acted as a reasonable impetus. We sent out the stocktake document, which covered areas such as employment activity; the extent to which boards had included LGBT people in service design, development and delivery; and, importantly, what support the boards would require. Rather than saying, "Here is a list of things that you need to do to meet the needs of this group of people", we took a much more encouraging approach and asked what the boards needed in order to take the issue on board.

Since then, we have had a lot of requests from boards for further information for ideas and contacts in other agencies. The exercise was simple to undertake—all that we did was to send out a questionnaire—but it generated a lot of interest and questions. Discussions are being held in the Scottish Executive equality unit and with some LGBT organisations about undertaking a similar exercise with the Convention of Scottish Local Authorities to consider local authority provision, but I can say no more on that in public at this stage.

As regards high-level support, when we look around us we do not see LGBT people reflected in billboard and television campaigns. Unfortunately, the only memorable campaign was the one to try to retain section 2A of the Local Government Act 1988—section 28—which had a detrimental effect on lots of people's lives in Scotland. That was a very public, homophobic billboard campaign. There are campaigns to stamp out sectarianism, to stamp out racism and to support people who are disabled, but there has been no significant campaign at the same level to say that there is no place for homophobia in Scotland. We have high-level support in the Scottish Executive Health Department, which has been hugely appreciated and has opened many doors for us to develop our work. We could not have done that work as an independent campaigning organisation.

As the report says clearly, one can do all that work in the NHS, but it is the prejudice and discrimination in Scottish society that causes the problems that bring people to our door in the first place. As part of the harm reduction or health improvement focus, it is important that we let LGBT people in Scottish society know that they are valued, that they are equal members of society, and that we will let people who discriminate against them know that there is no place for that.

The Deputy Convener: Bearing in mind the discrimination and homophobia that exist in certain sectors of Scottish society, one of the issues that you identify is the difficulty in conducting research when some of the people whom you want to research are still in the closet. Very often, the people who are researched are those who are out, fairly confident about their sexuality and able to take part in such research. What impact has that had? Have you been able to quantify the likely impact on research outcomes? What can we do to balance that lack of input or to reach wider groups of people?

Alastair Pringle: Some of the issues that you raise have been fairly well documented, but we have not yet managed to quantify them or to ensure that the research is balanced with regard to the representation of groups. We need to look into that in a lot more detail. We hope to employ a temporary research officer to help us to prioritise the vast range of research gaps.

However, it is important to say that, even though there is a group of people whom it has been easy to get access to through bars or social clubs, there are still gaps. A recent report by the NHS in Scotland in partnership with Ash Scotland considers smoking in the Scottish population. That report had a section on minority or excluded groups but it made no reference to LGBT people. The anecdotal evidence is that that group smokes heavily, so it is a shame that such gaps still exist when it is quite easy to access the target group.

10:15

The Deputy Convener: At the end of the project, you will be able to make cross-cutting recommendations to ensure that those gaps do not appear. We will investigate some of the wider issues as we go on, but it is important to pick up on those points.

In your briefing to the committee, you mention that the project has undertaken new research to address significant evidence gaps connected with, for example, rural issues and youth, lesbian and transgender health. You have given us some information on transgender issues, but are the other research projects complete? If so, what can you tell us about the results? Are those the kind of areas that the new research officer will address? What issues have arisen?

Alastair Pringle: In the first year of the project, we organised events in rural areas. One such event in Aberdeen was for lesbian and bisexual women and one in Fife was for gay and bisexual men. Rather than take the usual "go in, do research, go away" approach, we wanted to hold events for LGBT people living in those areas, to give them some health information. Fifty women attended the event in Aberdeen, which is one of the highest numbers of people to be involved in any research on lesbian and bisexual women in Grampian. The numbers were not so good in Kirkcaldy in Fife, but they put on quite a show.

The issues that arise in rural areas are not significantly different from the issues that arise in urban areas—people experience prejudice and discrimination and they cannot be out with family and friends. One difference was that, in rural areas, people have fewer local role models, so there are fewer people around them who can support them in coming out and let them know that it is okay. There is less of a social scene in rural areas so, when people want to socialise or to meet other LGBT people, they have to travel far.

Those are some of the lighter issues. However, there are other issues. Some people will get married, even though they are same-sex attracted, and then seek alternative outlets for sexual behaviour. I am aware of one person who would travel more than 150 miles—after saying that he was going to an evening meeting—to go to a public area for sex. He would then return home. There are obvious risks related to that sort of behaviour.

Self-esteem issues and mental health issues also arise, connected with the hiding of identity. Those issues are significant across the LGBT community, but they are perhaps more significant in rural areas.

Other issues arise to do with accessing health services. People who are born and brought up in local areas will likely have the same family doctor throughout their life. It can be very difficult to out oneself to one's family GP. Getting access to appropriate information was a key issue raised by people living in rural areas.

Elaine Smith (Coatbridge and Chryston) (Lab): You mentioned access to health services and I will come to that in a moment, but first I want to ask about a couple of things that you mentioned earlier.

You talked about the damage that was caused by the section 28 billboards. What damage did they cause? Have they had a lasting effect? Why do you think that there has been no positive campaign by the Executive on LGBT issues, similar to the other campaigns that you mentioned?

Alastair Pringle: I am not aware of any research that has been done specifically on the impact of the billboard campaign, so I cannot provide the committee with data relating to that. However, anecdotally and personally I can say that seeing images that said, basically, that certain people are not equal or valued and that their relationships damage children, marriage and associated values has an obvious impact on individuals and a community. I am sure that further work has been done on the issue and I can investigate that for members.

LGBT issues have not been taken on to the same extent as others partly out of fear, because it has not been done before. Advancing LGBT issues for the first time involves putting one's neck on the line, and the Health Department must be credited for doing that. In addition, the Scottish social attitudes survey that was produced last year indicated that there is significant homophobia in Scottish society. If members have the report in

front of them, they will see that it suggests that around 47 per cent of Scots believe that relationships between two men are always or mostly wrong. If that is what the Scottish population is saying—and the Scottish population is made up of the people who vote—one can see why there may be fear of or concern about taking on LGBT issues and standing up at the most senior level to say that there is no place for homophobia.

We have had a reasonable ride about in the tabloid press. We have been called radical militants and accused of promoting homosexuality across the NHS. There is some reticence about taking on LGBT issues because that has not been done before.

Elaine Smith: You say that the evidence is anecdotal, but if the billboards caused damage it is all the more important that a counter-campaign should be run. Given the figures that you cite for homophobia, the issue should be tackled in the interests of equality, regardless of whether that is comfortable. The Executive should be thinking about that.

Alastair Pringle: Absolutely. The issue is especially important in schools. I do not know whether this issue will be raised elsewhere, but one area of concern for us is the lack of commitment to challenging homophobia in schools and how we support teachers, against whom section 2A was predominantly aimed. Although the section was repealed, no work was done at a national level to make it clear that it was no longer law, to indicate what could be discussed and to provide materials to enable that to be discussed appropriately. Although 90-odd per cent of schools have policies on bullying, only about 6 per cent of those include an explicit reference to homophobia.

Elaine Smith: I am digressing slightly, but Zero Tolerance's respect project might be a useful tool, as schools are seeking to roll that out.

Alastair Pringle: Absolutely.

Elaine Smith: You raised the issue of health service access. On page 22 of your report, you refer to the findings of a 1993 study of medical students in the UK, which

"showed that 1 in 2 thought 'homosexual activity' was unacceptable in terms of lifestyle".

Your report also states that the stocktake exercise that the project undertook across the NHS showed that

"there is willingness to address LGBT health needs, but a general lack of knowledge and awareness among NHS staff of both the social issues that impact on LGBT people's health and how to respond to these at a service level."

The Inclusion project's briefing paper for the committee outlined the work that is being undertaken on

"'demonstration projects' to identify effective mechanisms for improvement in key areas".

The projects are mentioned on page 22 of "Towards a Healthier LGBT Scotland". The figures in that report for homophobic attitudes and lack of knowledge among health sector staff suggest that there is a need for targeted training and awareness raising. Will you give us details about the demonstration projects and about the level of engagement that you are encountering from the relevant health service staff? Can you report concrete outcomes of the projects yet, or will you do so later? I know that I raise quite a lot of points.

Alastair Pringle: Yes; I was trying to keep them all in my head.

I am glad that you mentioned the demonstration projects, which I suppose have generated the majority of my work this year. Individual meetings with each health board are tied into that work. There are LGBT link or liaison workers in health boards—there is no parity across boards in terms of who the LGBT link worker might be; they might be the director of nursing or the sexual health promotion officer. The key issue of staff training and awareness has been raised.

You will be aware from the briefing paper that demonstration projects have been set up with health boards in urban, rural and remote island communities, to try to ensure that we pick up on cultural as well as organisational issues. In every area, we are undertaking challenging homophobia training, which generally takes between three half days and three full days. In NHS Greater Glasgow, we worked with 75 mental health primary care staff, from receptionists to psychiatrists. In NHS Lothian, we are working with two GP practices and in NHS Western Isles we will start working with the Western Isles hospital in a couple of weeks' time. In NHS Lanarkshire, we are working with the board of directors and in NHS Tayside we are working on next-of-kin issues in relation to accident and emergency services—so we are working with a broad range of the different aspects of the health service. In all, we hope to undertake the training with about 300 staff. That will give us a good idea of people's attitudes to the issue and its relevance to their work.

The training has been completed only in Glasgow, but I think that we will complete the work in Edinburgh this week. The responses that we have received have ranged from "This training was life changing" to a letter that was, at best, vitriolic, which said that we were vulgar and that we were promoting homosexuality. The responses demonstrate attitudes in the NHS—and it is important to remember that those attitudes reflect attitudes in Scottish society in general. We should bear in mind last year's Scottish social attitudes survey. Some of the people who responded to the

survey work in the health service and we need to work with them.

We could not hope to undertake the same level of training on LGBT issues in all health boards in Scotland as is undertaken in relation to matters such as race and disability, so the projects provide us with a unique opportunity to find out what the challenges are if we want to raise staff awareness. There are no clear recommendations at this stage, but the training has helped staff to understand why LGBT issues are important and that it is not about "political correctness gone mad", as some staff said. Staff have been able to understand how the day-to-day service that they provide can develop and respond. They realise that it is simply a matter of respect for and understanding of the circumstances of people's lives—staff do not have to become a fount of knowledge on all areas of equality and diversity. Those are the early lessons that have been learned from the work. We hope that the five demonstration projects will present at a conference in February and we will have more details then.

Elaine Smith: Will you let the committee know the outcome of the work then?

Alastair Pringle: Absolutely. We will invite members to the conference, too.

You asked about the level of response. That has been patchy—I think that when the audit of health services was carried out the response rate was about 80 per cent. Since that audit, I have written to all health boards to request meetings with the LGBT link person and someone from training, human resources and organisational development. I think that six or seven meetings have been organised so far. It is difficult to maintain interest and momentum.

That is why it is important that we integrate our agenda with that of race and disability and so on. As you can understand, NHS boards are struggling with resources and in delivering their service. It is like six trains all trying to pull into the same station. We have got a bit of work to do to be more effective in the way that we communicate what we want.

10:30

Elaine Smith: Presumably NHS boards carry out equal opportunities training. Would you expect your work to become part of that?

Alastair Pringle: Yes, I hope that it will. Race equality schemes are carrying out race training. I have been working with the national resource centre for ethnic minority health on equality diversity and on getting all our agendas included in that training. We have also been considering different models of training. In Tayside, for example, we are discussing the possibility of induction-level training, in which we say that there is no place for discrimination and outline the groups that we are talking about. Another idea is having diversity champions, which means that one person on every ward or unit would go through, say, two days of training.

Elaine Smith: You talked about the importance of schools, and I mentioned the respect project, which can draw all of this in. Is there a place for plans to include LGBT issues at an earlier stage, for example during college and university courses? I am thinking of medical students.

Alastair Pringle: Yes. Again, there has been some initial discussion. The director of human resources in the Health Department, Mark Butler, is chairing a diversity task force, which is considering work-force issues. The task force has engaged some of the academic institutions that are involved in health training.

Elaine Smith: Has that been positive?

Alastair Pringle: Yes, it has. The academic institutions sit on the group, so they have been invited to attend meetings of the diversity task force. They attended the first one, which was only a few weeks ago. We are at the start of many of those agendas, so initial discussions have been held. All those areas need to be given some level of priority, and their importance should be impressed upon universities and colleges. People respond to the law—they respond to legislation when they have to. However, many of the issues are not covered by legislation; they are more human rights matters. It is about integration, and about raising the level of importance that is accorded to those issues. As medical training seems to be moving more towards communication and engaging patients in their own care, that might be a useful route in. The Health Department has held initial discussions through its equality diversity work.

Elaine Smith: Thank you.

The Deputy Convener: Did you want to ask anything in particular about the stocktake exercise, or do you feel that that has been covered?

Elaine Smith: Yes. In May last year, each NHS board nominated an LGBT lead to undertake a stocktake of the current planning provision of targeted services. It incorporated employment issues for LGBT staff and raised the importance of the forthcoming European Union employment directive, which will provide full workplace protection. You mentioned legislation—that directive will lead to legislation affecting sexual orientation. The response rate to the stocktake was 80 per cent, and the stocktake identified examples of innovative and good practice, and a number of challenges to developing services.

However, there were significant gaps in the responses. In some instances, a high proportion of those concerned did not provide any response.

The analysis of the results highlighted the point that it appeared that, in the main, one or two people were responding for bodies that often employ hundreds or thousands of staff. The report pointed out that

"it is unlikely that one person will be able to accurately represent and document the views and relevant activities of each organisation as a whole."

You said in response to one of my questions—and I think that you have said it in the report—that you praise the level of willingness and enthusiasm evidenced by the NHS in taking this on, and in responses to the stocktake exercise. How confident are you in the reliability of the stocktake results?

Alastair Pringle: It is the Health Department that needs to be congratulated on taking the issue on. We have struggled to get some of the NHS boards to respond to the work.

It is important to see the work as the first step in a long programme of work. For many health boards, this will be the first time that they have considered LGBT issues. We could not simply first raise awareness of the issues and explain to boards their relevance to planning and activities. I am not trying to excuse people, but the process is a slow, drip-feed one. The second part of the process is to meet the boards, even those that did not respond. We need to start discussing why they did not respond and whether they understand the issues.

I am confident that with the support that we receive from the Health Department, the integration of our work into future performance assessment frameworks will give us the measures that we need to ensure that everybody takes the issues on board. The time will come when the process will involve not a drip-feed or the provision of support, but telling boards what they have to do and why. We are a couple of years behind the work that has been done on race. Boards now give a much better response to, and have a much better understanding of, race issues. It is important that we set out not by saying that all boards had to have an LGBT action plan in two years, but by finding out what was happening and what support was required. More than anything else, the gaps show the level of support that will be required to deal with LGBT issues.

Elaine Smith: So you are identifying the challenges in developing appropriate and accessible health service provision. Can the LGBT organisations and the health service meet those challenges? You say that the process is a drip-feed one, but can the challenges be met?

Alastair Pringle: Some of the challenges can be met, but I do not envisage in the near future an LGBT-friendly health service across the board. I would be surprised if in the near future we had a health service in which, whether a person lives in Thurso or Glasgow, they can expect a friendly and accessible service and can say, "I'm gay, these are my problems," and get an appropriate response.

There are a host of challenges. As I mentioned in the documentation that I provided, one of them is that LGBT organisations, which are often voluntary or charity non-statutory organisations, try to provide much of the support beyond the medical interventions, which means predominantly sexual health screening—that is the main service that health boards have highlighted. Those organisations have very little profile; they tend to be funded from year to year and generally not by the health service. There is work to be done on building up that aspect of provision for LGBT people.

I also highlighted the fact that, although we are moving towards community health partnerships and other ways in which the health service intends to engage the public and patients, we have a long way to go before people who may not be out and who may be afraid to stand up and be counted feel able to do so in a health service that is trying to engage them openly.

Elaine Smith: Does the health service buy in services from the voluntary sector and, if not, should that happen? The issue is not just about mainline funding, because services can be bought in.

Alastair Pringle: Services can be bought in, although health board funding is piecemeal, as we have seen from the LGBT stocktake exercise. As NHS boards examine the make-up of their communities, they need to look beyond that to find out who provides support for different equality and diversity groups and then consider the gaps. There are more and more opportunities to do that through measures such as suicide prevention planning. As part of that, boards need to consider local mental health support and whether there is an LGBT switchboard. Recently, the switchboard in the Borders closed because of a lack of funding. Where will LGBT people in the Borders turn if they want emotional support?

It is also important to remember that the issue is not just for the Health Department; it is much broader. I know that the Executive's equality unit provides some funding for LGBT services, but does that have equity or balance? Do people think that through systematically? That is not just a numbers game, although the numbers game is important, as a significant minority in Scotland is involved. Do people consider to what extent they

meet the needs of and fund all those groups? The subject is multifaceted and it is difficult to provide a clear answer. We will reach our goal with the NHS, but we need to work better with a wider range of partners to do that.

Shiona Baird (North East Scotland) (Green): How concerned are you that your agenda will not be delivered if the funding crisis continues? The agenda depends on funding.

Alastair Pringle: The agenda is completely dependent on the funding. I am convinced that the Health Department and my colleagues in the health planning and quality division and in its involving people team are dedicated and committed to the agenda. I have no problems with that—it is not a tick-box issue for them.

I have been seconded from the NHS, so I am not a voluntary sector worker who is working with the health service. I am aware of organisational development issues and some of the challenges in the NHS. I feel confident that the Health Department will not sideline us. I suppose that the question is whether the equality and diversity strategy and unit, which are the proposed umbrella for the work, will receive funding. I have no idea how that will develop.

Mrs Nanette Milne (North East Scotland) (Con): I am interested in the communication side of the NHS and I am pleased that communication in general is now taught to medical students. In my day, we had to learn by our own hard and often bitter experience. I am glad that that is being taken on board and that at least a start has been made.

My questions are about mental health and addiction. You have touched on quite a lot of the issues, but perhaps further points will come to mind. A Glasgow study suggested that suicidal thoughts were two to three times more common among young gay men than they were among the general population. Another study suggested that nearly 80 per cent of mental health nurses in the health service were homophobic. Given what you have said about Scottish culture and the attitude to LGBT people, all that deters them from seeking help from the mental health service when they need it. What can be done in the mental health service to satisfy those needs?

Alastair Pringle: We have evidence gaps in every subject that the report covers. We do not have community profiles of LGBT people and their health issues. We do not have national data, and health surveys and the census do not include questions on sexual orientation. When any research is undertaken with communities, the needs of equality and diversity groups can be considered, to fill those significant gaps. It is always important to cover equality and diversity groups, because data for many of them do not exist either. That is the only way in which we will be able to cross-tabulate age and sexual orientation or ethnicity and sexual orientation.

I have undertaken initial work with the national programme for improving mental health and well-being. We agreed that local suicide prevention planning—the choose life programme—would be LGBT proofed, which means that the impact of planning on LGBT people would be considered. I will have a follow-up meeting on that next week.

In theory, equality proofing is a simple way of ensuring that the needs of different groups are considered. Equality proofing involves considering whether what an organisation does will have a negative outcome for groups of people, how an organisation can ensure a positive outcome for those people, whether it has the information that it needs and, if not, how it can find that information. Part of the demonstration project work has involved testing LGBT proofing.

We are working with our colleagues in the Executive's involving people team to develop a diversity impact assessment tool that could be used for anything from the new sexual health strategy to local service redesign or changes to a ward's opening times. The idea is that it should be a simple tool for doing such work.

Another useful example is addictions. Because of the report "Towards a Healthier LGBT Scotland", the alcohol action team from NHS Greater Glasgow got in touch to ask what it could do. We had a discussion on issues such as whether its initial assessment form includes sexual orientation and whether we would ask someone whether they are lesbian or gay or give them a self-completion form. We must think about the reality of LGBT people's lives and about how we incorporate that into the whole process.

Staff training is important and so are the people whom we employ in services. To what extent do we ask in job specifications for people to have knowledge and understanding of equalities issues and diversity? I am aware that that subject is raised in the agenda for change and I hope that we will start to see those issues in job specifications, certainly in the case of managers, so that the people who plan, design and develop services understand the impact of what they are doing in relation to those issues.

In a nutshell, we need more information and we need to make sure that services start to see things through diversity glasses. The issue is not about minority groups—gender is included in the diversity impact assessment and that is about men and women, so the individual needs of all people are included. The developments that I have mentioned will start to meet the gaps that we have identified.

10:45

Mrs Milne: In your report, the section on addictions suggests that LGBT people might be more amenable to treatment by LGBT staff. Do you think that training heterosexual staff to be sensitive to LGBT issues is enough or would it be better for LGBT people to be treated by LGBT staff?

Alastair Pringle: The same issue arises with the new men's health clinics. People say that they want to see only male staff; they want to see someone who is sensitive and who understands their needs. That information has perhaps come from cases in which people's experience of heterosexual staff has been poor or has arisen because of presumptions about heterosexuality. I am sure that some individuals, given the choice, would prefer to see staff who reflect their orientation. However, given the resource constraints, I do not envisage that happening. I hope that people can go anywhere in the mainstream service and have their needs met appropriately. Ensuring that places are LGBT friendly is a much better use of time and resources than setting up specialist clinics with LGBT staff throughout the country.

Mrs Milne: I am sure that mainstreaming and trying to change culture is the important thing in all equalities issues.

Alastair Pringle: I have a lot of experience of working with the Sandyford initiative in Glasgow and many gay men work in the gay men's sexual health service. Similarly, the Sappho sexual health service for lesbians has many lesbian women. As a stopgap, until we can bridge from where we are now to a LGBT-friendly health service, that might be useful.

The Deputy Convener: Do you have a question on sexual health, Nanette? We must be a wee bit aware of the time.

Mrs Milne: The report highlights the fact that it is more difficult to access information about the sexual health and well-being of lesbian and bisexual women. Do you think that there should be more research on that? Is the Inclusion project working in that area or is the issue about making relevant information more generally available?

Alastair Pringle: Gay men's sexual health would probably not have been addressed if HIV had not come along; it is important to highlight the fact that the bias is not gender based but illness or disease based. More work needs to be done on lesbian sexual health. We often have a lot of information about the issues, but we need to ensure that staff are aware of it. I have heard of many instances of GPs practically insisting to lesbian women that they use contraception and being unable to understand why the women are not doing so until they out themselves as lesbians. People should not have to do that. The presumption of heterosexuality is related to staff attitudes and awareness.

We must also ensure that NHS staff and all LGBT people, including lesbians, have appropriate and accessible information on all health issues. With the focus being on HIV, historically there has been a huge amount of information about sexual health for gay men, although it is now a bit out of date. There has been very little information for lesbians or younger people. I know that at Pride Scotland this year organisations such as Healthy Gay Scotland will launch new materials for young gay men. Some of the gaps are starting to be filled, but there is still much work to do to ensure that information is systematic and accessible by all NHS staff.

Mrs Milne: It would appear that fewer men are coming forward to be tested for HIV in Scotland than elsewhere in the UK. What factors underpin that? How do you plan to set out increasing the number of men who come forward for testing? Are men who are most at risk of HIV being targeted effectively, or is a different approach needed?

Alastair Pringle: I was concerned when I first saw the statistic that indicates that in Scotland we test less than in the UK and that in the UK we test less than in Europe as a whole. I am not in a position to answer your question. Our colleagues in HIV Scotland are doing significant work on the issue. Work is being done with various black and ethnic minority communities in Scotland in which HIV infection rates appear to be increasing. Further detail is provided by the HIV health promotion strategy that was written last year. Because the issue was being addressed elsewhere, I have not engaged with it fully, given the constraints imposed by the project's limited resources.

Shiona Baird: How soon can we reasonably expect to see that the work of the Inclusion project has had a positive impact on the target communities? How will that be monitored?

Alastair Pringle: I hope that the project's impact will be seen quite soon. We have just launched a poster campaign entitled "There is no place for discrimination in the NHS". I hope that, if the posters get into GP practices, for the first time people will be able to smile and say, "This service is for me." I do not know how we will monitor the efficacy of the campaign, which is a first step aimed at raising general awareness.

The demonstration projects will consider in detail issues such as how we monitor service use. I hope that, if the project continues and receives on-going funding, we will be able to work closely with and to keep revisiting the five pilot areas, to

establish whether LGBT people who are using services there see any difference.

There are significant challenges. I highlight the Greater Glasgow Primary Care NHS Trust mental health pilot, in which we have tried to engage with LGBT mental health service users from the area. I am sure that members can imagine the double discrimination that exists as a result of prejudice surrounding both sexual orientation and mental health problems. We have tried a range of ways of finding out what people's current experiences are. Through the Glasgow Association for Mental Health, a series of postcards has been sent to mental health services and LGBT venues to be filled in anonymously.

It is difficult locally even to get the baseline information. The information in "Towards a Healthier LGBT Scotland" is broad and general. For example, it suggests that 24 per cent of people surveyed had received homophobic treatment from their GP. We do not have details about that. It will probably be some time before we get accurate baseline information that allows us to examine the impact that the project has had on service users. I am pleased to say that from October our community development worker, whose role is to engage with LGBT communities and who is a 0.4 whole-time equivalent, will be working with us full time as we start to engage more with communities. There is a great deal of work to be done in that area.

Shiona Baird: What else could the Equal Opportunities Committee do to support your work? Are there key areas that we should investigate?

Alastair Pringle: Data gathering is one such area. The committee could try to influence, for example, the information and statistics division of the NHS and the census, to ensure that national population health data include sexual orientation. People are often not convinced that there is a problem until they see the numbers. The committee could address some of the gaps in the research in health or education—I have been giving examples of work that might be possible in relation to health, but much broader work needs to be undertaken. Many of the issues that have been raised today relate to the need to ensure that there is commitment at the most senior levels to challenging homophobia in society.

I have been impressed by the campaign to challenge racism in Scotland. Even though we still hear racist comments, such comments are much less common and people know that they are not acceptable. It would be wonderful if the Equal Opportunities Committee could achieve that in relation to LGBT issues.

Shiona Baird: We will do our best.

The Deputy Convener: Thank you, Alastair, for coming along to answer our questions this morning. Good luck with the Inclusion project in the future. No doubt you will come back to us to tell us how it is progressing.

We will have a short break while the witnesses change over. The minister has another engagement, so we must not take too much time.

10:56

Meeting suspended.

10:57

On resuming—

The Deputy Convener: I welcome Mr McCabe, the Deputy Minister for Health and Community Care, and thank him for coming to the meeting. I note that you have been listening to Alastair Pringle's evidence, which I hope will assist you in answering some of our questions. I also welcome Hector MacKenzie and Laura Ross from the Scottish Executive Health Department.

I put on record the fact that, to the department's credit, it is at the forefront of work on LGBT health issues. We have heard enough today to indicate that lessons might be learned across other departments and equality strands. We can take the work forward most productively if we regard the issue as being not just about communication with LGBT people. Alastair Pringle made many fundamental points about respect for people.

Minister, do you want to make a short statement before we go to questions?

The Deputy Minister for Health and Community Care (Mr Tom McCabe): I will say a few words. The committee has heard about the Inclusion project and the stocktaking and evidence gathering that are being undertaken to establish a benchmark, find out where we are now and try to ascertain what is required for the development of sensitive, appropriate and responsive services in the area. As the committee knows, the project will continue, and five demonstration projects are focusing on NHS staff training, which is critical, and other matters. That work is complementary to the fair for all race equality agenda.

As the committee knows, the Scottish Executive Health Department continues to host the LGBT discussion forum, which meets approximately quarterly. The forum enables us to gain more information and understanding and is an important aspect of our on-going work in the area.

The most important point to stress is that everything that we do is predicated on the knowledge that we do not have all the answers. Indeed, we are far from having all the answers, and it is important that we continue to try to improve attitudes towards and understanding and

acceptance of the agenda. We are aware that the LGBT community can be difficult to engage with and contact, so we need to understand the reasons for that and to develop innovative ways of overcoming it. All our work is predicated on that.

11:00

The Deputy Convener: Before I get into more detailed questions, I will ask you a simple question: was there anything about the report "Towards a Healthier LGBT Scotland" that surprised you?

Mr McCabe: I think that we have all been in politics too long now to be surprised greatly by anything. The report confirmed many of the things that we expected about the level of understanding and the degree to which attitudes need to change. In common with a number of other policy areas, the diversity of approach among health boards in Scotland was not surprising but worrying; we need a more uniform approach—as uniform an approach as we can possibly get.

The Deputy Convener: The research that we have at the moment and on-going work such as the stocktake suggest that a significant amount of work is needed to tackle homophobic and heterosexist attitudes in the NHS as an employer and a service provider. I have to say that such attitudes are sometimes expressed in the nicest possible way, but assumptions are made about lifestyles. Will you tell us what is being done to tackle those attitudes in response to the findings of the Inclusion project or as part of an on-going programme and how the success of those activities will be monitored?

Mr McCabe: The main point is that, from the information that we have gathered through the Inclusion project, we intend to draw up draft guidance for circulation to NHS boards throughout Scotland. I hope that that draft guidance will be circulated in autumn this year, and we intend to reissue the guidance in final form around April next year. Once the guidance has been issued, an assessment of how it is implemented will form part of the performance assessment framework, which is used continually and for the purposes of which the chief executive of the health service meets the NHS board chief executives and chairs annually.

The Deputy Convener: That is good. It is crucial that the implementation of the guidance be reviewed annually.

The stocktake exercise revealed that there was a need for further training for NHS staff on LGBT issues. What is the Health Department doing to ensure the development and delivery of that further training? How will the success of the training be monitored? Will it be covered by the performance assessment framework questions?

Mr McCabe: Yes. The draft guidance that we issue will contain reference to the need for staff training. As I said earlier, the assessment that is carried out annually through the performance assessment framework will try to assess how much each board has committed itself to an appropriate level of training for its staff.

The Deputy Convener: As you have already mentioned, there is quite a diversity in attitudes and service across different health boards, so the guidance will, I hope, be seen as a way of levelling up.

Mr McCabe: I hope that that is the case. One of the benefits of the Parliament has been our ability to focus and follow up on specific issues much more directly than perhaps was the case before, across a whole range of policy areas. That has highlighted deficiencies across a range of services, such as podiatry services, and I could rhyme off half a dozen different examples. We are involved in a process of trying to ensure that, irrespective of where a person lives, the standard of services is as equal and as equitable as possible.

The Deputy Convener: We have heard already, in Nanette Milne's question, about the need to include LGBT issues in training for staff before they join the health service, during their time at college or university. Do you agree that that would be useful and, if so, is there anything that you can do to ensure that that happens?

Mr McCabe: It would certainly be useful, and discussions have already taken place with the deans of the colleges in an effort to ensure that there is more of an element of such training in the training for doctors and other allied health professionals. It is pretty fundamental that, at as early a stage as possible, awareness of those issues should be raised among the professionals who will, after all, spend a great many years in our national health service.

The Deputy Convener: You mentioned the stocktake analysis. One of the issues that emerged from that was the fact that much of the information that was coming back from boards was really coming from just one or two people in organisations that involve thousands of people. That is a common problem that relates not only to this report. How confident are you that the information that the stocktake yielded is sound, and are there any plans to conduct more detailed research in the same areas?

Mr McCabe: That brings us back to the performance assessment framework. We will have to find out how people are applying the guidance and what they are doing at local level. On confidence about the kind of changes that we will effect and how they will be spread through the

organisations, I think that there are positive signs. As we focus on certain areas in the way that I mentioned earlier, we raise awareness and find out more about the way in which an organisation deals internally with a specific subject, and we find that ownership is spread wider because of the focus and the continual follow-up. I am pretty confident that we can improve the situation. It is always rash to say that we will achieve absolute success, but I think that we will see a marked improvement in ownership—if I can put it that way—within individual boards.

The Deputy Convener: One of the other things that emerged was that considerable sections were missed out in a number of the returned questionnaires and the report questions why that was and suggests that it should perhaps be investigated. That could be a way of identifying where there are key gaps in service delivery. Do you have any plans to follow up on that to discover exactly why those questions were missed out?

Mr McCabe: That is being followed up at the moment. In the specific areas where there were gaps, follow-up contact has already been made to try to establish why those gaps were there.

The Deputy Convener: I would like to ask a general question. Certain gaps have been identified in areas where there are specific issues, such as rural health services. Is that something that is being considered specifically?

Mr McCabe: I shall turn to Hector MacKenzie for that information.

Hector MacKenzie (Scottish Executive Health Department): As you know, Alastair Pringle's project is in its second year, and our aim is to use that second year to get clarity on those issues and to speak specifically to boards about where issues arise. Part of the work involves encouraging people to acknowledge the fact that they do not understand and that there is a gap in their knowledge, and we are trying to create a non-threatening arena in which they can come forward and say, "We don't understand. This is something that we need support on and we need an organisation behind us in the project." That way, we can come out and sit down with people, not naming and shaming them but encouraging them to develop the work positively.

We are using the same methodology that we used when we developed the ethnicity work, which the national resource centre has piloted. That gives us confidence that such an approach will work, because staff will find that they can see the facts that they need to understand where the gaps are. They will be able to speak to somebody who can give them the information that they need to fill those gaps and together they can go forward. We will then be able to produce the Health Department circular at the end of the year and at the end of the project. With that full knowledge, we will be able to set out a three-year programme of work that will be assessed, as the minister said, through the performance assessment framework and the annual accountability review process to ensure that it is delivered.

Shiona Baird: The stocktake analysis shows that much good work is going on, but that much of it seems to depend on LGBT organisations themselves. Does the Executive intend to widen the partnerships with LGBT communities and other relevant equality organisations in designing and delivering services?

Mr McCabe: Obviously, there is the proposed equality and diversity unit, which will start to consider a more pan-Executive approach to the issues. There is an acceptance that we will address them more comprehensively by bringing together the various strands of activity throughout the Executive. That is why the equality and diversity unit will be so important.

Shiona Baird: We heard about how important funding is in continuing LGBT organisations and for the equality and diversity unit. Is the Executive reviewing funding specifically for those organisations? Can the Health Department make a commitment to longer-term support to assist delivery of the LGBT report's recommendations?

Mr McCabe: I hope that the work that has been done so far indicates that there is a strong desire to maintain that commitment within the Executive and in the Health Department. However, I am not in a position at present to give firm commitments on funding on behalf of the Health Department and I am definitely not in a position to do so on behalf of the Executive in general.

I hope that the various strands of work indicate that there is a progressive approach to LGBT matters within the Executive and that there is an interest in continuing the momentum that has been established.

Shiona Baird: I am particularly interested in domestic violence. The report notes that there is currently no mainstream service provision for LGBT people who experience domestic abuse and that the Inclusion project is involved in the development of an information resource for health service staff regarding domestic abuse of LGBT people. Is any other activity planned or under way that is aimed specifically at addressing that gap in services?

Mr McCabe: Again, I refer back to the LGBT health forum, which is useful in helping us to assess exactly what the appropriate response should be. Research is going on and a major part of the work that we are doing is around helping health service staff to recognise an incidence of

domestic abuse when it presents from any community, but specifically from the LGBT community. It is important that health service staff can identify cases of domestic abuse and take a sensible approach to them.

Shiona Baird: I would be interested to see the report on the Tayside demonstration project in the accident and emergency unit because that might be an area in which domestic abuse incidences come to light. We look forward to that report.

We heard about how effective the campaign to tackle racism was. Does the Executive have plans to carry out a similar high-profile campaign against homophobia?

Mr McCabe: There are no plans to do that at the moment. It would be easy for the Executive to tick the political correctness box and launch a campaign without considering whether it might be counterproductive, given the Scottish community's state of preparedness.

Mention was made earlier of the section 28 campaign. With hindsight, we can see that although the legislation was well intended, given the responses with which we had to deal, a public information campaign that engaged with people in a different way before addressing the legislation might have produced a different reaction and result. There is a growing awareness within the Executive that, although there are many policy aspects within Scottish life that we need to address, there is great value in having an awareness-raising campaign before we go for high-profile media campaigns.

The latest example is smoking in public places. I will launch a consultation on 7 June, but we have spent four or five months raising awareness and increasing the amount of information that is in the community before taking the next step. That is important, because this is not just about engaging in high-profile campaigns; we need to do the appropriate research and ensure that any campaign will be positive and not counterproductive, and will not just satisfy us but will produce real results for the community.

11:15

Shiona Baird: How confident are you about the level of commitment within the Executive to tackling homophobia throughout Scotland?

Mr McCabe: There is considerable evidence of that commitment throughout the Executive, given the various strands of work that are under way. We have said that there is no place for homophobia in Scottish society. It is easy to say that, but we all acknowledge that it exists and that changing attitudes in Scotland will not be a short-term process. However, we in the Executive are committed to working on it. I am in a better position to talk about the Health Department, and I know that there is recognition that the work that it is doing is innovative and ahead of the game. That is not necessarily unreflective of the approach that is being taken throughout the Executive. There is a strong desire to tackle homophobia in the most appropriate way and to ensure that what we do is not counterproductive and is properly researched to get the best results.

The Deputy Convener: I have a brief comment to make about that, which picks up on something that Alastair Pringle said earlier. It is important for people to see that we are not doing something just because it is politically correct. The example that springs to mind is the work that is going on in relation to hate crimes. We have to say that we are considering LGBT issues in relation to hate crimes not because it is politically correct to do so but because research has been done that shows that people in that community, such as Alastair Pringle and I, are much more likely to be attacked. The reasons why we have to consider those issues are addressed in "Towards a Healthier LGBT Scotland". Research suggesting that there is a greater chance of mental health problems, addiction issues and self harm in the LGBT community answers the question why we must address the issue. When most people are made aware of such research, they accept that something needs to be done, but they feel uneasy about our doing something just because it is politically correct to do so. The research gaps are important in that respect; we need to tell people the reasons why something must be done.

Mr McCabe: That is an important point. We have to raise levels of awareness and assess our state of readiness to launch more high-profile campaigns. We are conscious that, if we miss out the important steps, we could do more harm than good.

Elaine Smith: I want to pursue another point. When you answered Shiona Baird's question, you said that a high-profile campaign might be counterproductive in some way. We heard earlier about the effects of the campaign against the repeal of section 2A of the Local Government Act 1988. If a campaign were to be launched promoting tolerance and equality, in what way could it be counterproductive?

Mr McCabe: We are talking about what can be a sensitive area; we should not underestimate the levels of misunderstanding and homophobia that exist in society. I talked about public information campaigns, the time leading up to high-profile media campaigns, the level of understanding that we help to generate and the way in which all that is done. The convener was right to mention the way in which we generate acceptance, and that there is a need for change and to say that we

need to bring such matters to people's attention much more readily.

Unless all of that work has been done, a gap in the market—if I can put it that way—might be created in which people could launch vigorous opposition campaigns. Perhaps—I stress that word—that is the mistake that we made with section 2A. That lack of preparedness allowed people to step into the gap in the market and to launch a pretty vitriolic campaign that, I am sure, caused people in the LGBT community serious discomfort and harm. Launching a high-profile media campaign too early might create the conditions in which people could exploit a lack of understanding and awareness in the community. I do not want to do that.

Elaine Smith: Earlier, I asked Alastair Pringle about Zero Tolerance's respect project in schools. I think that Margaret Curran and the Education Department are liaising with the group on that project but, given that the initiative has cross-cutting aspects, has the Health Department been involved in it? If not, do you think that it is possible that you would get involved in it, given that, in the long term, the project is concerned with the promotion of tolerance, understanding and so on among people from an early age? I presume that that would make conditions more suitable in the future for high-profile campaigning.

Mr McCabe: An important piece of work that is going on at the moment is the healthy respect national demonstration project. That project addresses respect for others, diversity, bullying in schools and helping children to understand that people should be respected, not abused, because of their differences. We hope to learn lessons from the project that we can roll out across the country.

Elaine Smith: Page 14 of "Towards a Healthier LGBT Scotland" notes that, although LGBT people experience significant problems that relate both to their mental and physical health,

"a review of both health inequalities theory and policies in the NHS in Scotland reveals that the health of LGBT people is largely ignored."

Earlier, you mentioned that draft guidance is being drawn up. Will it address that issue and will the committee have the opportunity to comment on it?

Mr McCabe: The guidance is designed specifically to address the gaps that exist and the attitude that exists in the health service—although it is by no means exclusive to the health service—that the question of whether someone is lesbian or gay is irrelevant to the way services are provided to them. There is not enough recognition of the fact that, on some occasions, sensitivities and understanding of certain issues are required.

The guidance will be issued in the form of a Health Department letter to health boards. I am quite happy to share a draft with the committee, which would be a positive way forward. To be quite honest, I am not entirely sure how such matters have been dealt with in the past, but I see no good reason why the committee should not have sight of the draft letter. Of course, the content of the guidance is a decision for the Executive, but we always welcome suggestions from parliamentary committees.

The Deputy Convener: That would be useful. Thank you, minister.

Elaine Smith: I will move on to the subject of transgender people's sexual health. The Scottish needs assessment programme report "Transsexualism and Gender Dysphoria in Scotland" states that access to treatment and support services is "haphazard". For example, there are no funded services for any aspect of gender reassignment or treatment in Scotland. Given the increasing evidence of good outcomes from treatment, the report recommends the importance of establishing a managed clinical network. Does the Executive have plans to provide such a network?

Mr McCabe: No. However, based on the findings of that research and on some other work, plans are under way for a managed clinical network. I am not quite sure whether it has been established; I do not think that it has. We recognise the worth of that recommendation and plans are in place to establish a managed clinical network for that group.

Elaine Smith: That is helpful.

Mrs Milne: I want to return to the issue of mental health. "Towards a Healthier LGBT Scotland" highlights

"a clinically and statistically significant association between suicide attempts and homosexuality".

As we heard earlier, because of the general culture in the country, people who have mental health needs are unwilling to come forward for treatment. I suggest that the problem also includes people with addiction problems. What is being done to address the mental health needs of the LGBT population? I am thinking in particular of the young ones.

Mr McCabe: In general terms, our suicide prevention strategy has received acclaim not only in this country, but throughout the world. I spoke to a group of trainers about it only a few weeks ago. Recently, we held two events—one in West Lothian and one in Glasgow—for people who work on suicide prevention strategies. Leading practitioners from the United States of America and Canada, who attended the sessions, were extremely impressed in general terms with how we have designed the choose life suicide prevention strategy. They expressed the strong view that the

approaches that we were taking in Scotland were extremely innovative. There is a clear need to be innovative, because some of our figures are extremely worrying.

Alastair Pringle alluded to the fact that the LGBT community had the opportunity to proofread the choose life suicide prevention strategy and to offer input. Given the high incidence of suicide to which Nanette Milne alluded, it is important that the LGBT community be given the opportunity to comment on the appropriateness of the approaches that are being taken.

Mrs Milne: Is anything being done about the problem of the perceived homophobic attitudes of mental health nurses in particular, which was alluded to in the report?

Mr McCabe: That takes us back to issues such as training for NHS staff, raising awareness, improving understanding and developing appropriate and sensitive methods of delivering services, as are required in this respect. There is recognition that people can very easily come up against such homophobic attitudes, so the point of the work that we are doing is to ensure that homophobic attitudes in the NHS are recognised and tackled. I hope that that is our direction of travel.

Mrs Milne: I want to raise the issue of HIV testing. Alastair Pringle said that he was surprised by the statistic that fewer gay men present for testing in Scotland than is the case in the UK in general. I was surprised and concerned by that statistic. Will you comment on that? Could more be done to ensure that the people who are most at risk present for testing?

Mr McCabe: I suppose that that brings us back to the convener's first question about what aspects of the report surprised me. A good answer to the question would have been that I found those statistics surprising. To be frank, it is worrying that the presentation rate in Scotland is lower than the UK average.

The Executive would want to take a serious look at the situation in order to satisfy ourselves that we are doing all that we can. Much work is going on to raise awareness among gay men of the need to present for testing. That work is being done not only by the Executive, but by a raft of organisations that are funded in part by the Executive. If that is not working appropriately, it is in all our interests to review what is happening and see how we can improve the situation.

11:30

Mrs Milne: My impression is that there was a flurry of activity a few years ago when we first heard about HIV and there was certainly a lot of awareness then. However, I understand that awareness is falling off among some younger people. That is worrying and we should consider that.

Mr McCabe: I could not agree more. The Executive wants to examine further the reasons for that and to see whether more need be done.

The Deputy Convener: What are your key short-term priorities for the work? How long do you think it will be before people in the LGBT community see a positive difference when they are engaging with health services in Scotland?

Mr McCabe: For me, the undoubted number one priority is to develop the guidance, get it out in draft form—ensuring that we get as wide a body of comment on it as possible—and then finalise it for issue to health boards. After that is done, we will have the benchmark that I mentioned earlier and we will be in a far better position to start assessing comprehensively how things are changing in the health service.

The Deputy Convener: It is clear that many of the findings of the Inclusion project are relevant to other departments of the Executive. How are the results of the work with the Inclusion project being fed into the wider work of the Scottish Executive in relation to LGBT issues and the wider equality agenda?

Mr McCabe: One example we mentioned here is the stocktake of the Inclusion project. We are now considering carrying out a similar exercise with local government. That is an interesting development; from here, we are starting to move out to large parts of the public sector. Where health and local government are combined, we have taken a bit of a quantum leap towards improving understanding and awareness of the need to consider how we design and deliver services that meet the needs of a wide variety of people. That is one of the interesting developments. Also, the equality and diversity unit is picking up some aspects of that work on a pan-Executive basis. Both those things indicate that we are not focused solely on health, and that the lessons that are being learned are being transposed to other aspects of the Executive's work.

The Deputy Convener: I thank the minister for his evidence and for offering us the opportunity to examine the draft guidance in the autumn and give input at that stage. That will be helpful.

Mr McCabe: Thank you.

The Deputy Convener: We now move into private session to discuss our approach paper.

11:33

Meeting continued in private until 12:03.

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Printed in Scotland by The Stationery Office Limited

ISBN 0 338 000003 ISSN 1467-0178