Substance Abuse and Mental Health Issues among the LGBT Community in India: A Study of Inter-relationship between Mental Health disorders and Stress, Coping, Perceived Social Support, Occupation, and Religiosity

RESEARCH PROJECT
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PRINCIPAL INVESTIGATOR
Prof. (Dr.) Susanta Kumar Padhy, Professor
Department of Psychiatry
All India Institute of Medical Sciences, Bhubaneswar, Odisha

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PREFACE

The LGBTQIA+ community in India has been one of the most socially excluded groups. They suffer from stigma and discrimination on multiple fronts, including in society, educational institutions, and the workplace. Numerous other factors, such as the high prevalence of mental illnesses, substance use disorders, and HIV, further complicate their lives. This is added by the lack of medical facilities catering to these populations' needs. Groundbreaking developments have been made during the last decade in terms of (1) the Enactment of the Transgender Persons Act 2019, (2) the decriminalization of section 377 of the Indian Penal Code, and (3) the development and implementation of many social welfare schemes by the central as well as state governments. Whether these measures have alleviated some of the issues faced by the LGBTQIA+ community needs to be seen. The exact dimensions of mental health and related problems among the LGBTQIA+ community are not studied adequately. Thus, we, the investigators of this study, are extremely pleased to present this study report on mental health issues, suicidality, and substance use among the LGBTQIA+ community in India.

The study investigates the rates of mental health issues, substance use, suicidality, and workplace issues among the LGBTQIA+ community and seeks to find their association with coping, religiosity, and social support. The study adopted a mixed-method approach. The study was conducted in four cities in India: (1) Lucknow, Uttar Pradesh; (2) Bhubaneswar, Odisha; (3) Mumbai, Maharashtra; and (4) Puducherry. The study was restricted to a specific sample size and a definite place for data collection. After providing the snapshot of the methodology used for this study, we provide the study results in terms of these mental health issues in different cities, followed by the association of mental health issues with coping, religiosity, and social support. We also provide data on the comparison of these mental health issues across various study centers. After the results, we provide recommendations on how the study findings should help formulate appropriate policy responses at the state and national levels.

The study was conducted with due diligence in a highly objective manner and met the rigorous ethical standards of research on such a sensitive population. Whenever possible, the study participants with identifiable mental health issues were provided with counseling and were referred for further management through existing liaising mechanisms. The study investigators have tried

torefrain from any generalization or sweeping statements about the community and have tried to avoid any terms that may be considered stigmatizing by such community members. The identities of the study participants have been kept confidential throughout the study period and during report writing. The study aims to fill the void in terms of LGBTQIA+ mental health and related issues.

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DISCLAIMER

This research project was sponsored under the Research Scheme of the National Human Rights Commission (NHRC), India. Due care has been exercised to prepare the report using the data from various sources. NHRC does not confirm the authenticity of data and the accuracy of the methodology to prepare the report. NHRC shall not be held responsible for findings or opinions expressed in the report. This responsibility completely rests with the researcher(s).

ABBREVIATIONS

- AB-PMJAY - Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
- AIIMS – All India Institute of Medical Sciences
- ASSIST – Alcohol, Smoking, and Substance Involvement Screening Test
- BSSI – Beck's Scale for Suicidal Ideation
- CES-D - Center for Epidemiologic Studies - Depression Scale
- COPE - Coping Orientation to Problems Experienced
- DASS - 21 - Depression, Anxiety, and Stress Scale 21
- DMHP - District Mental Health Program
- DSM - Diagnostic and Statistical Manual
- FGD - Focused group discussions
- FSW - Female Sex workers
- GHQ - General Health Questionnaire
- HED - Heavy episodic drinking
- HIV – Human Immunodeficiency Virus
- HRGs - High-risk groups
- ICD- International Classification of Diseases
- IDI – In-Depth Interview
- IDU - Injecting drug users
- IPC - Indian Penal Code
- IDUs – Injecting Drug Users
- IV – Intravenous
- IQR – Inter Quartile Range
- JIPMER – Jawaharlal Institute of Postgraduate Medical Education and Research
- LGBTQIA+ - Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual +
- MINI – Mini International Neuropsychiatric Interview
- MSJE – Ministry of Social Justice and Empowerment
- NACO - National AIDS Control Program
- NALSA - National Legal Services Authority

- NEP – National Education Policy
- NGO – Non-Governmental Organization
- NHRC – National Human Rights Commission
- NMHP – National Mental Health Program
- NSSI - Non-suicidal self-injury
- OSACS – Odisha State AIDS Control Society
- PI - Principal Investigator
- PM-DAKSH – Pradhan Mantri Dakshta Aur Kushalta Sampann Hitgrahi
- QOL – Quality of life
- SD – Standard Deviation
- SMILE - Support for Marginalized Individuals for Livelihood and Enterprise
- SSEPD – Social Security and Empowerment of Persons with Disabilities Department
- STI – Sexually Transmitted Infections
- SUD – Substance Use Disorder
- Tele MANAS – Tele Mental Health Assistance and Networking Across States
- UNAIDS – United Nations Programme on HIV/AIDS
- WHO – World Health Organisation

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EXECUTIVE SUMMARY

The study "Substance Abuse and Mental Health Issues among the LGBT Community in India: A Study of Inter-Relationship between Mental Health Disorders and Stress, Coping, Perceived Social Support, Occupation and Religiosity" was carried out with the following objectives:

1. To understand the mental health issues of LGBTQIA+ in India.
2. To assess the suicidal risk in the LGBTQIA+ community of India.
3. To assess the workplace related issues faced by LGBTQIA+
4. To screen for substance abuse and mental health disorders in the LGBT community
5. To assess the inter-relationship between factors like stress, coping, perceived social support, occupation, and religiosity and mental health disorders of persons from the LGBTQIA+ community in India.

The All India Institute of Medical Sciences, Bhubaneswar, in collaboration with Jawaharlal Institute of Postgraduate Medical Education and Research Puducherry and King George's Medical University, Lucknow, was entrusted with the responsibility to carry out this study. The study was carried out in four cities: Bhubaneswar, Mumbai, Lucknow, and Puducherry.

To achieve the study's objectives, it was decided to collect data using a mixed-method methodology – the study comprised both qualitative and quantitative components. The quantitative study was conducted with a cross-sectional interview of 1001 LGBTQIA+ participants from these four centers. An equal number of respondents were recruited from each center. The study used a respondent-driven sampling method for data collection purposes. Those who identified themselves as belonging to any of the LGBTQIA+ community were included in the study after written informed consent. The following scales were used for the study purpose: Depression, Anxiety, and Stress Scale -21 (DASS-21), Scale for Suicidal Ideation, Brief-Coping Orientation to Problems Experienced (COPE), Multidimensional Scale for Perceived Social Support (MSPSS), WHO Well Being Index – 5, Brief Religious Coping Scale (BRCS) and the World Health Organization – Alcohol, Smoking and Substance Involvement Screening Test (WHO-ASSIST). Three field investigators recruited specifically for the study purpose and trained by the study investigators

employed the quantitative and qualitative study components. The data were collected from January to December 2022. The qualitative study component was conducted using Focused Group Discussions (FGD) and In-Depth Interviews (IDI) of the LGBTQIA+ community members and service providers. A total of 16 IDIs (4 from each site) and 12 FGDs were conducted.

The findings from the quantitative part of the study revealed that rates of depression, anxiety, and stress were high among LGBTQIA+ community members. Almost 63% of the study participants were suffering from at least moderate depression. Similarly, rates of substance use were also high. Around 56% reported tobacco use, while more than 60% reported alcohol use. The use of cannabis was also higher than the general population use. Similarly, around 10% of the participants reported severe suicidal ideations at the time of the interview.

Mental disorders were more prevalent among transgenders as compared to other LGBTQIA+ communities. The scores of stress, depression, anxiety, and suicidality were significantly higher among transgender as compared to other LGBTQIA+ communities. Similarly, WHO-ASSIST scores for tobacco, alcohol, and cannabis use were significantly higher among the transgender group. There was a negative association between substance use (ASSIST scores) and problem-focused coping. Also, religiosity was negatively correlated with substance use (ASSIST scores).

The qualitative aspect studied the varied and unique challenges experienced by the LGBTQIA+ community, with a particular focus on mental health, including substance use and suicidality, and how the stressors, coping ways, education, employment, and religiosity impact the complex issues faced by them. The study revealed that childhood experiences for LGBTQIA+ individuals can be particularly stressful as they go through immense psychological conflicts with understanding and accepting their own gender identity. Non-acceptance and discrimination from family and peers during this crucial yet difficult phase can lead to emotional distress, depression, anxiety, and low self-esteem, setting the stage for mental health challenges in the future. Many participants revealed that the fear of stigma and rejection forces them to maintain dual identities, adding to the burden of their mental health struggles at each phase of life. Coming out as LGBTQIA+ can be emotionally draining, as individuals reported facing violence, expulsion from families, and social boycotts. Such negative experiences lead to a higher prevalence of mental health issues and an increased risk of suicidal thoughts and behaviours.

Minority stress, discrimination, and a lack of acceptance contribute significantly to suicidal tendencies within the community. Critical life stages, such as adolescence and societal pressure to conform to traditional gender roles, further elevate the vulnerability to suicidal behavior. Many suggested that strong educational retention may prevent the downward spiral in life and can protect against suicides. On the other hand, substance use emerged as a coping mechanism for many LGBTQIA+ individuals facing discrimination, harassment, and interpersonal conflicts. While substances may temporarily relieve stress, they often exacerbate mental and physical health issues, contributing to depression and dependency. This can also make them vulnerable to risky sexual behavior, increasing the chances of STIs.

Participants in the LGBTQIA+ community employ various coping strategies to navigate the challenges they face. These include self-reliance, advocacy, self-acceptance, and seeking support from the community. The Guru-Chela system, prevalent in certain regions, offers guidance and protection to individuals. For some individuals in the LGBTQIA+ community, religious beliefs and spirituality play a significant role in fostering mental positivity and providing a sense of belonging. Certain religious events and rituals act as sources of unity and support during major life changes, including gender reassignment surgery.

Based on our findings, we provide the following recommendations:

1. There is a need for regular monitoring of mental health issues and substance use in a nationally representative sample of the LGBTQIA+ community.
2. Scientific evidence-based treatment in an LGBTQIA+ affirmative manner needs to be made available for people with mental health and substance use-related issues.
3. Considering the high prevalence of mental health issues and substance use disorders, various measures, including liaising various social welfare schemes with telepsychiatry-based treatment initiatives, such as Tele-MANAS, may be considered. This may help reduce barriers these community members face regarding treatment-seeking for their mental health-related concerns.
4. Considering the high healthcare needs of this population, efforts should be targeted to increase the utilization of health insurance schemes such as AB-PMJAY and schemes of various state governments. This may help reduce out-of-pocket expenses for the LGBTQIA+ community, especially considering that many of them are from poor or very

poor backgrounds.

5. To improve the social support that is beneficial in improving the overall mental health of the LGBTQIA+ community, efforts should be made to increase further the number of self-care groups and Garima Greh – Shelter homes.
6. As this community suffers from a multitude of health-related issues, single-window service delivery models should be developed that can provide help and treatment for mental health issues, substance use, HIV prevention, treatment, and other services.
7. Efforts should be made to generate nationally representative data and analyze the impact of various welfare schemes introduced recently. Every piece of such study shall help incrementally inform the policies surrounding LGBTQIA+ mental health-related issues. This will help protect the health and social welfare of the LGBTQIA+ community.

1. INTRODUCTION

1.1 Background of the Study

LGBTQIA+ communities are gender or sexual minority communities. They are heterogeneous individuals with different gender identities or sexual orientations. Among the LGBTQIA+ community, 'L' refers to Lesbian, and 'G' refers to Gay. These individuals are those who experience attraction toward same-gender individuals. 'B' or Bisexual refers to individuals attracted to both genders. 'T' or Transgender person is one whose assigned gender at birth and expressed gender do not match. It includes trans-man and trans-woman as well as persons with socio-cultural identities such as Hijra, Kinnar, and Jogta. Q+ at the end denotes the dynamic nature of the LGBTQIA+ community and includes all other gender identities or sexual orientations not covered in the initials.

As per one estimate, around 45.4 million people in India belong to the LGBTQIA+ community (Kealy-Bateman, 2018). As per the census 2011 of India, about 4.88 lakh adults and 54,845 children identify as transgender individuals (*TransGender/ Others - Census 2011 India*). However, it is important to note that this census was carried out before transgender individuals were given legal recognition. As per one recent review, transgender individuals comprise around 0.1% to 2% of the general population (Spizzirri et al., 2021). Though they are clubbed together, the LGBTQIA+ population has different healthcare needs. They suffer from increased risk of many physical and mental health conditions. However, they face the same stigmatizing attitudes and discrimination against themselves as a group. The stigma and discrimination of the LGBTQIA+ community also lead to difficulty in getting the necessary healthcare.

1.2 History of the Transgender Rights Movement

A major landmark event in LGBTQIA+ healthcare occurred in 1973 when the American Psychiatric Association removed homosexuality as a disorder from the DSM (Diagnostic and Statistical Manual). This manual defines and classifies various psychiatric illnesses. The World Health Organisation (WHO) also removed the same from their classificatory system of psychiatric diseases – International Classification of Diseases (ICD) – 1990.

India has also witnessed many landmark events for the LGBTQIA+ community in the last decade. The Supreme Court of India – India's highest court gave legal recognition to the transgender community in 2014. During the same year, the Indian Psychiatric Society spoke openly about

homosexuality not being a mental illness or a disease. Before 2018, section 377 of the Indian Penal Code was used to criminalize sexual acts against the "order of nature" and to target this community indiscriminately. Section 377 IPC criminalized the consensual act of a sexual nature between two consenting adults in private. In 2018, the Supreme Court of India struck down this IPC section and emphasized that the right to health is indispensable to this community.

The Transgender Persons (Protection of Rights) Act was enacted on 5 December 2019. The Act safeguards the fundamental rights of the LGBTQIA+ community. The Act defines"transgender person" as "a person whose gender does not match with the gender assigned to that person at birth and includes trans-man or trans-woman (whether or not such person has undergone Sex Reassignment Surgery or hormone therapy or laser therapy or any such therapy), persons with intersex variations, genderqueer, and person having such socio-cultural identities as *kinnar, hijra, aravani and jogta."*This act highlights many vital aspects of the rights of transgender individuals, such as (1) the Provision of and need for formulating various social and welfare schemes, (2) the need for healthcare provisions related schemes, and (3) providing or supporting livelihood, vocational training, and facilitate self-employment. This act also prohibits discrimination against these individuals, and those guilty may attract punishment, including imprisonment. The act also provides for a certificate of identity as a transgender individual to major (18 years and above) individuals.

1.3 Social Welfare Measures by State Governments

Apart from these, several welfare schemes have also been implemented by various state and central governments to safeguard the rights of the LGBTQIA+ community. Following the NALSA vs. Union of India judgment, the central and state governments were directed to take action to secure the rights of the LGBTQIA+ community. The State of Kerala approved and ordered the application of the Transgender Policy in 2015. The policy aimed at equal rights of the community to equality, access to development opportunities, resources, and benefits, freedom of expression, dignity of life and violence-free life, and equal participation in decisions influencing their life and liberty. The policy recommended a right to access developmental opportunities in terms of access to education, employment, and healthcare utilization. The community was included under healthcare insurance schemes and was provided with free sex reassignment surgery, counseling, and separate HIV-sero-surveillance centers. They were also provided shelter homes, housing schemes, monthly pension schemes, and daycare centers for elders. Tamil Nadu also introduced such a scheme and became the

first state to form a Special Welfare Board for the transgender community. The state included the transgender community in its "Most Backward Classes" list.

In 2017, the Government of Odisha formulated a scheme named "Sweekruti" - a Scheme for the Promotion of Transgender Equality and Justice. The scheme aims at securing the community's rights and providing equitable justice. The key strategies under the scheme include (1) identification of all transgender persons in the state and providing them with certificates/smart cards, (2) provision of pre- and post-matric scholarships for transgender children, (3) strengthening self-help groups, (4) health and insurance support, (5) legal aid, and (6) counseling services. The state provided them the same benefits as those living below the poverty line—the policy aimed at improving their economic and social status. The scheme also provides for mental health and counseling support as well as personality development training in order to address the long-term effects of oppression and deprivation.

During the same year, the state of Karnataka published a detailed policy on transgender. The policy embraced a 3-pronged approach: (1) Enforce equal access, non-discrimination, and dignity, (2) identification of institutions and state departments responsible for the same, and (3) accountability. The policy proposes various measures: (1) empowerment → ensuring inclusion, self-identification, and non-discriminatory practices on public resources and legal aids, (2) remedial measures → workplace anti-discrimination policies, safe residence, positive media portrayal, (3) enabling measures → guidelines formation, monitoring, and sensitization of various staff such as doctors, parents, teachers, and so on (4) sustainability measures → scholarships, skill development, and utilization of existing schemes to include the community. To implement the policy, the state also recognized four agencies, namely the Transgender Persons' Cell, Transgender Support Unit, Co-ordination Committee, and Monitoring Committee. The policy laid down a timeline to implement the same.

The State of Andhra Pradesh also came up with a welfare policy for transgender, which included pensions, ration cards, housing, scholarships, and subsidized healthcare. A social security pension of 1500 INR per month is provided to transgender above 18 years of age. The other facilities include drinking water supply, sanitation facilities, skill development training, and better employment opportunities.

Similar developments have also been made regarding the welfare of the transgender community in other states, such as Uttarakhand, Maharashtra, Gujarat, and Assam.

1.4 Social Welfare and Other Schemes by the Central Government

On 3rd April 2017, the Ministry of Drinking Water and Sanitation issued guidelines on gender issues. Apart from focusing on men and women, the guideline also provided recognition of the third gender and instructed that the community must be allowed to use the public toilets of their choice. The guidelines instructed to ensure that this community is treated as equal citizens with equal rights under the Swachh Bharat Mission.

The Government of India constituted a National Council for Transgender Persons in 2020. The council has the following functions: (1) Advises government on policies, programs, and laws, (2) monitoring and evaluation, (3) review and coordination, and (4) redressal of grievances, among many other functions. The council includes five representatives from the transgender community.

The National Education Policy was released on July 29, 2020 (NEP,2020). The policy identifies transgender children as a Socio-Economically Disadvantaged Group. The policy aims to provide quality education equitably to such disadvantaged children. To achieve this, a "Gender-Inclusion Fund" is constituted to make education more inclusive. The said fund will be used to assist female and transgender children in gaining access to education (e.g., cash transfers, toilets, sanitation, bicycles, etc.).

In 2021, the Ministry of Social Justice and Empowerment formulated a social welfare scheme - SMILE - Support for Marginalized Individuals for Livelihood and Enterprise. The scheme has a sub-scheme specific to transgender - Comprehensive Rehabilitation for Welfare of Transgender Persons. The sub-scheme focuses on counseling, healthcare, education, employment, skill development, linkages, and rehabilitation. The scheme also set up ***Garima Griha,*** which is a housing facility that ensures food, clothing, recreation, and skill development to the transgender and those involved in begging. The skill development is done under the PM-DAKSH scheme. A national portal and helpline were also initiated to help transgenders with necessary information and solutions. Without having to interact with the office of the issue physically, any transgender person can get an identity card made from the portal. The scheme also has provision for gender reaffirmation surgeries through a comprehensive healthcare package. Finally, the scheme also has a provision for the Transgender

Protection Cell in each state to monitor the offenses against the community and ensure timely action. The MSJE provided a budget of 365 crore INR from 2021-22 to 2025-26 for this scheme.

Apart from these, health insurance is also available to transgender persons through the Ayushman Bharat TG Plus scheme. Each transgender person can avail of a cover of 5 lakhs per year. The package includes all transition-related healthcare requirements, including sex reassignment surgery and hormone therapy.

1.REVIEW OF LITERATURE

One of the most prominent theoretical and explanatory frameworks of sexual minority health risk is the minority stress model. Minority stress processes in LGBTQIA+ populations are based on factors associated with various stressors and coping mechanisms and their positive or negative impact on mental health outcomes (Meyer, 2003). Significantly, many of the concepts in the model overlap, representing their interdependency.

2.1 Challenges faced by the LGBTQIA+ population

Studies conducted on transgender life suggest that the transgender community has long been deprived of their rights and remains a marginalized group in society with limited opportunities for basic education, occupation, property inheritance, and livelihood. In the previous report of NHRC on Transgender Inclusivity in India, it was reported that 12% of the Transgender population engage in sex work, and 18% earn money by begging on railway platforms and traffic crossings. The majority of them earned less than 10000 INR per month. Upon asking about various constraints faced by the community in public, mental harassment, abuse, violence, discrimination, and transphobicattitudes were highlighted.

The community often faces the challenge of opening up about their gender identity and sexual orientation in public with the fear of rejection by family, peers, and society. Undoubtedly, such challenges can take a toll on the mental health of these individuals. Disclosure of being gay to family and non-family members and identification as transgender are associated with higher odds of depression diagnosis and dire social consequences, including suicidality (Tomori et al., 2016).

Chakrapani and colleagues conducted a study among 300 gays and 300 TG women using convenience sampling in six NGOs in four states in India. Almost 50% of gays reported any history of physical/sexual violence, while 84% of transwomen reported such a history (Chakrapani et al., 2017). Another study published in 2022 by Srivastava and colleagues looked at the association between victimization and sex work with depressive symptoms. The study included 1366 transwomen and 2182 gay participants from five states of India. Around 17% of gays and 30% of TG women reported at least one experience of abuse in the past six months. TG women in sex work were more

likely to have a history of sexual abuse.

On the other hand, gays involved in sex work were more likely to have a history of all types of abuse as compared to their peers who were not engaged in sex work. In multivariate logistic regression analysis, endorsement of polyvictimization and involvement in sex work was associated with higher odds of suffering from depression (Srivastava et al., n.d.) Thus, it becomes crucial to explore further mental health issues faced by this community in greater depth.

2.2 Mental health issues among the LGBTQIA+ population in the world

LGBTQIA+ people have been known to be at a higher risk of developing various mental disorders as compared to heterosexual people. These people are subjected to multiple forms of prejudice, social stigma, stress, and social exclusion. They are often subject to anti-homosexual hatred and violence. This might lead to the internalization of shame and the subsequent development of various psychiatric disorders. A systematic review of 28 studies suggested that there was at least a 1.5 times higher risk of depression and anxiety disorders among LGBTQIA+ people (King et al., 2008). This was true for current as well as lifetime risk. The meta-analysis also suggested a two-fold higher risk of suicide attempts in this population. A recently conducted meta-analysis also suggested similar findings (Wittgens et al., 2022). The study included 26 studies and a total of 519,414 heterosexuals, 10,178 lesbian/gay people, and 14,410 bisexual people. The meta-analysis indicated that these groups are at a higher risk for mental disorders than heterosexuals for all investigated diagnostic categories of mental illnesses. The odds ratio ranged from 1.97 to 4.81 across various categories. Bisexuals had a higher risk of depression and suicidality as compared to lesbians/gays, further confirming the findings of previous studies. The study also suggested no indication of decreased mental health disparities in recent years. Rates of non-suicidal self-injury (NSSI) are also high amongst the LGBTQIA+ population. A meta-analysis of 51 studies reported a prevalence of NSSI to be around 29% among sexual and 47% among gender-minority individuals (Liu et al., 2019). This was much higher than heterosexual/cisgender peers (around 15%). Transgender individuals (around 47%) and bisexual individuals (42%) were especially at higher risk among LGBTQIA+ populations.

2.3 Substance use among the LGBTQIA+ population

Substance use issues are also extensively studied in this population across the world. A meta-analysis was conducted to estimate the prevalence of alcohol use among bisexual, gay, and lesbian people from 105 eligible studies (Shokoohi et al., 2022). Lifetime use of alcohol was reported in 83.8% of

bisexual people and 76.8% of lesbian/gay people. Almost 85% of bisexual and gay/lesbian people had a history of past-year alcohol use. The study reported that the prevalence of heavy episodic drinking (HED) was 30% among bisexuals. Similarly, the rate of HED among gay/lesbian people was 25.5% as compared to a 21.3% rate among heterosexual individuals. Thus, bisexual people had higher rates of alcohol use and HED as compared to gay/lesbian people and their heterosexual counterparts. Similarly, the rates of alcohol and other substance use over the last 12 months were 1.5 times higher. Among these, lesbian and bisexual women were particularly at a higher risk of alcohol and drug dependence. At the same time, suicide attempts were significantly higher in gay and bisexual men, suggesting prominent differences even between various LGBQ+ populations.

2.4 Mental health issues among the LGBTQIA+ population in India

There is some literature accrued on mental health and related aspects among the LQBTQIA+ population in India.

Deb and colleagues (2010) conducted a study to assess psychiatric co-morbidities among gays attending STI clinics in Kolkata. The study utilized the General Health Questionnaire (GHQ). Almost 2/3rd the population in the study crossed the cut-off of 24, suggesting a high possibility of psychiatric morbidity (Deb et al., 2010). Safren and colleagues (2009) assessed depressive symptoms and HIV behavior risk among 210 gay subjects in Chennai, India (Safren et al., 2009). Depression was assessed using the Center for Epidemiologic Studies - Depression Scale (CES-D).Almost more than 50% of the participants screened positive for clinically significant depressive symptoms. Depressive symptoms were found to be associated with having unprotected anal sex and more male sex partners. In a multivariate model, Gays who were sex workers, who were unmarried, and those who perceived themselves to be at a higher risk of acquiring HIV infection had more depressive symptoms. In another study published using the same dataset, the authors reported that the HIV population in this sample was 8% and that depression was a significant predictor of HIV positivity and HIV-related risk behaviors (Thomas et al., 2009).

Sampath and colleagues (2018) conducted an online survey using an advertisement on a dating website exclusive to gays. The study aimed at estimating rates and correlates of depression in the gay population. The CESD-R scale (self-reported) was used to assess depression. Depression was present in almost 59% of the study participants (Sampath et al., 2018).

Prajapati and colleagues (2014) conducted a similar study in Ahmedabad to assess the psychiatric status of gay subjects. The authors used GHQ and reported that almost half of the sample was

suffering from psychiatric morbidity. The prevalence of psychiatric morbidity was high among gays with more than two sexual partners, those with STIs, and those with regular partners (Prajapati et al., 2014). In 2011, Sivasubramanian and colleagues reported a study using a sample of 150 gays from Mumbai. The study was conducted by the HumsafarTrust, an NGO working among gays in India. The study used confidential, quantitative mental-health interviews using a socio-demographics tool, MINI, to assess psychiatric diagnosis. As per the MINI, almost 45% of participants in this study reported current suicidal ideations. Of these, 15% were at high risk, 19% were at moderate risk, and 66% were at low risk for suicide. Depression was found in 29% of the participants, while 24% of the participants were suffering from an anxiety disorder (Sivasubramanian et al., 2011).

In a small study done on 32 patients seeking treatment for gender dysphoria at Imphal, it was found that 38% suffered from generalized anxiety disorder. One in 3 participants had a diagnosis of depression. Almost 42% of the subjects had current suicidality. Other psychiatric diagnoses were reported in less than 10% of study subjects (Hebbar et al., 2018).

In a cross-sectional Behavioral Tracking Survey - 2012, Patel and colleagues (2015) studied the factors associated with depression among gays. Factors such as being mobile for sex work outside their place of residence and having a positive history of physical or sexual violence were associated with a five times higher likelihood of depression among gays. Other factors related to depression were gays with STIs who didn't use condoms during anal sex, alcohol use history, and financial debt (Patel et al., 2015).

Another study conducted on a large sample of 11992 gays recruited via respondent-driven sampling further adds strength to these findings (Tomori et al., 2016). Many factors, such as substance use, disclosure of HIV status, and disclosure of sexual orientation to family and non-family members, were associated with higher odds of depression and suicidality. Surprisingly, no study participant reported getting treatment for their psychiatric conditions.

2.5 Substance use and high-risk behaviors among the LGBTQIA+ population in India

In a recent online survey conducted by Wilkerson and colleagues (2018) among 433 gays in Maharashtra reported that almost one-fourth of the study subjects used alcohol in a hazardous pattern. Around 12% of subjects reported illicit drug use, while 9% reported polysubstance use. Those subjects who reported hazardous drinking had more sexual partners and were less likely to be married to a woman. Subjects with polysubstance use had more history of interpersonal violence and had more sexual partners. Those who reported illicit drug use were more likely to be engaged in condom-

less anal sexual encounters (Wilkerson et al., 2018). Another online survey conducted by Bhambhani and colleagues (2021) on 4321 sexually active gays across all the states in India reported that almost one-fourth use alcohol, and 5% of them have chemsex. Both alcohol use and chemsex were associated with lower education, having a paid/casual sexual male partner, having more sexual partners in the preceding six months, and being "out" to others as gay (Bhambhani et al., 2021). Prabhu and colleagues (2022) conducted a study on gays using a respondent-driven sampling across ten cities in India. They recruited 8086 individuals and analyzed a total of 21,723 sexual partnerships. The study reported that the use of alcohol or drugs before intercourse either always or sometimes was associated with condom-less anal intercourse among gays (Prabhu et al., 2022). Thus, interventions targeting alcohol use are important to reduce HIV transmission in gays in India.

Yadavet al. (2014) examined the relationship between alcohol use and HIV-related sexual risk behaviors among gays. The study was conducted on 3880 gays recruited from 3 Indian states (Tamil Nadu, Maharashtra, and Andhra Pradesh). Around 60% of the study participants reported any alcohol use. About 40% of the study participants were frequent alcohol users (consuming alcohol at least once a week to daily use). The study also reported that the frequent alcohol users were more likely to be aged 25 years or above, less likely to identify themselves as male receptive partner (Kothi), and less likely to use condoms with any male partners (paying or regular) (Yadav et al., 2014). Thus, the study suggested a need to add alcohol use-related interventions in HIV prevention efforts, along with interventions for depression and anxiety.

2.6 Interrelationship between Mental Health disorders and Stress, Coping, Perceived Social Support, Occupation, and Religiosity among the LGBTQIA+ population in India

There is a bi-directional relationship between mental health issues and social support. Participants who reported a greater level of satisfaction from social support and who had higher self-esteem were at a lower risk of depression and suicidality in the Mumbai gay cohort (Sivasubramanian et al., 2011). Similarly, the participants who had greater social support were at a lower risk of anxiety disorder. Thus, interventions that may improve self-esteem and social support in the gay community may benefit them by improving their mental health outcomes.

A study was conducted in 2012 by Logie and colleagues to understand the association between stigma and depression among gays in India. The authors included 100 gays from Chennai (an urban location) and 100 from Kumbakonam (a semi-urban area) in Tamil Nadu. A total of 30% of participants from Chennai and 47% from Kumbakonam reported severe depression, indicating differences in depression

rates between urban and semi-urban locations. Also, gay subjects from urban areas reported higher levels of resilient coping than those from semi-urban areas (Logie et al., 2012).

Resilient coping and social support have been seen to be significant predictors of sexual risk among gays and TG women, respectively, in another study (Chakrapani et al., 2017). The authors also demonstrated that with the increase in the number of co-occurring psychosocial conditions, the HIV-related sexual risk also increases. Thus, the study provided the first evidence of the presence of syndemics among various psychosocial conditions on the HIV risk among gays and TG women.

It has also been seen that persons with mental illness are at greater risk of engaging in high-risk sexual behaviors. A study conducted by Mimiaga and colleagues (2013) to understand the psychosocial risk factors for HIV among the gay population in Mumbai suggested that the current depression diagnosis was significantly associated with an increased risk of engagement in unprotected anal sexual intercourse with a male partner. A similar association was also found with stressful life events (Mimiaga et al., 2013). Thus, HIV programs should take into account depressive symptoms as well and provide necessary interventions.

Understanding the various complex yet interwoven stressful experiences this community experiences, it is prudent to know the commonly employed coping reservoirs. Coping from stressors generally employs behaviors and thoughts that individuals use to manage the stressors they encounter. Emotional expression involves expressing one's feelings and emotions in a healthy and constructive manner, such as ventilating emotions to a person or journaling it.At the same time, Problem-solving involves identifying and addressing the source of the stressor and solving it. In contrast, cognitive reframing involves changing one's perspective on a stressor to reduce its impact on one’s functioning. These coping strategies can help individuals reduce the effects of specific stressors and mitigate the negative impact of stress on their mental health and well-being. By using these strategies, individuals can develop resilience and effectively face daily hardships. In general, many psychological factors and available resources to cope may not be so many in the case of the community. Usually, people seeksocial support for assistance and comfort provided by family, friends, and other social networks during times of need. Self-esteem as a template of effective coping is an individual's overall sense of self-worth and confidence in their abilities. It can act as a buffer against stress and help individuals maintain a positive outlook during adversities. These psychosocial factors act as a reserve of stable resources that individuals can draw upon during times of stress. They provide a sense of security and support that can help individuals cope with stressors more effectively. Gender and sexual minorities, on the other hand, may not have ample reservoirs to cope with the unique challenges they face in life.

They may isolate themselves and use maladaptive coping strategies like rumination, alcohol or drug use, or engaging in risky sexual behavior (Chaudoir et al., 2021). In a review by Wandrekaret al. in India, Transgender individuals generally have low resilience levels, with higher resilience observed among those with higher education, mainstream occupations, and living with their family of origin; LGBTQIA+ individuals tend to have more negative emotional regulation strategies and internal locus of control compared to cis individuals, with lesbian women showing the highest implementation of positive emotion regulation strategies and external locus of control, followed by gay men, bisexual individuals, and transgender individuals; heterosexual individuals tend to use active, instrumental, and positive coping strategies, while homosexual individuals rely more on behavioral coping strategies (Wandrekar et al.,2020). Resilient coping and social support, including peer support, family acceptance, supportive partners, and support from LGBTQIA+ communities, are negatively correlated with depression and stigma and mediate the relationship between stigma and depression, as reported in qualitative studies (Chakrapani et al.,2017).

Spirituality

A qualitative study by Beagan et al. (2015) explored the inter-sectionality of LGBTQIA+ identities inthe context of religiosity and spirituality. It identified the complexity and multifaceted issues they faced. Few of them experienced extreme challenges when religious views were not accepted. This also highlighted the importance of creating safe spaces for individuals to explore and integrate their spiritual and religious identities (Beagan BL et al., 2015).

2.7 Summary of Literature

Thus, the studies done in India suggest that depression and other psychiatric conditions are common, especially in the gay population. However, these studies are limited in number and have methodological limitations. Many of these studies are conducted on small sample sizes. Most of these studies focus on gays, while studies on other LGBTQIA+ populations are limited. Many studies adopt online survey methods, which have their methodological limitations. In most studies, depression and alcohol use are studied, while other psychiatric co-morbidities have received little attention. Alcohol and other substance use have also not been studied using standardized tools. Similarly, depression is also not assessed systematically in many of these studies. Thus, to overcome these issues, this study was planned, which tried to assess depression and other psychiatric co-morbidities along with substance use disorders in a more comprehensive manner.

3. OBJECTIVES

1. To understand the mental health issues of LGBTQIA+ in India.
2. To assess the suicidal risk in the LGBTQIA+ community in India.
3. To assess the workplace-related issues faced by LGBTQIA+ individuals.
4. To screen for substance abuse and mental health disorders in the LGBT community
5. To assess the inter-relationship between factors like stress, coping, perceived social support, occupation, and religiosity and mental health disorders of persons from the LGBTQIA+ community in India.

4. MATERIALS AND METHODS

4.1 Universe of the study

It is a multi-centric study. For this study, one city from each zone of India was selected.

Table 1: Sites for the study

Zone	**City (State)**
East Zone	Bhubaneswar (Odisha)
West Zone	Mumbai (Maharashtra)
North Zone	Lucknow (Uttar Pradesh)
South Zone	Puducherry (Union Territory)

4.2 Study Population

Individuals who described themselves as lesbian, gay, bisexual and transgender, and queer of 18 years or more age, willing to provide consent from the selected centers, were approached and included for the study purpose.

4.3 Research Design

Cross-sectional study (observational) design with a mixed-method approach (both qualitative and quantitative) was used to attain its objectives by:

- Individual in-depth interactive sessions
- Focused group discussions (FGD)
- Administering questionnaires on the basis of tools mentioned below

4.5 Sampling Design

To recruit participants from our target population (i.e., LGBTQIA+ individuals), we employed a respondent-driven sampling method, a chain-referral method that is a suitable chain-referral method for sampling such a hidden population. We recruited initial seeds with the help of NGOs working among this community and their community outreach workers. Initial seeds were chosen from a diverse group of 'seeds' from different LGBTQIA+ communities. With the help of the initial seeds, further eligible participants were recruited using unique referral coupons. The seeds were provided incentives for their participation in the study as well as for a successful referral. Through this iterative approach, we could recruit a large number of participants in a short duration of time, a sample size that sufficiently represented our sample of interest and allowed for a robust statistical analysis.

4.6 Sample size

The calculated sample size of 1000 (as calculated below) was divided among the four cities (Mumbai, Bhubaneswar, Lucknow, and Puducherry) from West, East, North, and Puducherry, respectively, equally with 250 from each site. (Bhubaneswar, Lucknow, Puducherry, Mumbai).

Sample Size calculation: As per ANOVA – F Tests, sample calculation was done using the G power software (Version 3.9.1.4) with an effect size f=0.1 (with small effect size), margin of error of 5%, power of 95%, with 3x2 table size with degree of freedom (df)= 2 with three groups of (Gay, Bisexual and Transgender population). Considering a drop out of 10%, the final sample size of 1000 (one thousand) was considered.

4.7 Data Collection

NACO (National AIDS Control Program) has an established TI (targeted intervention) program since the beginning of the HIV epidemic in India. TI program identifies populations who are more vulnerable to HIV infection and marks them as HRGs (High-risk groups). HRGs include FSW (Female Sex workers), gays, transgenders/ *hijras*, IDU (Injected drug users), truckers, and migrants. TI works with NGOs and CBOs to deliver their facilities to HRGs. The study was conducted in collaboration with local NGOs of the respective localities. Field visits were conducted with the aid of Peer educators or Outreach workers who were LGBTQIA+ community members.

4.8 Qualitative method of assessment

i. Individual in-depth interview (IDI) sessions with 16 persons of the LGBTQIA+ community (four from each site).
ii. Twelve Focus Group Discussions (FGDs) (three per site) with theLGBTQIA+ individuals, personnel from NGOs, and government set-ups associated with LGBTQIA+ Communities.

An interview guide was designed for IDI and FGD with the help of all the study collaborators. Individual in-depth interactive sessions were conducted by interviewers of each region who had sound knowledge of the regional language of the respondents. IDIs focused on challenges faced by the community, mental health issues, workplace related issues, and suicide. Further, Twelve Focus Group Discussions (FGDs) (three per site) with LGBTQIA+ individuals, personnel from NGOs, and government set-ups associated with LGBTQIA+ Communities were conducted, covering other domains such as stress and coping, perceived social support, occupational functioning, and religiosity. All the qualitative data was recorded as audio recordings after obtaining consent from willing respondents and also written down as notes during the interviews and FGDs. Data was further transcribed and translated. Various triangulation methods were used, and a phenomenological approach was used for the study. A standard code book was generated after a discussion with the collaborators. Major themes and sub-themes recognized were used for further qualitative analysis.

4.9. Quantitative method of assessment

For quantitative data, a semi-structured questionnaire was prepared and administered after the written informed consent of respondents. The trained field investigators collected the data in a single sitting of 45-60 minutes of interview. In collaboration with the local NGO, a pre-fixed date, time, and venue were fixed, and the respondents were informed well in advance. Data was collected through direct physical or telephonic interviews or online platforms, as appropriate to the LGBTQIA+ client and investigator. Responses were collected electronically with the help of Google Forms. Questions were translated and back-translated into the local language, i.e., Hindi, Tamil, and Odia, for ease of administration.

4.10 Liaison and referral of the LGBTQIA+ community to mental health services

Those who screened positive for having mental health issues were offered a detailed mental health

evaluation by the Mental Health Professionals at the nearest tertiary care center involved in the study. They ensured a close follow-up in liaison with the respective NMHP/ DMHP centers. This would provide a sustainable mental health service delivery to this marginalized group. In addition to screening for mental health issues, we also aimed to identify various workplace issues faced by this population and liaise with the SSEPD department for tailor-made individualized intervention and vocational guidance.

Table 2: Referral institutes for respective sites

Zone	**City**	**Tertiary Care**
East	Bhubaneswar	AIIMS, Bhubaneswar
West	Mumbai	LokmanyaTilak Municipal Medical College & Hospital, Mumbai
North	Lucknow	KGMU, Lucknow
South	Puducherry	JIPMER, Puducherry

5. INSTRUMENTS

5.1 Semi-structured Questionnaire (SSQ)

An SSQ was designed and used for assessing various socio-demographic variables. It included age, gender, education, occupation, monthly income, locality, family type, and religion.

5.2 Depression, Anxiety, and Stress Scale (DASS) -21

DASS-21 is a screening instrument designed to measure the emotional states of depression, anxiety, and stress **(**Lovibond S.H. &Lovibond P.F. 1995). The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/ involvement, anhedonia, and inertia. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, being easily upset/agitated, irritable / over-reactive, and impatient. Scores more than 9, 7, and 14 are cut-off scores for positive screen for depression, anxiety, and stress, respectively. Further, it divides the disorder categories into mild, moderate, severe, and extremely severe. The scale has been widely used in the Indian population. However, it is important to note that this is a screening instrument and does not give a diagnosis of depression or anxiety. The DASS-21 questionnaire is in the public domain and can be used free of charge for research purposes.

5.3 WHO – Alcohol, smoking, and substance involvement screening test (ASSIST Version 3.0)

This instrument has been developed by WHO. It is a public-domain research instrument. It covers the use of tobacco, alcohol, cannabis, cocaine, amphetamines-type stimulants, sedatives, hallucinogens, opioids, inhalants, and other drugs. ASSIST provides information about problems related to substance use in the last three months and if it has been ever used in a lifetime. A risk score is obtained for each substance. It falls into either a low, moderate, or high risk category, which determines the type of intervention from none, brief intervention, and brief intervention plus referral. Moderate risk is considered as problem use, and high risk is considered as dependence on the substance (WHO Assist Working Group,

2002).The WHO-ASSIST has been extensively used globally and has excellent validity and reliability. The questionnaire has also been used in India, including in the National Substance Use Survey 2019.

5.4 Scale for Suicide Ideation (SSI)

The SSI quantifies the intensity of current conscious suicidal intent by scaling various dimensions of self-destructive thoughts or wishes (Beck et al., 1979). It is a 19-item scale. Each item consists of three alternative statements graded in intensity from 0 to 2. A score of ≥ 21 indicates severe suicidal ideation. The scale has a high internal consistency and validity. The scale is widely used for the assessment of suicidality and has been used previously in Indian studies.

5.5 Brief COPE (Coping Orientation to Problems Experienced) Inventory

Coping skills were assessed using the Brief COPE Inventory (Carver, 1997). It's a 28-item scale with items scoring from 1-4. The total score ranges from 28-112. This assesses how people respond when they confront difficult or stressful life events. There are no "right" or "wrong" answers. Scale looks for a general pattern, not a specific "score." Coping skills can be divided into three major categories - emotion-focused, avoidance, and problem-focused coping. The scale is commonly used in clinical as well as non-clinical settings to assess the coping styles of individuals. The questionnaire was developed by Charles Carver and is available in the public domain. The same has been used extensively in India in previous studies.

5.6 Multidimensional Scale of Perceived Social Support

Perceived Social Support was assessed using MSPSS (Zimet et al., 1988). It is a short instrument designed to measure an individual's perception of support from 3 sources: family, friends, and a significant other. This instrument is 12 questions long, widely used, and well-validated. MSPSS is free to use scale and does not require a license. The scale has been validated in the Indian context and has been found to be a reliable tool for assessing social support in Indian society. There is no specific cut off for this scale. The scale provides mean subscale scores for each domain. As of now, there are no established population norms for MSPSS.

5.7 World Health Organization (WHO) -5 Well-Being Index

The WHO-5 well-being index is a short, self-administered scale that measures well-being over the last two weeks(WHO, 1998).It consists of five positively worded items rated on a 6-point Likert scale, ranging from 0 (at no time) to 5 (all of the time). A score of ≤50 indicates poor well-being and suggests further investigation into possible symptoms of depression. The scale is in the public domain and has been used extensively across the world, including in India. It is amongst the most widely used scales for this purpose. The scale has shown excellent clinimetric validity and can be used in a wide variety of populations.

5.8 Brief Religious Coping (RCOPE) Scale

BRCS is used to assess the use of religious-type coping skills (Pargament et al., 1988)..It enlists seven positive and seven negative religious coping strategies. The positive religious coping subscale of the Brief RCOPE taps into a sense of connectedness with a transcendent force, a secure relationship with a caring God, and a belief that life has a greater benevolent meaning. The negative religious coping subscale of the Brief RCOPE is characterized by signs of spiritual tension, conflict, and struggle with God and others, as manifested by negative reappraisals of God's powers (e.g., feeling abandoned or punished by God), demonic reappraisals (i.e., feeling the devil is involved in the stressor), spiritual questioning and doubting, and interpersonal religious discontent. It's a 14-item scale with items scoring from 1-4. The total score ranges from 14-56.Brief RCOPE is in the public domain and can be used without specific permissions. Its use has been validated in various communities, such as American theists, Jews, Hindus, and Muslims. The scale is used extensively for assessing religious coping across the world. It has been used in the Indian population previously. It has previously been translated into the Hindi language as well.

5.9 STATISTICAL ANALYSIS

The data was managed through MS Excel Spreadsheet. The descriptive statistic Mean (SD) and Median (Interquartile Range) were calculated for the continuous variables, and frequencies and percentages for the categorical variables. Normality was assessed by the Shapiro-Wilk statistic and its related p-value, and appropriate tests of significance (parametric/non-parametric) were performed. The data was analyzed using a licensed version of SPSS v24©IBM software.

For the qualitative analysis, the transcripts were checked against the audio files; data was read multiple times in detail, taking notes. Following this, 'codes' were created, which systematically tapped interesting aspects of the data across the entire data set. Various codes and corresponding data extracts were compiled into initial themes, ensuring that the themes captured the essence of the data extracts. Other researchers in the group verified the codes and the final themes and subthemes were identified. These were further analyzed and refined to summarize the report with verbatim extracts for each theme. (Brown and Clarke, 2006)

5.10 ETHICAL CONSIDERATION

The study was conducted after getting clearance from the ethical committee of the respective institution. All the eligible clients recruited in the study were informed about the nature and purpose of the study. Informed consent was taken from willing participants before recruitment. It was assured that personal information would be kept strictly confidential. The participants were allowed to withdraw from the study at any stage.

6. RESULTS

The study was conducted over one year between February 2022 and February 2023. NGOs and Government setups for the LGBTQIA+ community were identified in the study centers. After ethical clearance from the respective institutes, participants were recruited for the study. A total of 1001 individuals were included in the study. All the participants gave informed consent. For ease of understanding, the results are presented zone-wise, followed by a comparison across all zones. The data indicating inter-relationships between various demographic and clinical variables are discussed later, along with the qualitative results findings.

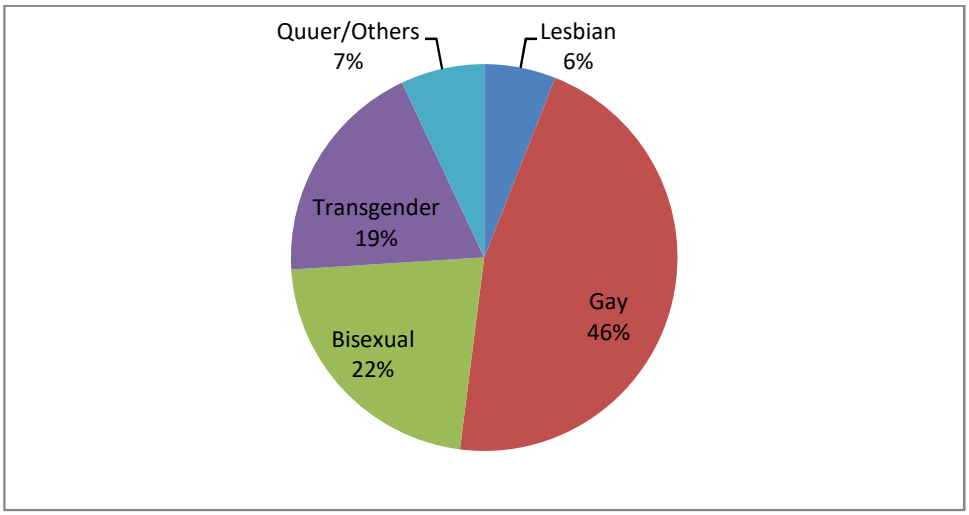
6.1 RESULTS- Lucknow

6.1.1 Age

The mean age of the respondents of Lucknow was 30.86 ± 5.16 years, and the median age was 30 (8) years.

6.1.2 Category of LGBTQIA+

Figure 1: Category of LGBTQIA+ Participants from Lucknow



6.1.3 Education

Most of the persons were educated beyond high school education. The average years of education attained by the study population from Lucknow was 9.74 (3.38) years.

Table 3: Education of LGBTQIA+ Participants from Lucknow

		n=250	%
Education of respondent	Illiterate/Primary School	38	15.2
	Middle School	43	17.2
	High School	71	28.4
	Intermediate or post-high school diploma/ Graduate	74	29.6
	Post Graduate	24	9.6

6.1.4 Education of head of family

Table 4: Education of head of family of LGBTQIA+ Participants from Lucknow

		n=250	%
Education of head of family	Do not want to disclose/Illiterate	87	34.8
	Primary School	114	45.6
	Middle School and above	49	19.6

6.1.5 Occupation

The majority of the participants (48.8%) were employed as unskilled/semi-skilled workers. About one-half (58.5%) revealed unskilled/semi-skilled jobs being done in the family as well.

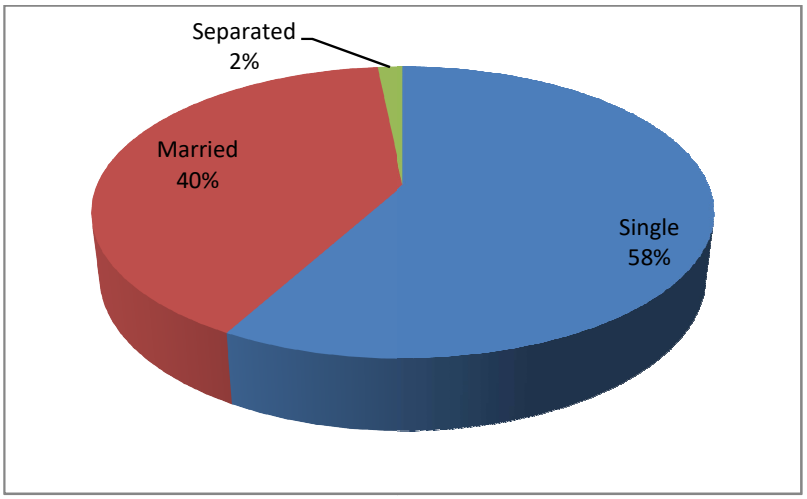
Table 5: Occupation of LGBTQIA+ Participants from Lucknow

		n=250	%
Occupation of respondent	Unemployed	79	31.6
	Unskilled/ Semi-skilled	122	48.8
	Clerical, Shop owner, farmer	49	19.6
Occupation of head of family	Unemployed/Unknown	55	22
	Unskilled/ Semi-skilled	146	58.4
	Clerical, Shop owner, farmer	49	19.6

6.1.6 Marital status

The majority of the population was single. Interestingly, 13.3% (n=2) of the lesbians, 46.1% (n=47) of gays, 21.8% (n=36) of bisexuals, 19.4% (n=12) of transgenders and 7.7% (n=4)of queer individuals were married. Overall, 40.4% of the Lucknow LGBTQIA+ population was married.

Figure 2:Marital status of LGBTQIA+ participants from Lucknow



6.1.7 Monthly Income

The majority of the participants earn up to 18496 INR per month. The monthly family income also showed a similar trend, reflecting the significant financial stress prevailing in the LGBTQ+ community.

Table 6: Monthly Income of LGBTQIA+ participants from Lucknow

		n=250	%
Monthly income of respondent	6175-18496 INR	22	91.2
	<6175 INR	228	8.8
Monthly income of head of family	6175-18496 INR	192	76.8
	<6175 INR	58	23.2

6.1.8 Religion

Table 7: Religion of LGBTQIA+ participants from Lucknow

		n=250	%
Religion	Hindu	145	58
	Islam	90	36
	Christian	15	6

6.1.9 Type of family

The majority of the population belonged to nuclear family (97.2%). The rest (2.8%) belonged to extended/joint families.

6.1.10Locality

Table 8: Locality of stay of LGBTQIA+ participants from Lucknow

		n=250	%
Locality	Urban	38	15.2
	Semi- urban	189	75.6
	Rural	23	9.2

6.1.11 Mental Health Issues

Using the DASS 21 self-report, average scores of depression, stress, and anxiety were 1.88(2.51), 2.3(1.44), and 0.09(0.51), respectively. None of the participants from the Lucknow center screened for severe depression, anxiety, or stress. However, a total of 1.6% of participants screened for mild depression, and 0.4% screened for moderate depression.

Suicidality

Suicidality was assessed using the scale for suicidal ideation. A score of ≥ 21 indicates severe suicidal ideation. Only two respondents, both gays, i.e., 0.8%, reported having severe suicidal ideation at the time of assessment.

Prevalence of substance use

Alcohol was the most common substance used ever in a lifetime by the participants, followed by tobacco. On risk stratification of current tobacco users, only 1.8% had high risk and a majority of 95.3% had moderate risk use. A total of 66.9% of alcohol users had moderate risk, and 0.4% had high-risk use. Almost half of the cannabis users had moderate risk use. None of them were used high-risk pattern. Whereas 1.18% of sedative users had moderate risk and 2% had high-risk use.

Overall, most common substance used in the community in a problematic pattern (harmful use/dependence) was tobacco (84%) followed by alcohol (59.6%), cannabis (18%), sedatives (10%) and inhalants (3%).

Figure 3: Patterns of substance use among LBTQIA+ participants from Lucknow

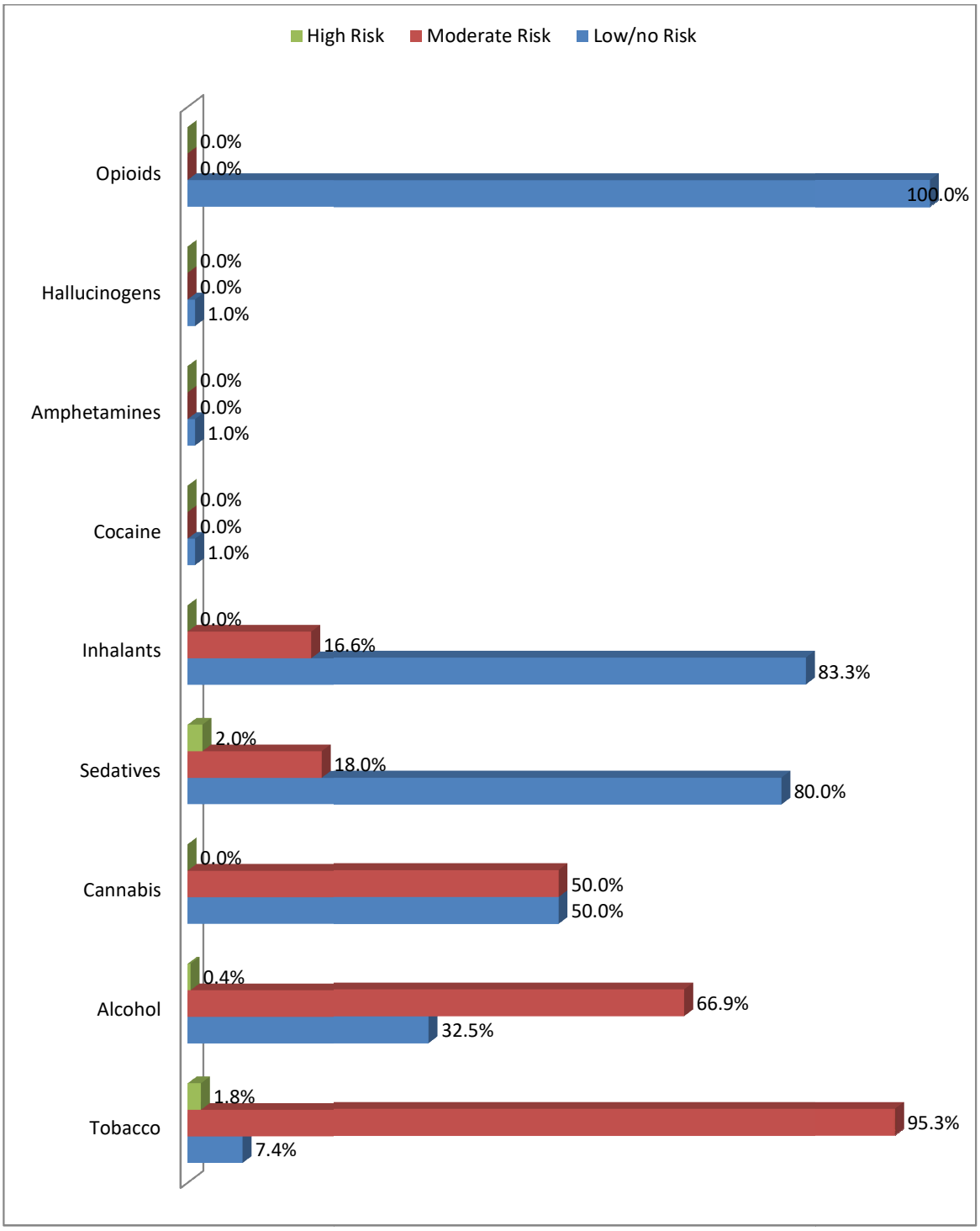
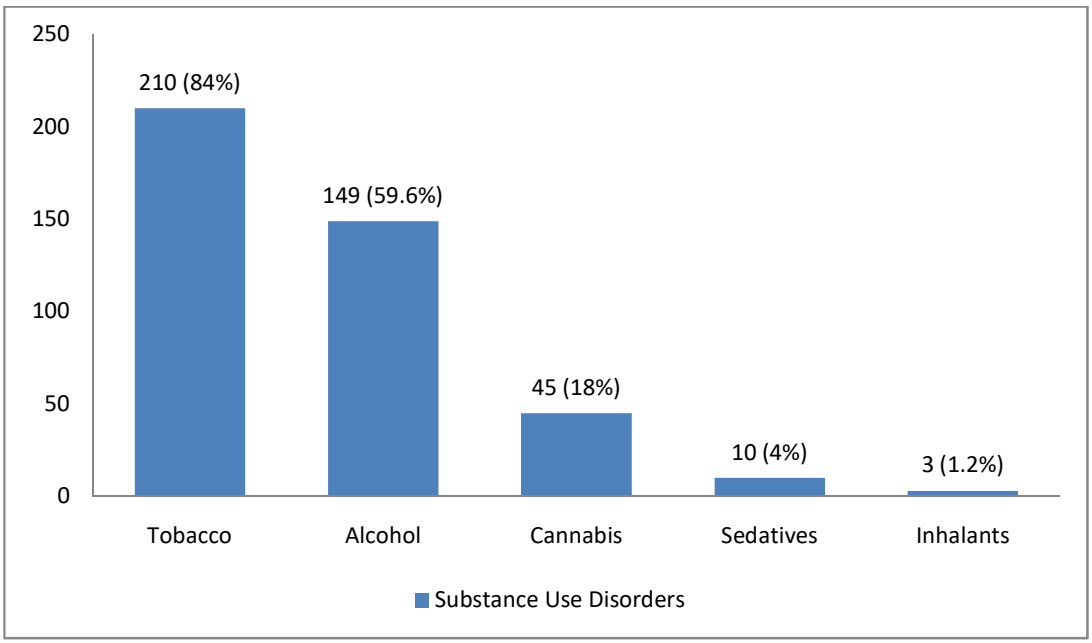


Figure 4: Prevalence of substance use disorders among LGBTQIA+ Participants from Lucknow



6.1.12 Assessment of Coping Skills

The majority of the members adopt emotion-focused coping to confront stress and difficulties. Avoidance style was observed to be used the least.

Table 9: Coping Skills scores among LGBTQIA+ Participants from Lucknow

Total score range (28-112)	Mean ± SD
Problem focused	20.94 ± 2.17
Emotion focused	27.24 ± 2.25
Avoidance	14.47 ± 2.11

Brief Religious Coping Scale (Score 14-56)

Most of the individuals adopted a positive religious coping style.

Table 10: Religiosity scores among LGBTQIA+ Participants from Lucknow

	Mean ± SD
Positive	14.16 ± 2.47
Negative	1.91 ± 1.86

6.1.13 Perceived Social Support

Most of the community members got social support from a significant other member. Family's support was the least.

Table 11: Perceived social support among LGBTQIA+ Participants from Lucknow

	Mean ± SD
Significant Others	5.19± 0.73
Family	2.32 ± 1.16
Friends	5.55 ± 0.57
Total	4.34 ± 0.62

6.1.14 Well-Being

The mean score of the population was 61.79 ± 12.93. A total of 31 respondents (12.4%) had poor wellbeing, i.e. score≤50.

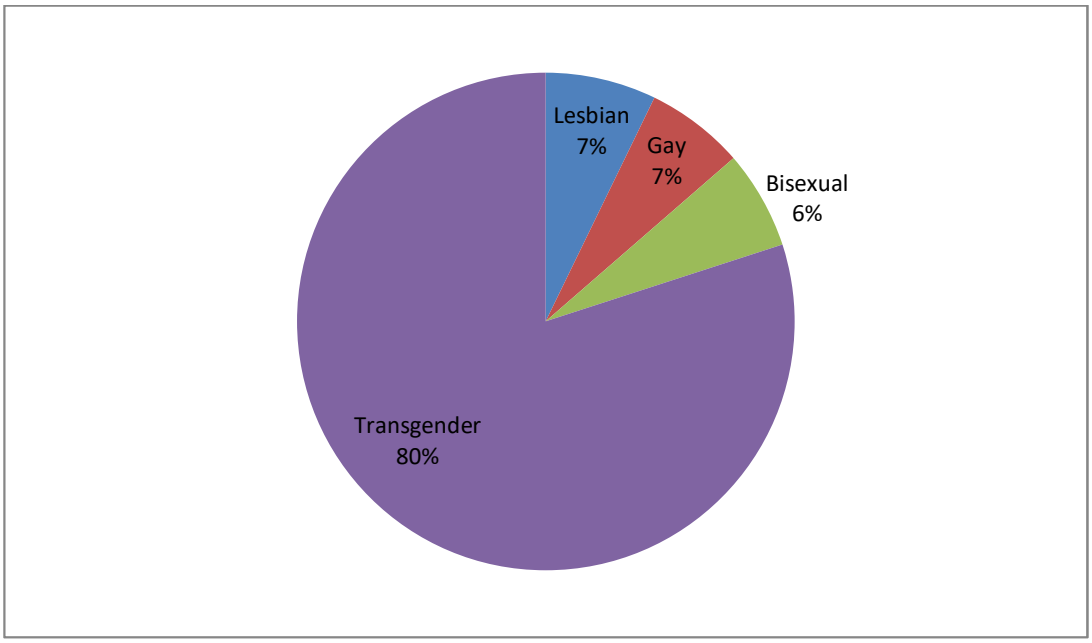
6.2.1 RESULTS- Mumbai

7.2.1Age

The mean age of the participants in Mumbai was 27.41 (±6.43) years. The median age was 27 years (with an IQR of 30-22).

7.2.2 Category of LGBTQIA+

Figure 5: Category of LGBTQIA+ participants from Mumbai



6.2.2Marital status

Most recruited participants were single or unmarried (n=233; 93.2%). Very few (<5% were married at the time of interview). Only 0.8% (n=3) of the lesbian community and 0.7% (n=8) of the bisexual community were married.

Table 12: Marital status of LGBTQIA+ participants from Mumbai

Marital status	n=250	%
Single / Unmarried	233	93.2
Married	11	4.4
Widowed	1	0.4
Divorced	3	1.2
Separated	2	0.8
Total	250	100.0

6.2.3Education

Nearly 3/4 of the participants were educated till high school or less. Around 13% of the study participants were illiterate. More than one-fifth of the participants studied till graduation or post-graduation.

Table 13a: Education of LGBTQIA+ participants from Mumbai

		n=250	%
Education of respondent	Illiterate Primary School	34	22.8
	Primary School	58	1.6
	Middle School	53	17.6
	High School	44	21.2
	Intermediate or post-high school diploma	4	23.2
	Graduate/Post Graduate	57	13.6

7.2.5 Education of head of family

Around 9/10th of the participants reported that the head of the family was educated till 10th or less.

Table 13b: Education of head of family of LGBTQIA+ participants from Mumbai

		n=250	%
Education of head of family	Do not want to disclose/Illiterate	86	34.4
	Primary School	72	28.8
	Middle School	60	24.0
	High School	18	7.2
	Graduate/Post Graduate	14	5.6

6.2.4Occupation

Around 56.4% of the participants were unemployed at the time of the interview. Around 18.8% of the participants' heads of the family were also unemployed at the time of the interview. Very few reported that the head of the family were professional or semi-professional. The occupation status of the head of the family is depicted in Table 14.

Table 14: Occupation of LGBTQIA+ participants from Mumbai

		n=250	%
Occupation of respondent	Unemployed	141	56.4
	Unskilled	31	12.4
	Semi-skilled	24	9.6
	Skilled	19	7.6
	Semi-professional/Professional	4	14
Occupation of head of family	Unemployed	47	18.8
	Unskilled	37	14.8
	Semi-skilled	63	25.2
	Skilled	55	22
	Clerical, Shop owner, farmer	44	17.6
	Semi-professional/Professional	4	1.6

6.2.5Monthly Income

The participants' monthly income ranged from 0 to 184900 INR (mean: 9229.38; SD: 15386.31).

6.2.6Religion

Most of the study participants were Hindu by religion (n=176; 70.4%). Around 19.2% of participants belonged to the Muslim religion.

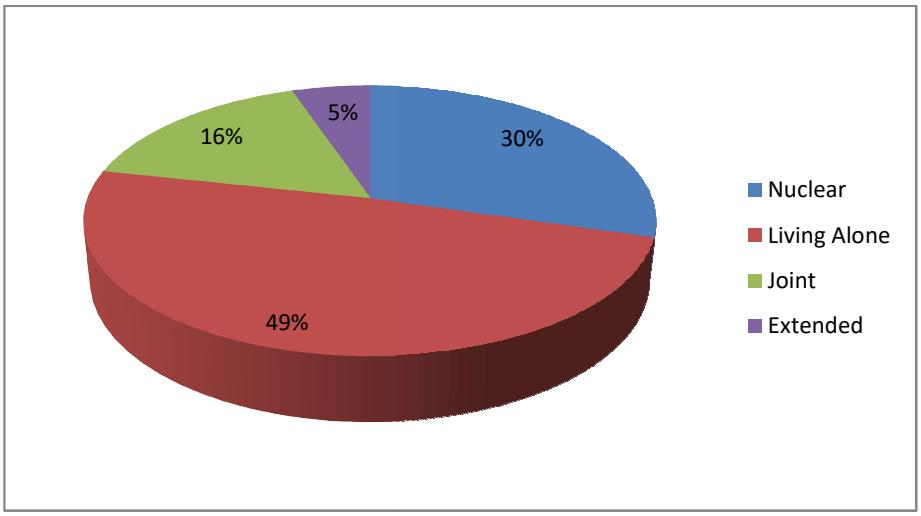
Table 15: Religion of LGBTQIA+ participants from Mumbai

		n=250	%
Religion	Hindu	176	70.4
	Islam	48	19.2
	Christian	11	4.4
	Sikh	2	0.8
	Buddhism	13	5.2

6.2.7Type of family

Around 48.8% of participants (n=122) were staying alone. A total of 74 (29.6%) participants belonged to the nuclear family, while 13 (5.2%) participants were from an extended nuclear family. About 16.4% (n=41) belonged to a joint family.

Figure 6: Type of family among LGBTQIA+ participants from Mumbai



6.2.8Locality

All participants belonged to urban (n=248; 99.2%) or semi-urban (n=2; 0.8%) locality.

6.2.9Mental Health Issues

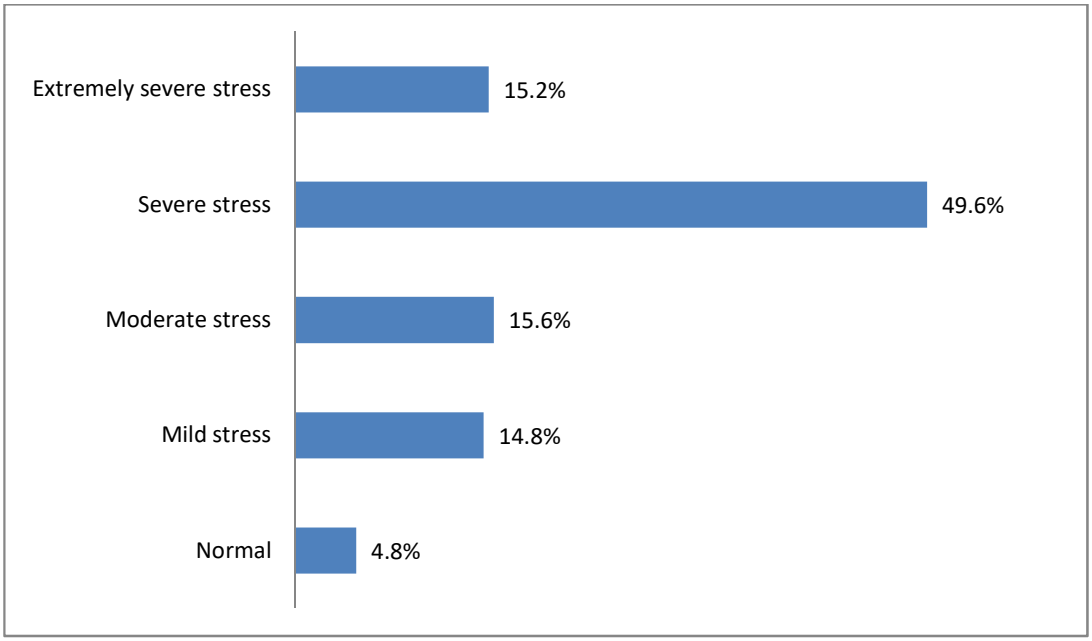
Stress

More than 80.4% of the study participants reported suffering from moderate, severe, or extremely severe stress (Table 14). Only 4.8% of the recruited participants reported no stress.

Table 16: Stress among LGBTQIA+ participants from Mumbai

Stress category	n=250	%
Normal	12	4.8
Mild Stress	37	14.8
Moderate Stress	39	15.6
Severe Stress	124	49.6
Extremely Severe Stress	38	15.2
Total	250	100.0

Figure 7: Stress among LGBTQIA+ participants from Mumbai

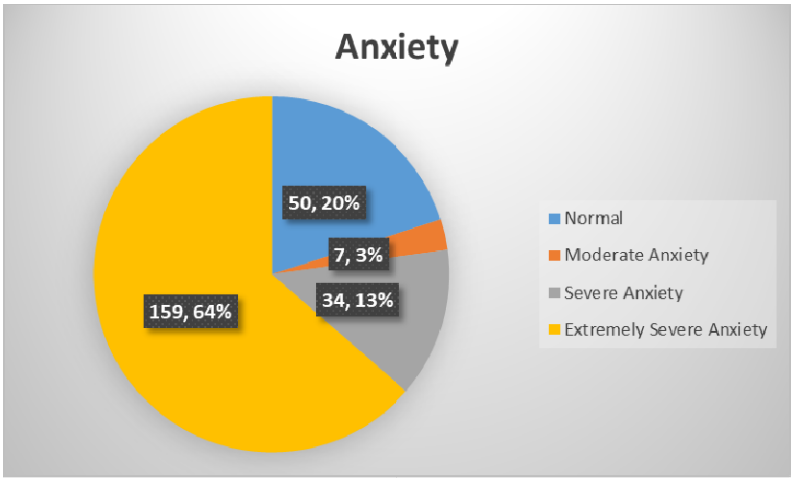


Anxiety

Apart from stress, anxiety was also very common among the study participants. Around 77.2% of the study participants fell into the severe to extremely severe anxiety category as

per the DASS 21 (Table 10). Only 20% of participants reported no anxiety issues.

Figure 8: Anxiety among of LGBTQIA+ participants from Mumbai



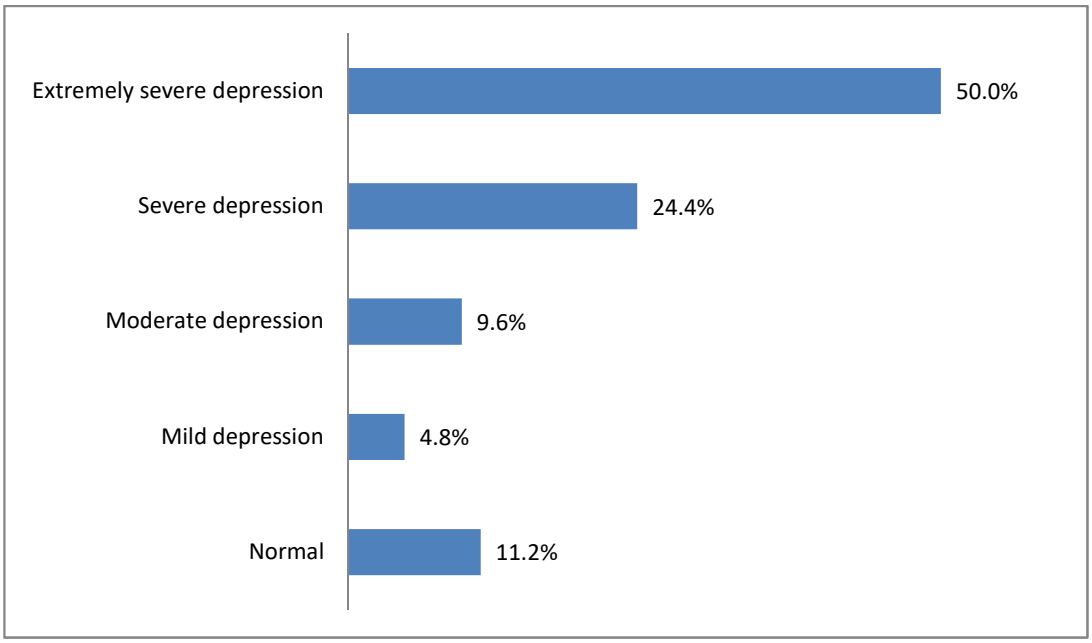
Depression

The rates of depression were also high among the study participants (table 11). Around 84% of the study participants also suffered from moderate, severe, or extremely severe depression. A total of 28 participants (11.2%) reported no depression, while 12 (4.8%) reported mild depression.

Table 17: Depression among LGBTQIA+ participants from Mumbai

Depression category	n=250	%
Normal	28	11.2
Mild Depression	12	4.8
Moderate Depression	24	9.6
Severe Depression	61	24.4
Extremely Severe Depression	125	50.0
Total	250	100.0

Figure 9: Depression among of LGBTQIA+ participants from Mumbai



Suicidality

Suicidality was assessed using a Scale for Suicidal ideation. Score of ≥ 21 indicates severe suicidal ideation. 60 respondents, all of them being transgenders, i.e., 24%, reported having severe suicidal ideation at the time of assessment.

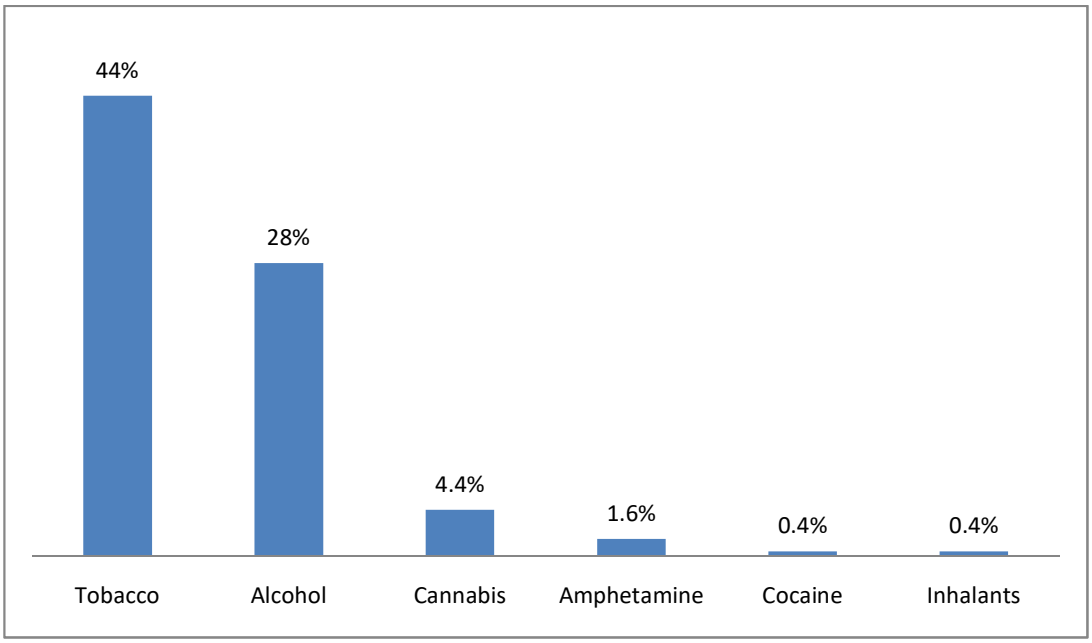
Prevalence of substance use

Table 12 depicts problematic substance use (harmful use plus dependence) reported by the participants as per the WHO ASSIST v3.0. By far, tobacco (44.0%) was the most common substance used in problematic fashion by the participants. In addition, alcohol use was also a common problem, with 28% (n=70) of participants requiring help (problem users). Around 4.4% of the participants also reported using cannabis in a problematic manner. Other illicit drug use was less commonly reported.

Table 18: Prevalence of substance use disorders among LGBTQIA+ participants from Mumbai

Substance use	n=250	%
Tobacco	110	44.0
Alcohol	70	28.0
Cannabis	11	4.4
Cocaine	1	0.4
Amphetamine	4	1.6
Inhalants	1	0.4
Hallucinogens	0	
Opioids	0	
Sedatives/Hypnotics	0	

Figure 10: Prevalence of Substance Use Disorders among LGBTQIA+ participants from Mumbai



6.2.10Assessment of Coping Skills

Most of the members adopt emotion-focused coping to confront stress and difficulties. Avoidance style was observed to be used the least.

Table 19: Coping Skills scores among LGBTQIA+ participants from Mumbai

Total score range (28-112)	Mean ± SD
Problem focused	21.23 ± 5.03
Emotion focused	30.08 ± 6.45
Avoidance	19.82 ± 4.29

Brief Religious Coping Scale (Score 14-56)

Majority of the individuals adopted negative religious coping style.

Table 20: Religiosity scores among LGBTQIA+ participants from Mumbai

	Mean ± SD
Positive	8.50 ± 3.18
Negative	10.60 ± 2.90

7.2.13 Perceived Social Support

The majority of the community members got social support from a significant other or family member. Friends' support was perceived to be the least.

Table 21: Perceived social support among LGBTQIA+ participants from Mumbai

	Mean ± SD
Significant Others	6.25± 3.41
Family	6.25 ± 3.28
Friends	5.75 ± 3.36
Total	5.25 ± 3.35

7.2.14 Well Being

The mean score of the population was 50.93 ± 20.19. A total of 114 respondents (45.6%) had poor wellbeing, i.e. score≤50.

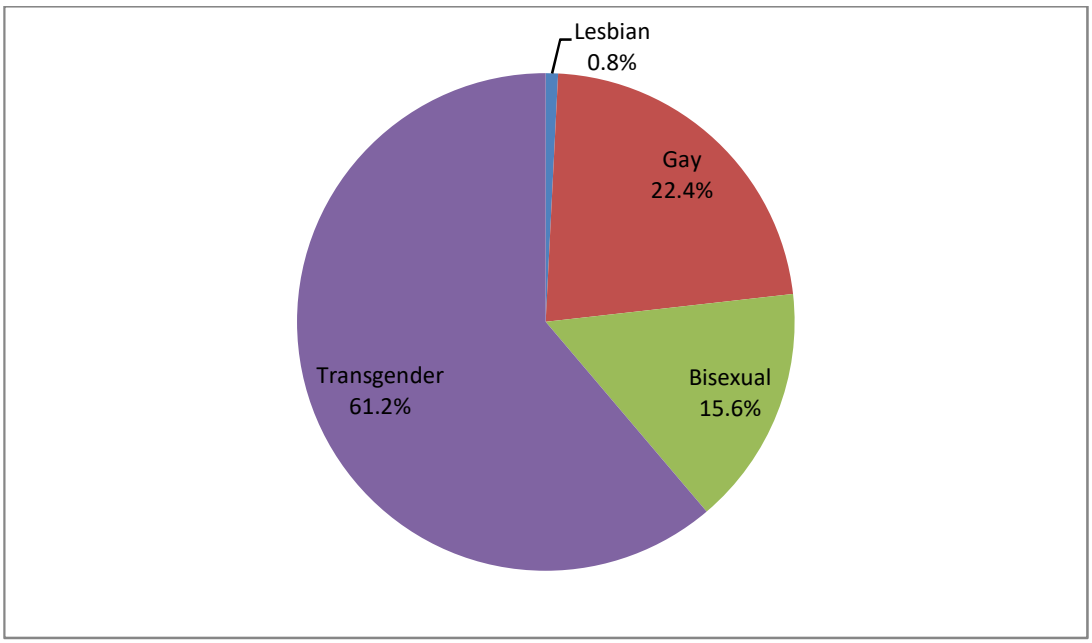
6.3 RESULTS- Puducherry

6.3.1 Age

The mean age of the participants in Puducherry was 28.07 (±9.26) years. The median age was 26 years (with an IQR of 11).

6.3.2 Category of LGBTQIA+

Figure 11: Category of LGBTQIA+ participants from Puducherry



6.3.3 Marital status

Most of the recruited participants were either single or unmarried (n=206; 82.4%). Only 13.6% (n=34) of the population was married. Within the community, 7.6% (n=9) of gays, 5.3% (n=4) of bisexuals and 20.8% (n=21) of transgenders were married.

Table 22: Marital status of LGBTQIA+ participants from Puducherry

Marital status		n=250	%
	Single / Unmarried	206	82.4
	Married	34	13.6
	Divorced	2	0.8
	Separated	8	3.2
	Total	250	100.0

6.3.4 Education

The average years of education achieved for the participants were 11.29 ± 3.64 years. Majority of the participants were educated till high school or less.

Table 23a: Education of LGBTQIA+ participants from Puducherry

		n=250	%
Education of respondent	Illiterate	6	2.4
	Primary School	5	2.0
	Middle School	28	11.2
	High School	102	40.8
	Intermediate or post-high school diploma	49	19.6
	Graduate/Post Graduate	49	19.6
	Profession/ Honors	11	4.4

6.3.5 Education of head of family

Around 95.2% of the participants either did not disclose the education of the head of the family or reported that they did not have any formal education.

Table 23b: Education of head of family of LGBTQIA+ participants from Puducherry

		n=250	%
Education of head of family	Do not want to disclose	232	92.8
	Illiterate	6	2.4
	Primary School	2	0.8
	Middle School	3	1.2
	High School	5	2.0
	Post high school	2	0.8

7.3.6 Occupation

Around 13.2% of the participants were unemployed at the time of the interview. A total of 136 participants (54.4%) were working as unskilled workers. Further, around 30.4% of participants were working as skilled or semi-skilled workers.

Table 24: Occupation of LGBTQIA+ participants from Puducherry

		n=250	%
Occupation of respondent	Unemployed	33	13.2
	Unskilled	136	54.4
	Semi-skilled	38	15.2
	Skilled	38	15.2
	Semi-professional/Professional	5	2.0
Occupation of head of family	Do not want to disclose/ Unemployed	241	96.4
	Unskilled	3	1.2
	Semi-skilled	2	0.8
	Skilled	4	1.6

The majority of the participants did not disclose the occupation of the head of the family. Rests of them were either unemployed or engaged in semi-skilled, unskilled, or skilled work.

6.3.7 Monthly Income

Most of the participants earn up to 18496 INR per month. The monthly family income also showed a similar trend, with all the members having < 6175 INR income per month, reflecting the significant financial stress prevailing in the LGBTQIA+ community.

Table 25: Monthly Income of LGBTQIA+ participants from Puducherry

		n=250	%
Monthly income of respondent	>18496 INR	9	3.6
	6175-18496 INR	125	50.0
	<6175 INR	116	46.4

6.3.8 Religion

Most of the study participants were Hindu by religion (n=176; 70.4%). Around 19.2% of participants belonged to the Muslim religion (Table 26).

Table 26: Religion of LGBTQIA+ participants from Puducherry

		n=250	%
Religion	Hindu	236	94.4
	Islam	4	1.6
	Christian	10	4.0

6.3.9 Type of family

Around of 56.8% participants (n=142) were staying in nuclear families. A total of 36.4% stayed alone.

Table 27: Type of family of LGBTQIA+ participants from Puducherry

		n=250	%
Family Type	Nuclear	142	56.8
	Living Alone	91	36.4
	Joint	15	6.0
	Extended	2	0.8

6.3.10 Locality

The majority of participants belonged to rural localities (63.6%)

Table 28: Locality of stay of LGBTQIA+ participants from Puducherry

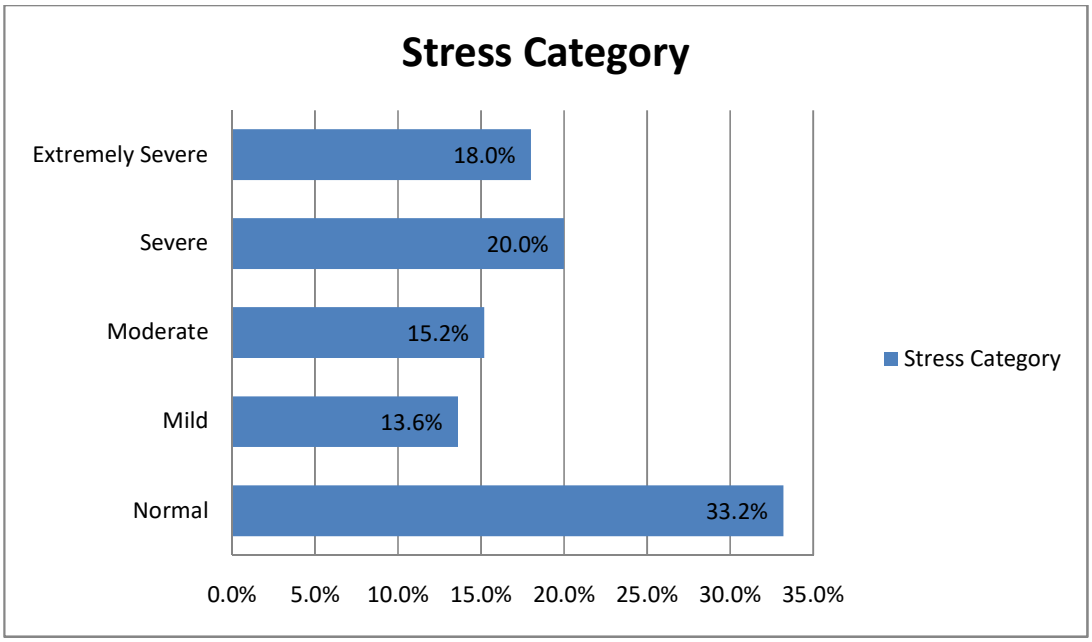
		n=250	%
Locality	Urban	72	28.8
	Semi- Urban	19	7.6
	Rural	159	63.6

6.3.11 Mental Health Issues

Stress

More than 53.2% of the study participants reported suffering from moderate, severe, or extremely severe. Around 33.2% of the recruited participants reported no stress.

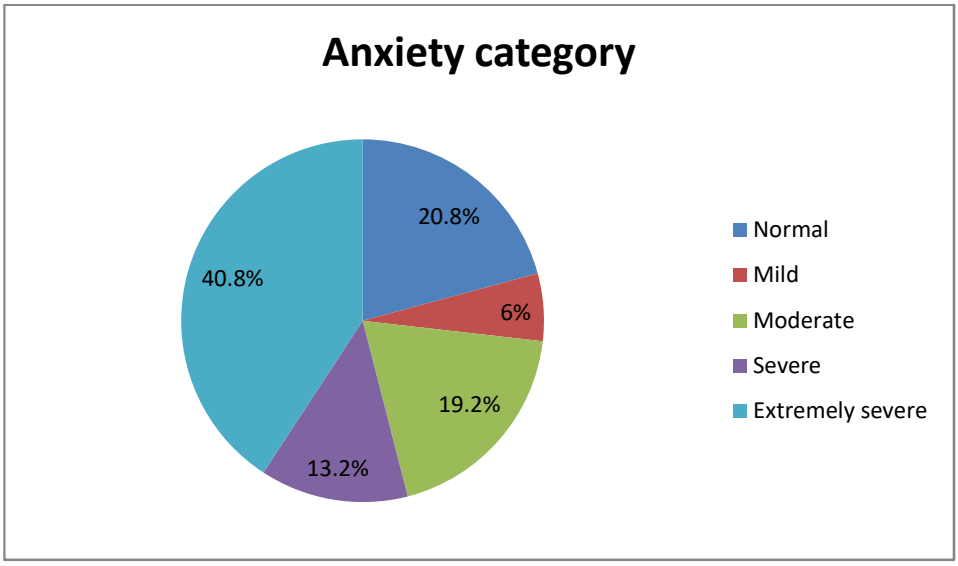
Figure 12: Stress among LGBTQIA+ participants from Puducherry



Anxiety

Apart from stress, anxiety was also very common among the study participants. Around 73.2% of the study participants fell into the moderate or severe to extremely severe anxiety category as per the DASS 21. Only 20.8% of participants reported no anxiety issues.

Figure 13: Anxiety among LGBTQIA+ participants from Puducherry



Depression

The rates of depression were also high among the study participants (table 11). Around 68% of the study participants also suffered from moderate, severe, or extremely severe depression. A total of 53 participants (21.2%) reported no depression, while 27 (10.8%) reported mild depression.

Suicidality

Suicidality was assessed using a Scale for Suicidal ideation. Score of ≥ 21 indicates severe suicidal ideation. 35 respondents (31 transgenders, 2 bisexuals, 1 gay, and 1 lesbian), i.e., 14%, reported having severe suicidal ideation at the time of assessment.

Prevalence of substance use

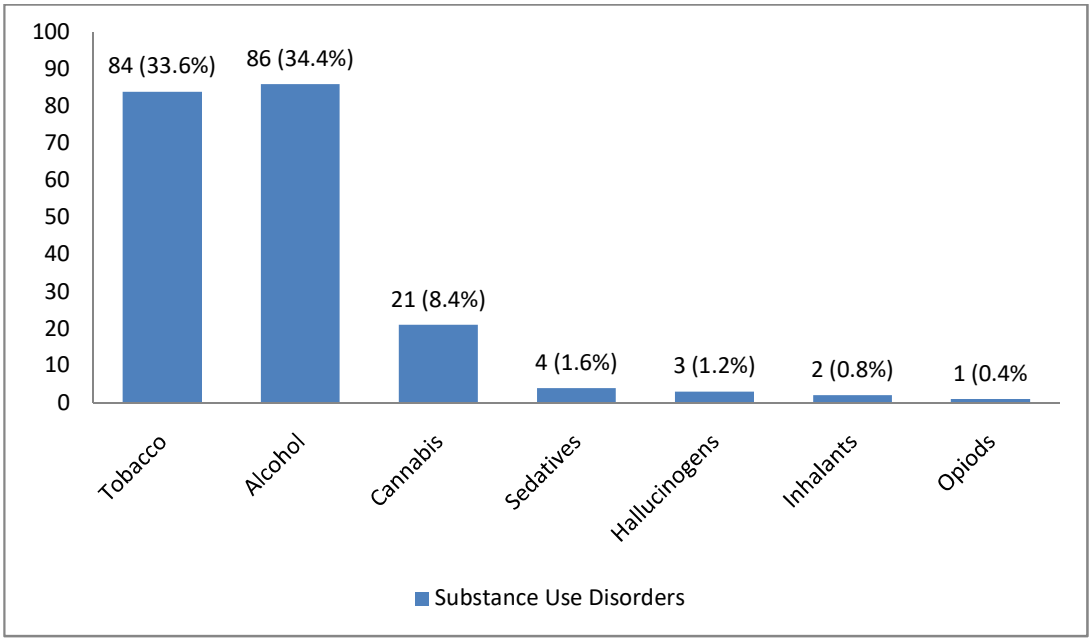
Alcohol was the most common substance used ever in lifetime by the participants followed by tobacco. Amongst the current users, only 1.9% had tobacco dependence. A total of 8.7% had alcohol dependence, and 9.1% had cannabis dependence.

The most common substance used in the community in a problematic pattern (harmful use/dependence) was alcohol (34.4%), followed by tobacco (33.6%), cannabis (8.4%), and sedatives (1.6%).

Table 29: Pattern of substance use among LGBTQIA+ participants from Puducherry

	Low/No Risk, n (%)	Moderate Risk, n (%)	High Risk, n (%)
Tobacco (n=104)	20 (19.2)	82 (78.8)	2 (1.9)
Alcohol (n=126)	40 (31.7)	75 (59.5)	11 (8.7)
Cannabis (n=33)	12 (36.4)	18 (54.5)	3 (9.1)
Cocaine (n=1)	1 (100)	0	0
Amphetamines (n=3)	3 (100)	0	0
Hallucinogens (n=5)	2 (40)	3 (60)	0
Sedatives (n=5)	1 (20.0)	3 (60.0)	1 (20.0)
Opioids (n=1)	0	0	1 (100)
Inhalants (n=2)	0	2 (100)	0

Figure 14: Prevalence of Substance Use Disorders among LGBTQIA+ participants from Puducherry



6.3.12 Assessment of Coping Skills

The majority of the members adopt emotion-focused coping to confront stress and difficulties. Avoidance style was observed to be used the least.

Table 30: Coping Skills scores among LGBTQIA+ participants from Puducherry

Total score range (28-112)	Mean ± SD
Problem focused	22.63 ± 5.41
Emotion focused	32.20 ± 5.42
Avoidance	17.96 ± 3.91

Brief Religious Coping Scale (Score 14-56)

Most of the individuals adopted positive religious coping style.

Table 31: Religiosity scores among LGBTQIA+ participants from Puducherry

	Mean ± SD
Positive	14.75 ± 7.59
Negative	2.70 ± 4.37

6.3.13 Perceived Social Support

Most of the community members got social support from a significant other or friends' member. Family support was perceived to be the least.

Table 32: Perceived social support among LGBTQIA+ participants from Puducherry

	Mean ± SD
Significant Others	4.80± 2.14
Family	3.12 ± 2.04
Friends	3.75 ± 1.96
Total	3.92 ± 1.76

6.3.14 Well Being

Mean score of the population was 48.37 ± 22.35. A total of 137 respondents (54.8%) had poor wellbeing, i.e. score≤50.

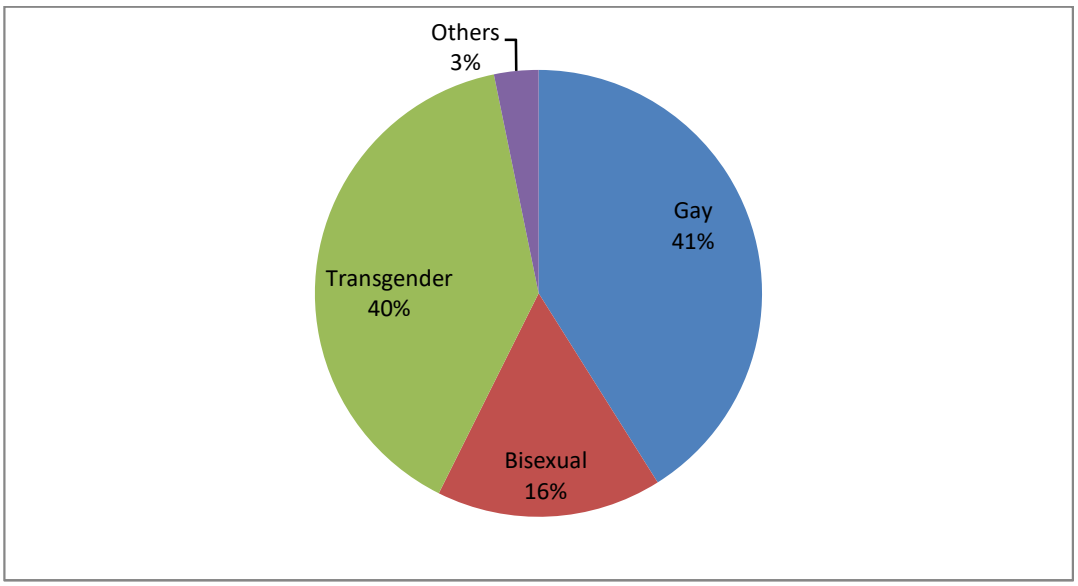
6.4 RESULTS- Bhubaneswar

6.4.1 Age

The mean age of the participants was 33.55± 11.27 years. The median age was 30 years (with an IQR of 14).

6.4.2 LGBTQIA+ Category

Figure 15: Category of LGBTQIA+ participants from Bhubaneswar



6.4.3 Marital status

Most of the recruited participants were either single or unmarried (n=153; 61%). Interestingly, 34.9% (n=46) of gays, 13.9% (n=29) of bisexuals, 33.5% (n=4) of transgenders and 2.7% (n=6) of queer/other individuals were married. Overall, 33.9% (n=85) of the LGBTQIA+ population from Bhubaneswar was married.

Table 33: Marital status of LGBTQIA+ participants from Bhubaneswar

Marital status	n=250	%
Single / Unmarried	153	61
Married	85	33.9
Separated	13	5.2
Total	250	100.0

6.4.4 Education

Average years of education achieved for the participants were 7.9 ± 4.4 years. Majority of the participants were educated till high school or less.

Table 34a: Education of LGBTQIA+ participants from Bhubaneswar

		n=250	%
Education of respondent	Illiterate	44	17.5
	Primary School	56	22.3
	High School	110	43.8
	Intermediate or post-high school diploma	26	10.4
	Graduate/Post Graduate	14	5.6
	Profession/ Honors	1	0.4

6.4.5 Education of head of family

Around 95.2% of the participants either did not disclose the education of the head of the family or reported that they did not have any formal education.

Table 34b: Education of head of family of LGBTQIA+ participants from Bhubaneswar

		n=250	%
Education of head of family	Do not want to disclose	5	2.0
	Illiterate	92	36.7
	Primary School	114	45.4
	High School	30	12.0
	Intermediate or post-high school diploma	8	3.2
	Graduate/Post Graduate	2	0.8

6.4.6 Occupation

Around 13.2% of the participants were unemployed at the time of the interview. A total of 136 participants (54.4%) were working as unskilled workers. Further, around 30.4% of participants were working as skilled or semi-skilled workers.

Table 35: Occupation of LGBTQIA+ participants from Bhubaneswar

		n=250	%
Occupation of respondent	Unemployed	10	4.0
	Unskilled	151	60.2
	Semi-skilled	13	5.2
	Skilled	23	9.2
	Clerical/shop owner/ farmer	34	13.5
	Semi-professional/ Professional	20	8.0
Occupation of Head of the Family	Did not disclose/ Unemployed	10	4.0
	Unskilled	124	49.4
	Semi-skilled	9	3.6
	Skilled	18	7.2
	Clerical/shop owner/ farmer	69	27.5
	Semi-professional/ Professional	21	8.4

Most of the participants did not disclose the occupation of the head of the family. Rests of them were either unemployed or engaged in semi-skilled, unskilled, or skilled work.

6.4.7 Monthly Income

Most of the participants earn up to 18496 INR per month. The monthly family income also showed a similar trend with all the members having < 6175 INR income per month reflecting the significant financial stress prevailing in the LGBTQIA+ community.

Table 36: Monthly Income of LGBTQIA+ participants from Bhubaneswar

		n=250	%
Monthly income of respondent	>18496 INR	8	3.2
	6175-18496 INR	115	45.8
	<6175 INR	128	51.0
Monthly income of head of family	>18496 INR	24	9.6
	6175-18496 INR	134	53.4
	<6175 INR	93	37.1

6.4.8 Religion

All the study participants were Hindu by religion.

6.4.9 Type of family

Around 56.8% participants (n=142) were staying in nuclear families. A total of 36.4% stayed alone.

Table 37: Type of family of LGBTQIA+ participants from Bhubaneswar

		n=250	%
Family Type	Nuclear	130	51.8
	Extended	3	1.2
	Living Alone	88	35.1
	Joint	30	12.0
	Extended	2	0.8

6.4.10 Locality

Majority of participants belonged to rural locality (63.6%)

Table 38: Locality of stay of LGBTQIA+ participants from Bhubaneswar

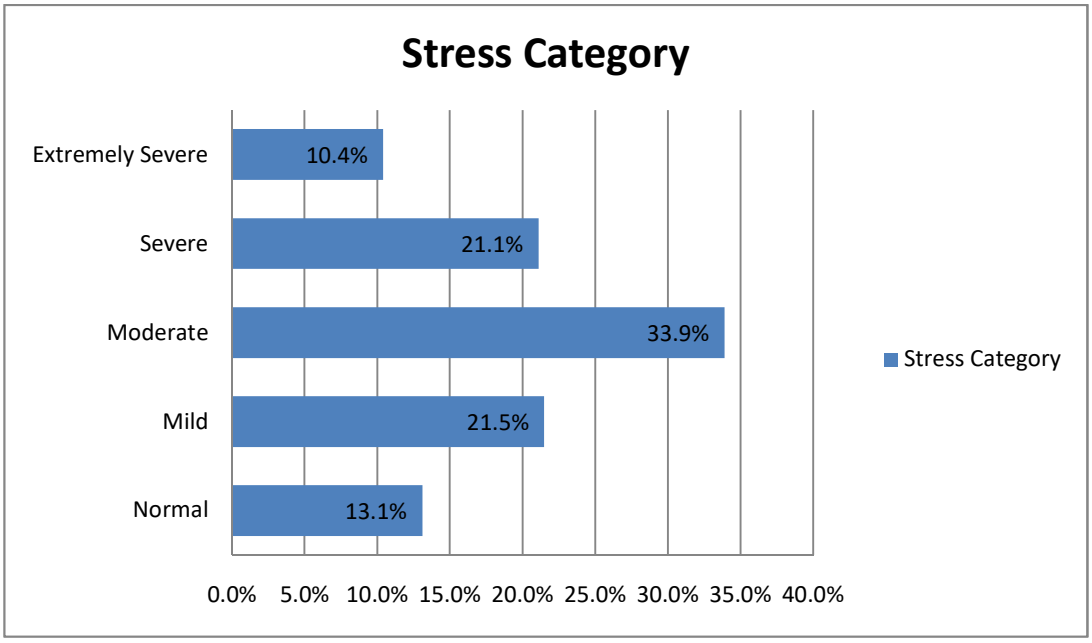
		n=250	%
Locality	Urban	72	28.7
	Semi- Urban	30	12.0
	Rural	149	59.4

6.4.11 Mental Health Issues

Stress

Around one-third, i.e., 33.9% of the study participants, reported suffering from moderate stress, and 31.5% reported having severe or extremely severe. Only 13.1% of the recruited participants reported no stress.

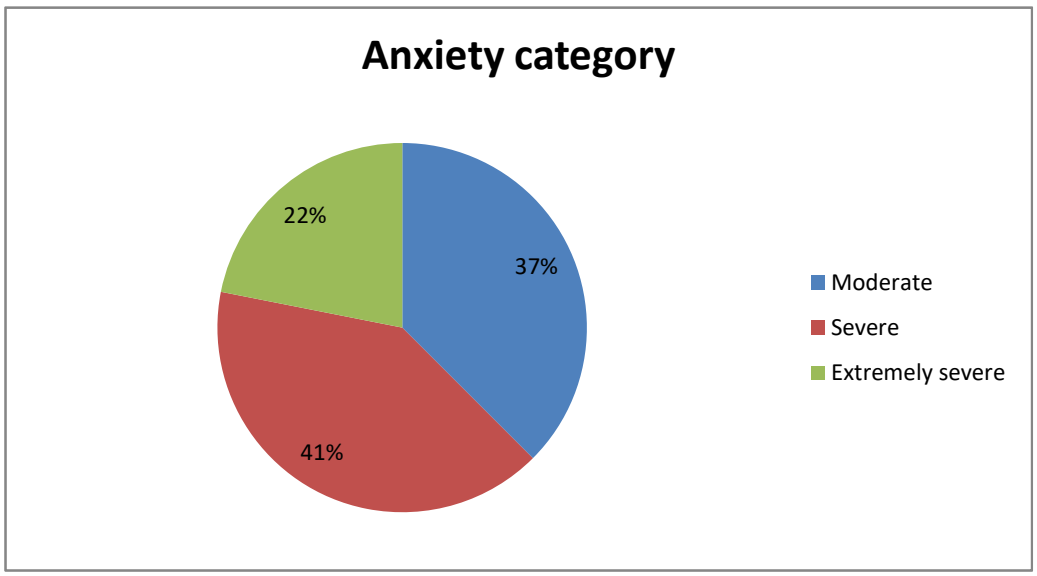
Figure 16: Stress among LGBTQIA+ participants from Bhubaneswar



Anxiety

Apart from stress, anxiety was also very common among the study participants. All the study participants fell into the moderate or severe to extremely severe anxiety category as per the DASS 21.

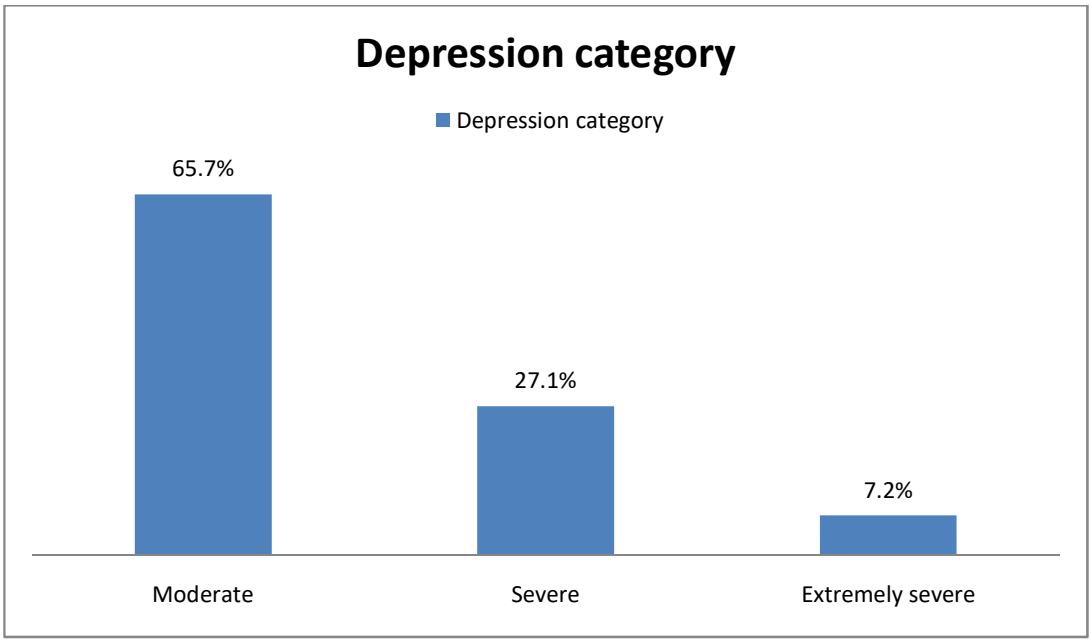
Figure 17: Anxiety among LGBTQIA+ participants from Bhubaneswar



Depression

The rates of depression were also high among the study participants. All the study participants suffered from moderate, severe, or extremely severe depression.

Figure 18: Depression among LGBTQIA+ participants from Bhubaneswar



Suicidality

Suicidality was assessed using Scale for Suicidal ideation. Score of ≥ 21 indicates severe suicidal ideation. Only 1 of the respondents (gay) reported having severe suicidal ideation at the time of assessment.

Prevalence of substance use

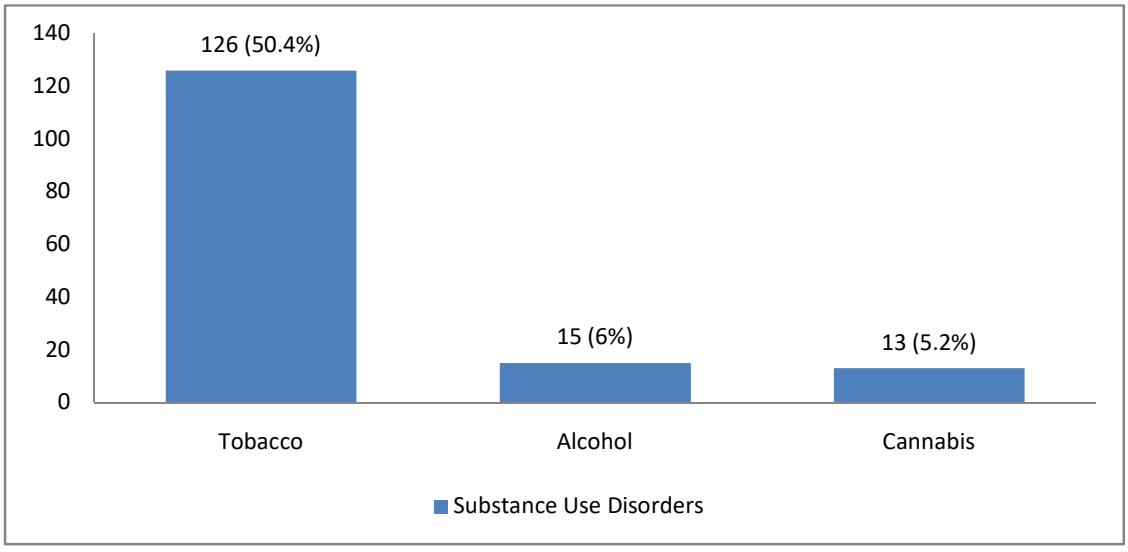
Alcohol was the most common substance used ever in a lifetime by the participants, followed by tobacco and cannabis. No participant reported using other substances such as cannabis, cocaine, amphetamine-type stimulants, inhalants, sedatives or sleeping pills, opioids, or hallucinogens. Amongst the users, none of the participants were dependent on substances. However, 85.1% had a harmful pattern of use of tobacco.

The most common substance used in the community in a problematic pattern (harmful use/dependence) was tobacco (50.4%) followed by tobacco (6%) and cannabis (5.2%).

Table 39: Pattern of substance use among LGBTQIA+ participants from Bhubaneswar

	Low/No Risk, n (%)	Moderate Risk, n (%)	High Risk n (%)
Tobacco (n=148)	22 (14.9)	126 (85.1)	0
Alcohol (n=167)	152 (91.0)	15 (9.0)	0
Cannabis (n=20)	7 (35)	13 (65)	0

Figure 19: Prevalence of Substance Use Disorders among LGBTQIA+ participants from Bhubaneswar



6.4.12 Assessment of Coping Skills

The majority of the members adopt emotion-focused coping to confront stress and difficulties. Avoidance style was observed to be used the least.

Table 40: Coping Skills scores among LGBTQIA+ participants from Bhubaneswar

Total score range (28-112)	Mean ± SD
Problem focused	26.88 ± 2.85
Emotion focused	31.67 ± 2.78
Avoidance	14.04 ± 1.82

Brief Religious Coping Scale (Score 14-56)

The majority of the individuals adopted a positive religious coping style.

Table 41: Religiosity scores among LGBTQIA+ participants from Bhubaneswar

	Mean ± SD
Positive	26.40 ± 2.63
Negative	7.94 ± 2.91

6.4.13 Perceived Social Support

The majority of the community members got social support from friends and family members. Any significant other's support was perceived to be the least.

Table 42: Perceived social support among LGBTQIA+ participants from Bhubaneswar

	Mean ± SD
Significant Others	4.24± 2.42
Family	4.44 ± 1.93
Friends	5.45 ± 1.43
Total	4.67 ± 1.31

6.4.14 Well Being

Mean score of the population was 80.33 ± 12.70. A total of 9 respondents (31.8%) had poor well-being, i.e. score≤50.

6.5 RESULTS: Comparative Data

6.5.1 Socio-demographics

- The mean age of the respondents was 29.97 ± 8.71 years. The participants from Bhubaneswar were comparatively older than those of other centers. Similarly, gay and bisexual participants were older than lesbian and transgenders.
- The average years of education attained was 9.28 years ± 4.13 years for the overall population. The median years of education was 10 (5) years. A comparison between centers shows that the education level attained was significantly lower in Bhubaneswar and higher in Puducherry. On similar lines, as compared to other groups, the average years of education was lower in the transgender community. This reflects possible barriers in the education and schooling sector, which vary across cities and communities.
- Discrimination, hostility, verbal and physical abuse, lack of sensitization, shame and stigmatization were cited by the respondents as some of the causes of early school/college drop out. However, despite the barriers, the majority of the population studied up to High School certificate.
- The majority of the participants (42.8%) were employed as unskilled workers. Various unskilled works, such as domestic help, daily wage, maid, factories, etc., were cited as sources of employment. Typically,transgenders were engaged in 'ashirvaad', where they get money in return for blessings. 'Badhai' or 'challa' has been considered a traditional *hijra* occupation since ancient times. A quarter (26.3%) of respondents was unemployed and resorted to begging and taking community help for money.
- 58.4% of the participants earn less than 6175 INR per month, 33.5% earn up to 18496 INR, while those earning more than 18496 INR per month are only 8.1%. This shows significant financial stress prevailing in the LGBTQIA+ community due to irregular employment or being underpaid.
- Majority of the overall population belonged to Hindu religion (80.7%) followed by Islam (14.2%), Christianity (3.6%), Buddhism (1.3%) and Sikhism (0.2%). This is analogous to the general population statistics.
- Although the majority of the population was single (71.9%), it is pertinent to note that around 23.1% were married. A total of 14.3% (n=5) of lesbians, 35.3% (n=102) of gays, 51.3% (n=77) of bisexuals, and 7.4% (n=37) of transgenders were married. The

difference was statistically significant between transgender when compared to others (p<0.001).

Table 43: Comparison of socio-demographics across centers

Mean (SD)/n (%)		Mumbai	Lucknow	Bhubaneswar	Puducherry	F/x2	p
Age		27.41(6.43)	30.86(5.16)	33.55(11.27)	28.07(9.26)	28.29	<0.001
Years of Education		8.21(4.12)	9.74(3.38)	7.90(4.4)	11.29(3.64)	39.75	<0.001
Education of respondent	Illiterate	34	11	44	6	314.99	<0.001
	Primary School	58	27	56	5		
	Middle School	0	43	0	28		
	High School	97	71	110	102		
	Intermediate or post-high school diploma	4	74	26	49		
	Graduate or above	57	24	15	60		

Table 44:Comparison of socio-demographics across LGBTQIA+ category

Mean (SD)/n (%)		Lesbian	Gay	Bisexual	Transgender	F/x2	p
Age		25.49(4.13)	31.36(9.35)	31.57(11.12)	29.02(7.57)	6.87	<0.001
Years of Education		4.80(1.02)	3.99(1.47)	3.94(1.58)	3.61(1.53)	6.87	<0.001
Education	Illiterate	0	29 (10%)	18 (12%)	46 (9.2%)	111.45	<0.001
	Primary School	1 (2.9%)	24 (8.3%)	14 (9.3%)	107 (21.4%)		
	Middle School	0	19 (6.6%)	12 (8%)	36 (7.2%)		
	High School	16 (45.7%)	111 (38.4%)	48 (32%)	198(39.6%)		
	Intermediate/ post-high school diploma	6 (17.1%)	64 (22.1%)	33(22%)	38 (7.6%)		
	Graduate or above	12 34.3%)	42 (14.5%)	25 (16.6%)	75 (15%)		

Figure 20: Monthly income of study participants

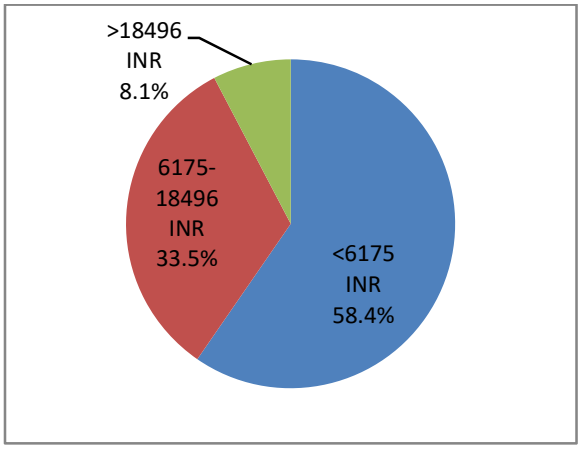


Figure 21: Religion of study participants

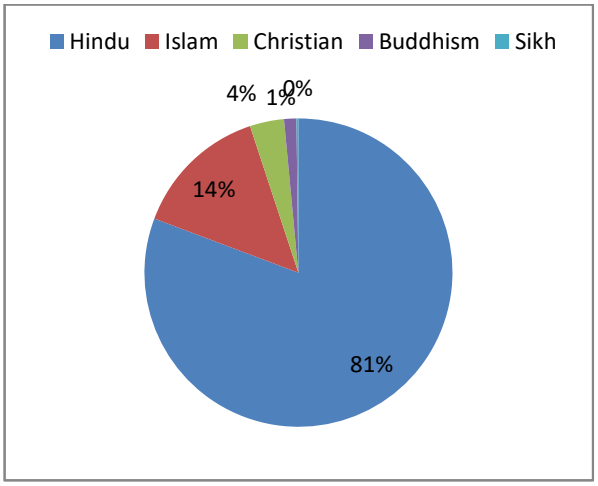


Figure 22: Type of family of study participants

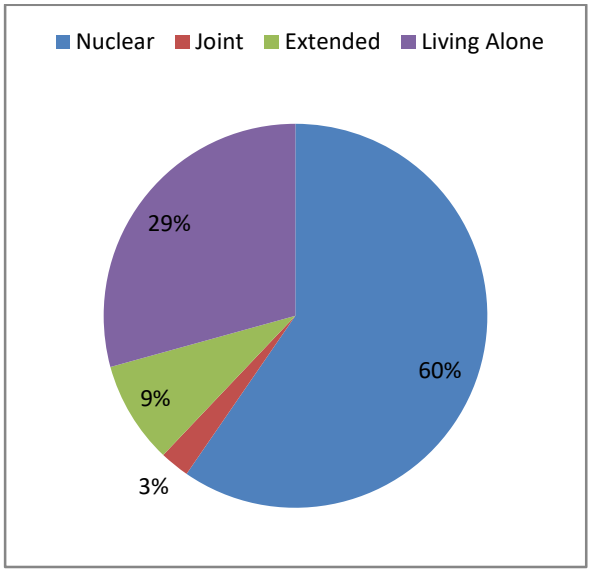
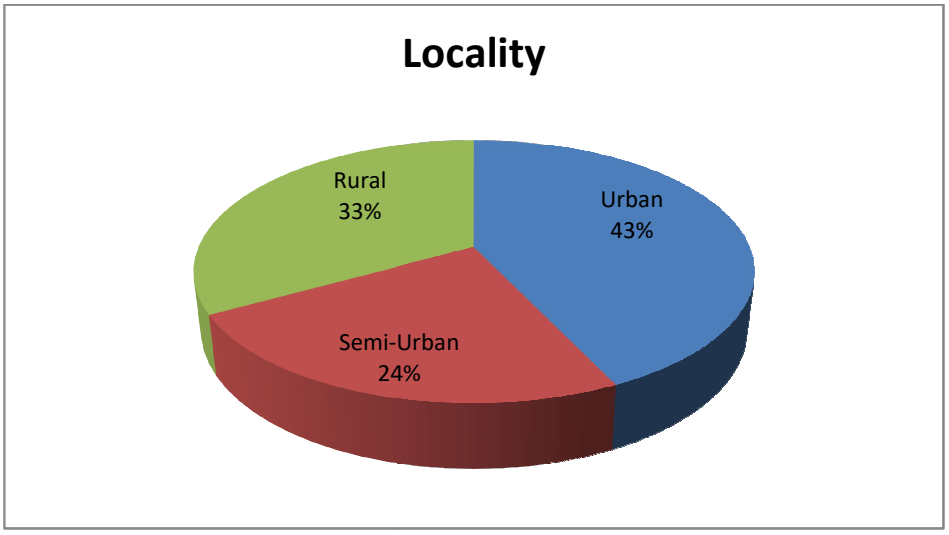


Figure 23: Locality of stay of study participants



6.5.2 Mental Health Issues

- Common mental health issues like depression, stress, and anxiety were screened using the DASS-21 instrument.
- Almost 60.3%, 64.1%, and 66.6% of the total population screened positive for some degree of stress, anxiety, and depression.
- There was a statistically significant difference in scores of depression, anxiety and stress scores between different subgroups of the community.
- Between different subsections within the community, the transgender and gay communities mostly screened positive for depression.
- Stress and anxiety scores were also significantly high in Transgender and Gay communities.
- When compared between different centers, mental health issues were significantly high in individuals from Mumbai, followed by those from Puducherry and Odisha.

Table 45: Prevalence of mental health issues across subsections of LGBTQIA+ community

DASS-21	Lesbian n= 35	Gay n= 289	Bisexual n= 150	Transgender n= 500	Total n=1001
Stress	11(31.24%)	129(44.6%)	57 (38%)	407 (81.4%)	604(60.3%)
Anxiety	2 (5.8%)	146(50.5%)	68 (45.3%)	426 (85.2%)	642(64.1%)
Depression	16 (45.7%)	156 (54%)	67 (44.7%)	428 (85.6%)	667 (66.6%)

Table 46: Comparison of mental health scores across subsections of LGBTQIA+ community

DASS-21	Lesbian Mean (SD) n= 35	Gay Mean (SD) n= 289	Bisexual Mean (SD) n= 150	Transgender Mean (SD) n= 500	Test statistic F	p
Stress	10.06(8.25)	13.36(11.04)	11.87(10.02)	24.28(11.18)	66.46	<0.001
Anxiety	3.03(5.82)	9.47(9.81)	8.28(8.81)	18.41(9.55)	65.02	<0.001
Depression	7.37(7.55)	12.25(10.66)	9.65(8.61)	23.06(10.79)	79.32	<0.001

Table 47: Comparison of mental health across centers

DASS-21	Lucknow Mean (SD) n= 250	Mumbai Mean (SD) n= 250	Bhubaneswar Mean (SD) n= 251	Puducherry Mean (SD) n= 250	Test statistic F	p
Stress	2.3(1.44)	27.51(8.15)	22.73(6.85)	20.58(11.56)	489.34	<0.001
Anxiety	0.09(0.51)	18.64(8.81)	17.04(3.83)	17.78(11.29)	359.25	<0.001
Depression	1.88(2.51)	24.58(9.43)	19.88(5.32)	21.21(12.12)	384.66	<0.001

6.5.3 Suicidality

a) Suicidality was assessed using Scale for Suicidal ideation. A score of ≥ 21 indicates severe suicidal ideation.

- 98 respondents (1 lesbian, 4 gay, 2 bisexual, and 91 transgender individuals), i.e., 9.79%, reported having severe suicidal ideation at the time of assessment. All India's rates of suicides, i.e., incidence of suicides per one lakh (1, 00,000) of the population, was 12.0 during the year 2021 (NCRB,2021).
- The suicidal intent which is reflected in item numbers 16,17,18,19 of SSI was strikingly high in the transgender population as compared to other genders. Similarly, passive suicidal desire was also high in transgenders (40.4%). This can be attributed to greater gender-based victimization, discrimination and societal rejection faced by them.Identity disclosure and family non-acceptance were some of the major reasons cited for having suicidal ideations.
- More bisexuals, as compared to others, responded that they did not have any wish to live (46.6%) and expressed continuous suicidal ideation (46.6%). The same proportion of bisexuals also expressed a moderate to strong desire to make an active attempt.
- Suicide as a reason to escape/decrease/solve the problems in their lives was cited by the majority of lesbians, followed by gays, bisexuals, and transgenders, reflecting differing coping mechanisms of the various sub-communities.
- The majority of the population reporting severe suicidal ideation were from Mumbai (n=60, 61.2%). The Puducherry had 35.7% of participants with severe suicidality. The north and Odisha had comparatively fewer individuals reporting severe suicidal ideation at 2.1% and 1%, respectively. This corroborates with the national suicide statistics, which show higher suicidal rates in the state of Maharashtra and the union territory Puducherry (NCRB, 2021).

Table 48: Item responses on Scale for Suicidal Ideation

S.no.	SSI item	Lesbian n= 35	Gay n= 289	Bisexual n= 150	Transgender n= 500	Total n=1001
1.	Wish to live	4 (11.5%)	24 (8.3%)	7 (46.6%)	192 (38.4%)	227 (22.7%)
2	Wish to die	17 (48.5%)	128 (44.2%)	59 (39.3%)	262 (52.4%)	485 (48.4%)
3	Reasons for living/dying	2 (5.7%)	30 (10.4%)	9 (6%)	208 (41.6%)	249 (24.8%)
4	Desire to make active suicide attempt	2 (5.7%)	20 (6.9%)	7 (46.6%)	230 (46%)	260 (26%0
5	Passive suicidal desire	3 (8.5%)	48 (16.6%)	13 (8.6%)	202 (40.4%)	267 (26.7%0
6	Time duration of ideation/wish	2 (5.7%)	16 (5.5%)	7 (46.6%)	172 (34.4%)	197 (19.7%)
7	Frequency of ideation	2 (5.7%)	17 (5.9%)	8 (5.3%)	206 (41.2%)	233 (23.3%0
8	Attitude towards ideation/wish	2 (5.7%)	21 (7.3%)	8 (5.3%)	227(45.4%)	258 (25.8%)
9	Control over action	1 (2.8%)	17 (5.9%)	8 (5.3%)	100 (20%)	126 (12.6%)
10	Deterrents to attempt	3 (8.5%)	22 (7.6%)	11 (7.3%)	220 (44%)	257 (25.7%)
11	Reason for attempt	32 (91.4%)	142 (49.1%)	68 (45.3%)	276 (5.2%)	537 (53.7%)
12	Method: specificity/planning	2 (5.7%)	24 (8.3%)	9 (6%)	209 (41.8%)	244 (24.4%)
13	Method: availability/opportunity	2 (5.7%)	23 (7.9%)	7 (46.6%)	230 (46%)	262 (26.2%)
14	sense of capability to carry out attempt	2 (5.7%)	20 (6.9%)	8 (5.3%)	179 (35.8%)	209 (20.9%)
15	Expectancy of	2 (5.7%)	18 (6.2%)	7 (46.6%)	214 (42.8%)	241 (24.1%)

	actual attempt					
16	Actual preparation	1 (2.8%)	12 (6.2%)	2 (1.3%)	201 (40.2%)	216 (21.6%)
17	Suicide note	1 (2.8%)	3 (1%)	0 (0.0%)	162 (32.4%)	166 (16.6%)
18	Final acts	1 (2.8%)	8 (2.8%)	3 (2%)	143 (28.6%)	155 (15.5%)
19	Concealment of contemplated attempt	2 (5.7%)	23 (7.9%)	2 (1.3%)	197(39.4%)	224 (22.4%)

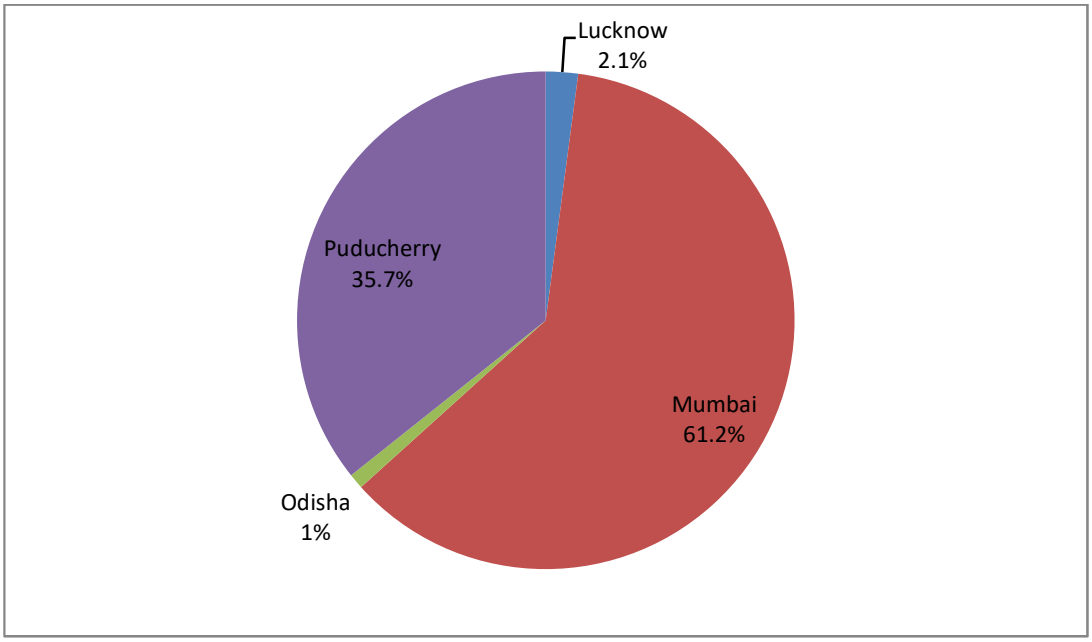
Table 49: Comparison of Suicidality scores across subsections of LGBTQIA+ community

Scale	**Lesbian Mean (SD) n= 35**	**Gay Mean (SD) n= 289**	**Bisexual Mean (SD) n= 150**	**Transgender Mean (SD) n= 500**	**Test statistic F**	**p**
BSSI	3.94(6.30)	3.35(4.87)	2.51(4.31)	10.93(9.96)	50.83	<0.001

Table 50: Comparison of Suicidality scores across centers

Scale	**Mumbai Mean (SD) n= 250**	**Lucknow Mean (SD) n= 250**	**Bhubaneswar Mean (SD) n= 251**	**Puducherry Mean (SD) n= 250**	**Test statistic F**	**p**
BSSI	15.59(7.73)	5.44(3.24)	1.08(3.74)	5.98(10.39)	194.91	<0.001

Figure 24: Suicidality prevalence across centers



6.5.4 Substance use

- The pattern of substance use varied among different communities. Substance use risk was stratified into low/moderate/high risk. Moderate or high risk users require clinical intervention.
- It was observed that out of 1001 participants of the study, 560 (55.9%) reported using tobacco ever in their lifetime, while 609 (60.8%) reported using alcohol ever. 159 (15.8%) reported using cannabis, 60 (5.9%) reported using sedatives, 30 (3%) reported using inhalants, 7(0.7%) reported using amphetamines and hallucinogens each, and 4 (0.4%) reported using cocaine and opioids each.
- There was a significant difference between different communities in the pattern of use of different substances.
- The most common substance use disorder was that of tobacco followed by alcohol, cannabis and sedatives.
- Tobacco and alcohol use disorders were more prevalent in the bisexual community, with tobacco use disorders in 71% of the population and alcohol use disorders in 53.3%.
- On the other hand, cannabis, inhalants, and sedatives were used in a risky pattern by transgenders.
- n=6, 0.6% were injection drug users.

- Substance use varied across different centers as well, with all the four major substances like alcohol, tobacco, cannabis, inhalants, and sedatives being used in harmful use/dependent patterns by the individuals from Lucknow center. Apart from this, tobacco use was significantly high in Bhubaneswar, while alcohol and cannabis use were significantly high in Puducherry. There was no significant difference in the pattern of inhalants used across centers.

Overall, in addition to mental health issues, we found substance use quite prevalent in this population. Our study showed lifetime use of tobacco, alcohol, cannabis, and sedatives in 55.9%, 60.8%, 15.8%, and 5.9% population, respectively. On assessing the dependence pattern of substance intake, the majority had alcohol dependence, followed by cannabis, sedatives, and tobacco. This is slightly different from national statistics, which suggest that after Alcohol, Cannabis and Opioids are the next commonly used substances as per the Magnitude of Substance Use Survey in India (*Survey Report.2019*). Data from the 2020 National Survey on Drug Useand Health (NSDUH) suggests that 21.8% had alcohol use disorder in the past year, and 41.3% reported past-year marijuana use (*Substance Use and SUDs in LGBTQ* Populations*, 2017)

Figure 25: Prevalence of Substance Use Disorders in study participants

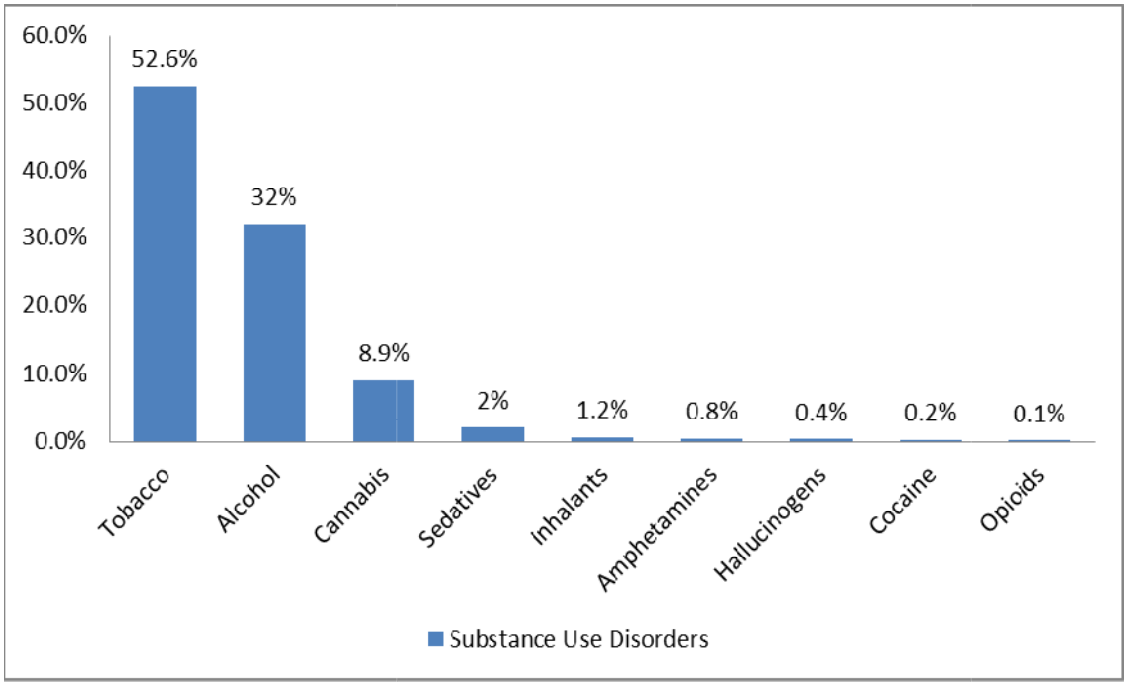


Table 51: Substance Use pattern across categories of LGBTQIA+ community

		Lesbian (n=35)	Gay (n=289)	Bisexual (n=150)	Transgender (n=500)	X^2, df, p-value
Tobacco	Ever Use	16 (45.7%)	206 (70%)	117 (78%)	203 (40.6%)	X^2= 107.93 5, <0.001*
	Current use	16 (45.7%)	186 (64.3%)	114 (76%)	203 (40.6%)	X^2=107.39 5, <0.001*
	Moderate/high risk	16 (45.7%)	184 (63.7%)	108 (71%)	197 (39.4%)	X^2=77.63 5, <0.001*
Alcohol	Ever Use	23 (65.7%)	216 (75.1%)	128 (85.3%)	216 (43.2%)	X^2=140.51 5, <0.001*
	Current use	22 (6.7%)	205 (70.9%)	124 (82.7%)	199 (39.8%)	X^2=139.737 5, <0.001*
	Moderate/high risk use	16 (45.7%)	97 (33.6%)	80 (53.3%)	113 (23)	X^2=60.61 5, <0.001*
Cannabis	Ever Use	3 (8.6%)	48 (16.7 %)	57 (34%)	52 (10.4 %)	X^2= 51..74 5, <0.001*
	Current use	1 (2.9%)	29 (10%)	35 (23.3%)	39 (7.8 %)	X^2=33.34 5, <0.001*
	Moderate/high risk use	1(2.9%)	25 (8.7%)	27 (8%)	34 (34 %)	X^2=21.32 5, 0.001*
Inhalants	Ever Use	0	8 (2.8%)	5 (3.3%)	16 (13.2%)	X^2=2.12 5, <0.001*
	Current use	0	1 (0.3%)	1 (0.7%)	4 (0.8%)	X^2=4.02 5, 0.546
	Moderate/high risk use	0	1 (0.3%)	1 (0.7%)	4 (0.8%)	X^2=1.03 5, 0.96
Sedatives	Ever Use	1 (2.9%)	25 (8.7%)	14 (9.3%)	10 (3.6%)	X^2=13.05 5, 0.02*
	Current use	1 (2.9%)	11 (3.8%)	7 (4.7%)	10 (3.6%)	X^2=5.610 5, 0.345
	Moderate/high risk use	1 (2.9%)	8 (2.8%)	0	10 (3.6%)	X^2=5.26 5, 0.38

Table 52: Comparison of Substance Use pattern in LGBTQIA+ community across centers

		Mumbai (n=250)	Lucknow (n=250)	Bhubaneswar (n=251)	Puducherry (n=250)	X^2, df, p-value
Tobacco	Ever Use	91 (36.4%)	216 (86.4%)	148 (59.2%)	104 (41.6%)	X^2=154.74 3, <0.001*
	Current use	89 (35.6%)	213 (85.2%)	133 (53%)	86 (34.4%)	X^2=168.47 3, <0.001*
	Moderate/high risk	89 (35.6%)	210 (84%)	126 (50.2%)	84 (33.6%)	X^2=153.8 6, <0.001*
Alcohol	Ever Use	94 (37.6%)	221 (88.4%)	167 (66.8%)	126 (50.4%)	X^2=151.48 3, <0.001*
	Current use	92 (36.8%)	220 (88%)	159 (63.3%)	104 (41.6%)	X^2=168.31 3, <0.001*
	Moderate/high risk use	70 (28%)	149 (59.6%)	15 (6%)	86 (34.4%)	X^2=198.97 6, <0.001*
Cannabis	Ever Use	15 (6%)	90(36 %)	20 (8%)	33 (13.2 %)	X^2=107.43 3, <0.001*
	Current use	14(5.6%)	58 (23.2%)	18 (7.2%)	17 (6.8 %)	X^2=54.98 3, <0.001*
	Moderate/high risk use	11(4.4%)	45 (18%)	13 (5.2%)	15 (6 %)	X^2=46.65 6, <0.001*
Inhalants	Ever Use	9 (3.6%)	18 (7.2%)	0 (0.0%)	2 (0.8%)	X^2=28.23 3, <0.001*
	Current use	1(0.4%)	2 (0.8%)	0 (0.0%)	1 (0.4%)	X^2=2.01 3, 0.56
	Moderate/high risk use	1(0.4%)	2 (0.8%)	0 (0.0%)	1 (0.4%)	X^2=2.01 3, 0.56
Sedatives	Ever Use	1 (0.4%)	50 (20%)	4 (1.6%)	5 (2%)	X^2=120.37 3, <0.001*
	Current use	1 (0.4%)	22 (8.8%)	3 (1.2%)	3 (1.2%)	X^2=41.65 3, <0.001*
	Moderate/high risk use	0 (0.0%)	16 (6.4%)	0 (0.0%)	3 (1.2%)	X^2=40.55 6, <0.001*

6.5.5 Assessment of Coping Skills

Majority of the members adopt emotion-focused coping to confront stress and difficulties. Avoidance was observed to be higher amongst transgender.

Table 53: Comparison of coping patterns across categories of LGBTQIA+ community

Mean Brief COPE Inventory Score	Problem focused	Emotion focused	Avoidance
Lesbian	16.77± 4.49	23.97 ± 4.46	13.40 ± 1.68
Gay	22.76 ± 4.75	29.15 ± 4.43	14.82 ±2.70
Bisexual	23.25 ± 5.35	29.16± 5.02	15.89 ±3.28
Transgender	23.31 ± 4.29	31.87 ± 4.69	18.09 ± 4.43
Total population	22.92 ± 4.74	30.30 ± 4.96	16.57 ± 4.02

Brief Religious Coping Scale (Score 14-56)

Religious Coping style was assessed using Brief Religious Coping Scale (BRCS).

Majority of the individuals adopted a positive religious coping style such as looking for a stronger connection with God, seeking God's love and care, asking forgiveness etc.

Table 54: Comparison of religiosity across categories of LGBTQIA+ community

	Negative	Positive
Lesbian	9.63 ± 8.85	15± 2.82
Gay	5.07 ± 4.94	18.53 ± 7.45
Bisexual	4.90 ± 5.57	17.08± 8.29
Transgender	9.88 ± 7.50	17.62 ± 5.99
Total population	7.54 ± 6.99	± 6.75

6.5.6 Perceived Social Support (PSS)

The lesbian community had the lowest perceived social support, followed by transgender.

The majority of the community members got social support from friends and significant others rather than family members. This can be an indicator of family rejection of the community members as reported in the qualitative interviews.

Table 55: Comparison of social support across categories of LGBTQIA+ community

	Significant Others	Family	Friends	Total support
Lesbian	17.14± 4.95	9.83 ± 4.39	16.63 ± 5.74	43.6± 9.84
Gay	17.99 ± 7.39	12.58 ± 6.43	19.92 ±6.01	50.5±13.82
Bisexual	18.82 ± 7.73	13.99± 7.45	20.81 ±5.66	53.62±13.24
Transgender	16.84 ± 7.33	13.52 ± 7.01	16.12 ± 6.73	46.48±16.31
Total population	17.66 ± 7.36	13.17 ± 7.09	18.11 ± 6.61	48.95±15.17

6.5.7 Well Being

Well-being is a short self-reported measure of current mental well-being. Total score ranges from 0-100. Mean score of the population was 60.38 ± 21.6. Transgender reported the poorest well-being, followed by Lesbians. A total of 290 respondents (28.9%) had poor well-being, i.e., score≤50. Again, the majority of those who reported poor well-being belonged to transgender community (n=210, 72.4%), followed by gays (n=44, 15.2%), bisexuals (n=28, 9.7%), and lesbians (n=8, 2.7%).

Table 56: Comparison of well-being across categories of LGBTQIA+ community

	Significant Others
Lesbian	58.17± 21.17
Gay	66.55 ± 17.67
Bisexual	64.00 ± 18.53
Transgender	55.14 ± 23.41
Total population	60.38 ± 21.60

6.6 RESULTS- Study of Interrelationship

6.6.1 Interrelationship of socio-demographics and mental health

A. Gender and Place

The effect of place on depression, anxiety, and stress scores varies significantly across different genders. So, we conducted post hoc LSD tests.

Depression

A factorial ANOVA found a significant difference in depression scores based on both gender and place, $F=125.59$, $p<0.001$. Furthermore, a significant interaction between center and gender was found, $F=23.83$, $p< 0.001$.

- A Bonferroni post hoc test found that depression was significantly higher in transgender followed by gays, bisexuals and lesbians.
- It was also found that depression was significantly higher in Mumbai followed by Puducherry, Odisha and Lucknow.
- TG of Mumbai had significantly greater scores on depression than that of Puducherry, Odisha and Lucknow.
- Bisexuals from Odisha had significantly greater severity of depression, followed by those from Puducherry, west, and Lucknow.
- Gays and Lesbians of Puducherry had significantly greater scores on depression.

Anxiety

Factorial ANOVA found a significant difference in anxiety scores based on both gender and place, $F=120.73$, $p<0.001$. Furthermore, a significant interaction between center and gender was found, $F=30.04$, $p< 0.001$.

- A Bonferroni post hoc test found that anxiety was significantly higher in transgender and lower in lesbians. Gays and bisexuals had no significant difference in anxiety scores.
- It was also found that anxiety was significantly higher in Mumbai and lower in Lucknow. The scores were not significantly different between Odisha and Puducherry.
- TG of Mumbai had significantly greater anxiety than that of Puducherry, Odisha, and Lucknow.

- Bisexuals from Odisha had significantly greater severity of anxiety, followed by those from Puducherry, west, and Lucknow.
- Gays and Lesbians of Puducherry had significantly greater scores on anxiety.

Stress

Factorial ANOVA found a significant difference in anxiety scores based on both gender and place, $F=136.46$, $p<0.001$. Furthermore, a significant interaction between center and gender was found, $F=18.01$, $p< 0.001$.

- A Bonferroni post hoc test found that stress was significantly higher in transgender followed by gays. Lesbians and bisexuals had no significant difference in stress scores.
- It was also found that stress was significantly higher in Mumbai followed by Odisha, Puducherry and Lucknow.
- TG of Mumbai had significantly greater anxiety, followed by Odisha, Puducherry, and Lucknow.
- Bisexuals from Odisha had significantly greater stress, followed by those from Puducherry, west, and Lucknow.
- Gays from Odisha and Lesbians of Puducherry had significantly greater stress scores.

B. Other socio-demographics

- There was no significant relationship between age and mental health.
- There was a statistically significant negative correlation between years of education and mental health, i.e., lower the level of education, the higher the scores of depression ($r = -.17$, $p<0.001$), stress ($r = -.17$, $p<0.001$) and anxiety ($r = -.16$, $p<0.001$).
- There is a significant difference in mental health scores between participants with different marital statuses. Divorced, separated, and single individuals had significantly greater depression ($F= 21.46$, $p<0.001$), stress ($F= 17.61$, $p<0.001$), and anxiety ($F= 14.69$, $p<0.001$) scores than married or widowed individuals.
- Income was negatively correlated with all mental health scores ($p<0.001$)
- Depression scores did not vary significantly between individuals from nuclear and extended families but were significantly greater than individuals staying alone and those belonging to joint families ($F= 75.85$, $p<0.001$)
- Stress – Nuclear = Extended > Staying alone > Joint ($F= 77.01$, $p<0.001$)
- Anxiety scores were significantly higher in individuals from nuclear families ($F= 55.61$, $p<0.001$)

- Urban population had significantly higher mental health issues ($p<0.001$)

C. Occupation

- The occupation had a significant impact on mental health. The depression, anxiety, and stress scores were significantly different between different types of employment.
- Maximum scores were in the skilled workers, professionals, and unemployed groups. This difference can be understood by the heterogeneity of the study sample in terms of employment. Bonferroni post hoc test revealed that while there was a significant difference in anxiety levels between the unemployed group and clerical, shop owner ($p=0.005$) and semi-professional workers ($p<0.001$), there was no statistically significant difference in anxiety across other occupation groups. Stress scores also followed a similar pattern ($p<0.001$). In addition, depression scores were significantly different between unemployed and unskilled workers ($p=0.007$).

Table 57: Correlation between occupation and mental health

Scale		**Depression**	**Anxiety**	**Stress**
Employme -nt Status	**Unemployed**	19.37(13.39)	14.58(11.19)	20.06(13.65)
	Unskilled	16.05(11.55)	12.81(10.71)	17.24(11.99)
	Semi-skilled	17.43(11.77)	13.93(9.73)	18.30 (11.33)
	Skilled	20.28(9.76)	17.83 (10.17)	24.18 (10.04)
	Clerical, shop owner	10.70(9.50)	9.14(9.15)	12.38(10.58)
	Semi-professional	8.18(11.74)	4.94(7.78)	10.59(11.80)
	Professional	18.61(9.17)	15.30(8.04)	21.30(9.48)
ANOVA (F)		9.63	8.94	9.94
P value		<0.001*	<0.001*	<0.001*

Thus, overall we found that single status, lower education and income had correlation with

higher mental health scores. These findings were also found in a similar community-driven survey in Hong Kong, which found that those who were single, had a lower monthly income, and identified as transgender women reported lower quality of life (Suen et al., 2018). Research has found that among LGB persons age 60 and older, 10% had considered suicide at some point in their lives. Of that, 29% stated their suicidal thoughts were a direct result of their sexual orientation (Irwin et al., 2014). The study done by Suen et al. (2018) also suggested that those who were younger and had lower income also expressed higher suicidality (Suen et al., 2018). However, we did not find any significant association of socio demographics with suicidality.

6.6.2 Interrelationship between mental health disorders with coping, social support and wellbeing

A. Coping skills

Problem-focused coping includes planning, instrumental support, and active coping. Emotion-focused coping includes acceptance, religion, positive reframing, emotional support, and humor. The more dysfunctional/avoidance coping includes denial, self-distraction, substance use, behavioral disengagement, self-blame, and venting. All three coping styles were adopted in the case of mental health issues to varied degrees.

Table 58: Correlation between mental health and coping styles

r, p	Problem Focused Coping	Emotion Focused Coping	Avoidant Coping
Stress	0.264,<0.001*	0.434,<0.001*	0.430,<0.001*
Anxiety	0.316,<0.001*	0.501,<0.001*	0.461,<0.001*
Depression	0.227,<0.001*	0.433,<0.001*	0.441,<0.001*

B. Social support

Perceived social support was negatively correlated with stress, anxiety, and depression scores. Participants, who scored higher in depression, stress and anxiety had significantly lesser perceived social support.

Table 59: Correlation between mental health and social support

r (p)	PSS Score
Stress	-0.14, <0.001*
Anxiety	-0.14, <0.001*
Depression	-0.11, <0.001*

C. Well being

Well-being was negatively correlated with stress, anxiety, and depression scores. Alternatively, higher the mental health issues lower the wellbeing.

Table 60: Correlation between mental health and wellbeing

r (p)	WHO well-being Score
Stress	-0.13, <0.001*
Anxiety	-0.17, <0.001*
Depression	-0.21, <0.001*

We found participants who scored higher in depression, stress, and anxiety had significantly lesser perceived social support. The perceived social support was specifically lower among lesbians and transgender people, as discussed previously. Research has shown community connectedness to be the strongest protective factor for mental health impairments (Inderbinen et al., 2021). It is possible that high levels of stigma may lead people to internalize negative beliefs about themselves, and this internalized stigma may, in turn, affect their ability to recover from stressful events, leading to maladaptive coping strategies.

6.6.3 Correlates of Suicidality

A. Mental Health Disorders

A positive correlation was observed between suicidality scores and mental health issues.

Table 61: Correlation between mental health and suicidality

r (p)	BSSI Score
Stress	0.37,< 0.001*
Anxiety	0.35, <0.001*
Depression	0.39, <0.001*

B. Coping skills

Suicidality was negatively correlated with problem-focused coping and positively correlated with emotion-focused and avoidant coping. It is evident that participants harboring suicidal ideations tend to adopt dysfunctional coping strategies like denial, self-distraction, substance use, behavioral disengagement, self-blame, and venting.

Table 62: Correlation between Suicidality and coping styles

r, p	Problem Focused Coping	Emotion Focused Coping	Avoidant Coping
BSSI	-1.05, <0.001*	0.16, <0.001*	0.53, <0.001*

C. Religiosity

Suicidality was negatively correlated with positive religious coping and positively correlated with negative religious coping strategies.

Table 63: Correlation between Suicidality and religiosity

r (p)	Positive Religious Coping	Negative Religious Coping
SSI	-.29, <0.001*	0.46, <0.001*

D. Perceived social support

As expected, individuals with low perceived social support had higher Suicidality. Social support is a proven protective factor for suicides. Thus, leveraging social support may play an important role in the prevention of suicides in the community.

Table 64: Correlation between Suicidality and social support

r, p	Perceived social support
BSSI	-0.299, <0.001*

Research has found that among LGB persons aged 60 and older, 10% had considered suicide at some point in their lives (Irwin et al., 2014).A recent systematic review revealed a consistent relationship across studies between suicidal behaviors among LGBTQIA+ and symptoms of depression, gender-based victimization, and bullying, and lack of parental support (Bochicchio et al., 2021). In our study, we found suicidality in 9.79% of individuals. The majority of the populations reporting severe suicidal ideation were from the western part of the country, followed by Puducherry, north, and Odisha, in line with national suicide statistics (NCRB, 2021).

Apart from having mental health issues, we observed that people with higher suicidality adopted poorer coping strategies (emotion-focused and avoidance) and had negative religiosity. These findings expand the role of sexual and gender minority stigmas by showing that they not only directly affect mental health but also may indirectly influence mental health by reducing both resilient coping and perceived social support. Hence, targeting community awareness and adopting stigma reduction strategies can improve the mental health outcomes of this population. Minority stress theory also suggests that social support and connection to one's community often act as protective factors in the face of minority stress (Meyer, 2003).

6.6.10Correlates of substance use

A. Mental health disorders

People with substance use disorders may have other mental health disorders, and people with mental health disorders may also struggle with substance use. This bidirectional correlation

was seen in tobacco, alcohol, and cannabis use, which were significantly correlated with stress, anxiety, and depression scores.

Table 65: Correlation between mental health and substance use

r, p	Tobacco use	Alcohol use	Cannabis use
Stress	-0.299,<0.001	-0.296,<0.001	-0.105,0.001
Anxiety	-0.291,<0.001	-0.286,<0.001	-0.068,0.032
Depression	-0.296,<0.001	-0.290,<0.001	-0.087,0.006

B. Coping skills

Coping styles varied among different substance users. While tobacco and alcohol users significantly used for problem and emotion-based coping. Cannabis users typically used avoidance methods as well as problem-focused methods. This indicates the more dysfunctional methods adapted by cannabis users, necessitating the need of intervention.

Table 66: Correlation between substance use and coping styles

r, p	Problem Focused Coping	Emotion Focused Coping	Avoidant Coping
Tobacco use	-0.203,<0.001	-0.191,<0.001	-0.036,0.260
Alcohol use	-0.240,<0.001	-0.182,<0.001	-0.052,0.102
Cannabis use	-0.101,0.001	-0.033,0.291	-0.109,0.001

C. Religiosity

Irrespective of type of substance, both positive and negative religiosity was adopted by individuals.

Table 67: Correlation between substance use and religiosity

	Negative Religiosity	**Positive Religiosity**
Tobacco use	-0.157,<0.001*	-0.134,<0.001*
Alcohol use	-0.187,<0.001*	-0.204,<0.001*
Cannabis use	-0.110,0.001*	-0.086,0.006*

D.Well being

Alcohol use was significantly negatively correlated with wellbeing. Tobacco and cannabis use had non-significant relation with wellbeing. This might be due to most of the alcohol users were using it in a dependent pattern as contrast to tobacco and cannabis users.

Table 68: Correlation between substance use and wellbeing

	WHO Well being
Tobacco use	-0.043,0.177
Alcohol use	-0.097,0.002*
Cannabis use	-0.046,0.147

Overall, we observed community members often resort to substances to get relieve from stress which results from chronic discrimination, injustice, exploitative jobs, and micro-aggressions. Substances are used as a coping mechanism which adds to the vicious cycle of mental health outcomes and addictions. Our study suggests a need to add substance use-related interventions, along with interventions for mental health issues among LGBTQIA+ population. Beyond the direct effect of sexual and gender minority stigmas on mental health and substance use, coping styles can also act as mediators (Chakrapani et al., 2017).

6.7 Qualitative Research Findings

The qualitative aspect of the study was aimed at exploring the unique personal experiences of the community pertaining to their experience of stress either at the individual level, their own community level, or a broader socio-political level, keeping in line with the minority stress construct. The unique and specific sources of stress leading to various mental health outcomes were discussed across the lifespan. The complex interplay of gender identity, roles, family and societal expectations, meager support and generational marginalization were highlighted. The various focused group sessions also elicited the perspective of the personnel from NGOs and government set-ups associated with the LGBTQIA+ community. A phenomenological approach was adopted for data analysis, using triangulation methods to enhance the study's validity. Major themes and sub-themes were identified, and a common codebook was generated in collaboration with study partners. Furthermore, community leaders known as "Gurus" were actively involved in recruiting individuals for the FGDs and IDIs. The study successfully conducted a total of 12 FGDs (3 from each site) and 16 IDIs (4 from each site).The various group compositions for FGDs and IDI participants are discussed below.

Socio-demographic composition of participating community members

Lucknow

From Lucknowcenter, the following was the composition of participants: Individual In-Depth Interviews (IDIs) had a total of 4 respondents, with an age range from 19 to 47 years. The participants belonged to different categories, with one identifying as transgender (TG), one as lesbian (L), one as bisexual (B), and one as gay. Marital status varied among the respondents, with most being unmarried and a minority being married. With regards to their educational attainment, the majority of participants had completed high school. Vocation-wise, the majority of them were unskilled workers. The monthly income of the participants ranged from 5,000 to 25,000 Rupees per month, reflecting different economic circumstances and most of the participants lived alone.

Additionally, the research involved Focused Group Discussions (FGDs) with 3 groups, each consisting of 5 to 6 respondents of age range from 19 to 55 years. The categories represented

in the FGDs had one transgender (TG), one lesbian (L), one gay (G), and one bisexual (B) participant in each group. Except for a few married individuals, the rest of them were either single or separated. There was a mix of school dropouts and graduate levels of education. The employment status of the individuals included unskilled workers, self-employed individuals, and unemployed participants. The monthly income for FGD participants ranged from 10,000 to 50,000 Rupees per month. Similarly, the family type showed a combination of individuals living alone and some living with their families.

Puducherry

In the Pondicherry centre, three FGDs were conducted, and a total of 15 respondents, an average of 5 in each group, participated. The age range of the participants was between 18 and 54 years.

The groups consisted of three transgender individuals, one of whom worked with NGOs, one bisexual individual, and one gay individual, with no lesbian participants. There were four unmarried individuals, two separated individuals, and four married individuals.

The educational backgrounds of the participants ranged from school dropouts to undergraduates and one postgraduate. The various employment of participants included sex workers, self-employed individuals, unemployed persons, unskilled workers, a beggar, an outreach worker, a peer educator, and an executive. The monthly income of the participants ranged from Rs. 7000 to Rs. 19000 per month. About the living arrangement, two participants lived alone, three lived with their families, and five lived with the LGBTQ+ community.

There were two transgender individuals, one bisexual individual, one gay individual, and no lesbian participants in the IDIs. One participant was married, two were unmarried, and one was divorced. Two of the participants lived alone, while two lived with their families. All of the IDI participants had completed their education up to the undergraduate level. The participants had varied employment: a Bharatanatyam Master, a cook, a sex worker, and an outreach worker. Their monthly income varied from Rs. 8500 to 15000 per month.

Mumbai

The Mumbai centre, coordinated by the NGO Tweet Foundation, interviewed a total of four

participants for IDIs, ranging in age from 19 to 47 years. The participants consisted of one transgender woman, one transgender man, one lesbian, and one bisexual individual. Regarding marital status, most respondents were unmarried, with only one participant being married. Education levels varied; most participants had completed high school and some had attained a graduate degree. The participants consisted mainly of skilled and unskilled workers. The monthly income for the IDI participants ranged between 5,000 to 20,000 rupees. Notably, most of the IDI participants lived alone in their respective family settings.

The FGDs had a total of 3 groups, each comprising five participants. The age range spanned from 19 to 47 years. The composition had one transgender woman, one transgender man, one gay individual, one bisexual, and one transgender individual from an NGO. Marital status consisted of predominantly unmarried individuals, with two participants being married. Regarding education levels, the majority had completed high school and some had a graduate degree. The professions of the FGD participants consisted of unskilled workers, self-employed individuals, and unemployed individuals. The monthly income for the FGD participants ranged from 10,000 to 20,000 rupees. The majority of participants lived alone, and a few resided with their families.

Odisha

A total of 3 FGDs and 4 IDIs were conducted from Odisha. In the FGDs,an average of 5 to 6 participants were in each group. Each group consisted of one TG, one bisexual, one gay participant, and 2 TGs working with NGOs and Government bodies in various combinations.

The participants' age ranges were distributed across different groups, with age cohorts including 18-25, 20-50, and 30-55, which indicated a broad representation of age diversity in the study. In terms of marital status, unmarried participants were predominant in most of the discussions. Some groups had a mix of both unmarried and married individuals, and a few participants were separated. When considering the educational background of the participants, the majority had completed high school in most of the focus groups, while some had pursued higher education, and only a few had a post-graduation degree. The employment of the participants ranged from unskilled workers, farmers, vendors, and professionals in some cases, showcasing a wide range of occupational diversity. Monthly incomes among the participants varied; ranging from 6,000 to 30,000 Rupees. In terms of family structure, many participants lived alone in their respective focus groups. However,

some individuals lived with their families, suggesting varied family support dynamics among the participants.

Initially, the field investigator encountered some challenges in meeting with the participants, primarily because many of them worked at night and rested during the day. Additionally, those working day hours faced difficulties in participating due to their busy schedules. Moreover, some participants had reservations and doubts about the research, which were thoughtfully addressed through discussions with the community leader. With time and effort, the researcher successfully built rapport and trust, making the participants feel more at ease and ultimately comfortable in participating in the study.

The various themes and subthemes identified and discussed are as below.

6.7.1 Chronic stress and mental health implications in LGBTQIA+ community

The bilateral effect of mental health and physical health has been highlighted by the Mumbai respondents. Physical ill health arising out of chronic stress applies to the community in a more pronounced manner. Major themes that emerged from the IDIs and FGDs were the various mental health issues in the community arising at major life stages of a person who experiences gender identity issues, identification, acceptance, identity disclosure, and various levels of discrimination. The various experiences that led to “stress” resulted in poor mental health in the community are described below:

a) **Adverse childhood experiences in the community**

Childhood can be esp. stressful when one is confused about why they are different from others. Play is important toa child’s cognitive-sensory motor and socio-emotional development. The issue of confusion regarding gender and the inability to accept gender-defined roles starts hampering the day-to-day play circle of the child. Inability to enjoy gender-assigned games while playing with peers can adversely affect the emotional growth and social connectivity of a child. Some respondents described how a family or peers could label the child being “sick” for not enjoying gender-assigned play activities. Also, such children can face rebuke, discrimination, and isolation from peers at an early age, resulting in poor socialization and self-esteem. In the Indian context, which often promotes patriarchy, there are many unpleasant “slangs” associated with femineity or lessened masculinity. Such labels can stay forever and adversely affect the child's growth and personality development.

Mental health issues emerging from such stressful social interactions can result in self-isolation, ideas of self-harm, suicide attempts, distrust in others, poor self-esteem, depression, anxiety, school refusal,and academic decline. Internalizing the stigma associated with certain mannerisms or clothing choices can lead to constant self-scrutiny in such children. Unfortunately, the school curriculum is not geared to provide a safe and dignified platform for a child struggling with such issues. Neither the participants were aware of any helpline for young children who are facing gender dilemmas. Many participants suggested the importance of sensitizing young children in school to foster mutual respect and inclusivity using age-appropriate methods to reduce incidences of bullying in schools againstLGBTQIA+ children. This can go a long way to fostering positive mental health in schools and retaining such children in education.

b) **Identity formation and complexities**

From various interviews, the participants described their journey from childhood to growing up, facing challenges that were centered on either their gender or sexuality. As per them, self-identification and acceptance is a stormy journey, especially for children. There is not much information available that is child-friendly and clear, so the child goes through dilemmas, mental stress, and many other psychological issues.Even while growing up, the respondents reported continuously scrutinizing their behavior in public. They discussed the importance of constantly self-correcting their demeanor and behavior in public or social gatherings to avoid identification. Being identified by one's feminine voice or gait can bring shame to not only the individual but the entire family, who is looked down upon by their social circle. This highlights the stigma of identification, the brunt of which the individual and the family have to pay. Acceptance by society is still an important factor in community individuals, so the pressure of a dual life persists in every dimension of their social interaction. Many families are unaware of the gender issues of a growing child and raise them with biologically assigned gender norms. Hence, the child also tries to accommodate as per the family practice but eventually feels trapped and confused. Often, the child is not able to discuss these issues with the family for fear of losing support and affection. However, in some families where parents are able to sense the “different behavior” of the child, seeing the child struggle can make parents more comforting and empathetic. The respondents emphasized how early intervention at individual and family levels can provide a safer and more accommodating ground for disclosure, resulting in more support and positive childhood experiences. Making child-friendly resources and training doctors to provide a safe space to talk about such issues, esp.

for children can make this journey less damaging to mental health. This can indirectly result in better academic and social achievement for the child.

-TG Mumbai: I loved to play "shadishadi /gharghar". I used to love to play with girls but boys started name-calling me as "Baileya* "and teasing me. Family feels it is an illness and those who tease they don't care how I feel. I feel lonely.*
-TG Lucknow: I used to question "why me?" I have brothers and sisters who are normal.
-TG Lucknow: Our body does not match with our minds. This creates a lot of stress

'ShadiShadi' or 'GharGhar' is a kind of pretend game the children play, taking up gender roles and responsibilities.

c) Disclosure of sexual/gender identity and its implications

Sexual preferences and gender identification are often implicit, although adolescents still go through a period of turbulence embracing it. In the case of individuals from the community, gender identification, disclosure, and acceptance processes are extremely complex and often a psychologically draining issue alongside the usual adolescent issues. As per the respondents, theconflict of disclosure vs. secrecy about one's gender or sexuality is a double-edged sword. The negative reinforcements from society, gross dismissal of their existence, and the perception of LGBTQIA+ as a "sickness" often deter them from freely expressing their identities. The members expressed unease and hesitancy to disclose to their loved ones, esp. families. Many of them faced extreme repercussions, leading to physical and emotional violence, parents abruptly stopping their studies, and even being expelled from the family. This led to early educational discontinuation, further exploitation from being homeless, and a social boycott. Fearing such consequences, many have taken extreme measures to hide their sexual /gender identities. The fear of social rebuke and boycott often suppresses the freedom to express, dress as per one's own choice, and engage in romantic relationships. The community members shared grave concerns about disclosure either by self or by hearsay, leading to further harassment and blackmail. In some cases, the individual is targeted as they are presumed to be a sexual minority. This can range from the perpetrator making financial demands to sexual abuse in potentially dangerous situations. Coaxing for unnatural sexual acts, group sex, unprotected intercourse, forcing intercourse under intoxication, or with medications enhancing sexual vigor can be risky for the mental and physical health of the community persons. This makes them highly vulnerable to STIs (Sexually Transmitted

Illness). At the same time, they expressed their helplessness as they don't feel supported by lawmakers and police. The public outrage and rapid action by police in case of sexual assault towards a female victim is relatively swift, but such response is not seen if the victim is a sexual minority or transgender. In one such instance, as recalled by a participant from Mumbai, a community person's fingerprints and educational documents were confiscated by the perpetrator in exchange for money. He was blackmailed about his sexual orientation. He almost thought of selling his kidneys to pay the blackmailer. This reflects the magnitude of exploitation and abusive treatment this community faces, forcing them to stick to a dual life under immense stress, leading to mental health issues. Navigating the complexities of expressing romantic interest within the LGBTQIA+ community can be incredibly challenging and, at times, downright daunting. Unlike heterosexual individuals, those in the LGBTQIA+ community often have to face a barrage of hurdles, including the very real fear of bullying, shaming, and discrimination from their peers. Living with this constant hyper-alertness can be mentally and emotionally exhausting. Every word, gesture, tone, and posture is carefully analyzed and weighed to avoid reinforcing harmful stereotypes that society might associate with their identity. They always felt being on edge, always trying to protect themselves from potential harm or rejection. This chronic state of stress takes its toll, impacting their mental and physical well-being. The pressure to keep their true selves hidden and the fear of being judged or rejected by others can lead to heightened anxiety, depression, and other stress-related issues. It's like carrying an invisible burden every single day, and it's not an easy weight to bear. For some, this hyper-vigilant approach to life can even lower their threshold for perceiving threats. They become so accustomed to facing challenges that their minds are always on alert, ready to protect them from potential harm. It is a survival mechanism born out of the need to navigate a world that might not fully accept them for who they are.

The Odisha group reported of a particular group of TGs called "Bahurupikinnar" which is a term used for persons who do sex work temporarily for money at roadside and behave as straight persons at other times. However, the reason of such a choice was not elaborated.

-TG Odisha: I am always aware of the way I talk or walk. I can't tell anyone. No one will understand and in fact they will rebuke and bully me. I can't sleep being under constant stress. I am unable to do my homework. I sometimes don't feel like eating too. Because of this I fall sick very often.

d) Differential experiences of stress in LGBTQIA+

Various subgroups of the LGBTQIA+ community have some common as well as unique stressors in life. Respondents from the bisexual and gay community, specifically from Mumbai, shared their ways of being able to camouflage their identities, but the pressure for maintaining dual identities often takes a toll on their mental health. They often become the targets of hate and discrimination based on their sexuality.

On the other hand, the bisexual group acknowledged the multifaceted trauma the transgender community goes through at each juncture of life. The respondents from Odisha reported that the transgender community faces particularly complex issues compared to the L/G/B community. For example, Sex reassignment surgery, although the most preferred outcome for them, has its own implications. The healing period from surgeries can be many months to years for some. Gender assignment surgeries are often done at various stages, e.g., breast reconstruction/reduction, genital reconstruction, etc. It can have various physical limitations as well. Following surgery and enhancement of certain body aspects, they perceive as being more vulnerable to sexual harassment and discrimination while using public transport. This again indicates the conflict between inner desirability and closeness to preferred gender vs. the societal oppression and harassment once their identity is fully out in public following SRS. The community often feels that their existence is completely sexualized as people see them as only "sex workers", which attracts more hostility and hate crimes towards them. In contrast, L/G/B individuals may maintain a level of anonymity as their external appearance may not reveal their sexual orientation or identity. Bisexual individuals, according to the respondents, often feel compelled to hide their sexuality, particularly if they are married, due to societal stigma and taboos. They may lead a double life, presenting different aspects of themselves at home and on social networks. Gay individuals, as reported by the respondents, tend to experience less stress than lesbians. Lesbians often struggle to open up and share their problems with others due to fear of discrimination and gossip. Although they may confide in a few close friends, many lesbians are hesitant to reveal their sexuality.

- TGMumbai: When I was traveling on a bus, a lady did not even allow me to sit for 30 minutes. Even though I was in a male dress, I didn't know what was wrong with me for her. She did not accept my sitting and told me not to sit there

-TG Lucknow: We are seen and treated differently everywhere be it at home, work or outside.

-TG Odisha: I faced a lot of issues in transportation. They chase us when we go home, work

and ask for sex. If I don't agree they kick my bike, kick me, pull my dupatta and hit me with their bike. I have fallen off my bike thrice like that.

-TG Lucknow: Even if a police sees us at night, he/she thinks that we don't need protection as they assume that we are out for sex work only.

e) Suicidality in the LGBTQIA+ community

While discussing mental health issues, respondents also discussed their perception of suicide among the community members. A complex multifactorial issue, suicide, in this community is amplified by the minority stress dimensions. Social isolation, chronic helplessness, and unending struggles at every front of life make these individuals more vulnerable to suicide.

The respondents from the Mumbai and Odisha groups were more vocal about the issue of suicide. Often, harassment plays an important trigger for suicidality. According to the respondents from Odisha, sexual harassment against sexual minorities is a complex issue of power dynamics between the common public and marginalized LGBTQIA+ individuals who have no voice for their rights. Untoward and exploitative sexual advances by people and sexual acts can result in physical issues that they are unable to disclose at home, leading to helplessness and suicidal thoughts. It is crucial for law-making agencies to form policies that safeguard their safety against sexual harassment. Societal non-acceptance and discrimination, demeaning, and offensive behavior further isolate them, leading to suicidal thoughts. The lack of family acceptance plays a significant role in suicidal behavior. When people face stigmatization at their workplace, educational institutions, and even within their own family, they feel they have nowhere to turn, leading them to contemplate suicide. To better understand individuals who are gender non-conforming, parents must prioritize understanding their children's wishes towards life. Unfortunately, due to shame, many parents may punish their children, resulting in suicide in extreme cases. Therefore, creating a safe and accepting environment that fosters open communication and acceptance within families is crucial.

The respondents from Odisha identified several reasons behind suicide, including interpersonalconflicts and breakups with romantic partners. Additionally, family and societal pressure to conform to traditional gender roles often leads to forced marriages and subsequent adjustment issues, resulting in feelings of shame and helplessness that may lead to suicide. They also reported that in Odisha, many used kannier (Nerium oleander) seeds with jaggery as a method of choice to commit suicide. Furthermore, the lack of emotional support for LGBTQIA+ individuals exacerbates social isolation, which is a significant risk factor for suicidal behavior. The inability to socialize and engage in recreational activities without

worrying about safety and discrimination restricts the ability of LGBTQIA+ individuals to relieve stress, which may contribute to suicidal thoughts. Discrimination and sexual advances based on stereotypes from the general public limit the basic freedoms of LGBTQIA+ individuals. In contrast to non LGBTQIA+ individuals, who have more opportunities to relax and reduce stress, LGBTQIA+ individuals are more prone to suicidal behavior. Transgender individuals face even more significant challenges as they are often unable to visit public recreational spaces without fear of being targeted or approached for sexual favors by men. The participants highlighted several critical periods in an LGBTQIA+ individual's life that can increase their susceptibility to suicidal behavior. Late adolescence, particularly during college, is a time of immense change and social interactions. It is also when one begins to recognize and accept one's sexuality, which can make them feel different and strange, potentially leading to suicidal thoughts. The second critical period is around the age of 25 years and beyond, when social pressure to conform to societal norms, such as marriage, becomes more pronounced, leading to feelings of suffocation and helplessness that can result in suicide. According to many participants from Odisha, gender identification and disclosure, as well as acceptance by society, pose a more significant risk of suicide than any other period. However, many participants also expressed a belief that life is a gift from God and should not be prematurely ended by one's own hand, even in the face of external challenges.

The respondents from Mumbai expressed the need for psychological interventions, and life-skills programs should be implemented, and support programs for parents of LGBTQIA+ individuals should be made available. Mental and emotional preparation for an LGBTQIA+ individual regarding bodily changes and creating safe spaces to discuss them is essential. A healthy dialogue should be encouraged as a part of family therapy, particularly regarding social pressure and the consequences of forced marriages.

Despite increased awareness, stigma and discrimination towards sexual minorities still exist, leading to negative attitudes and micro-aggressions that can trigger suicidal thoughts. These experiences can be particularly damaging during childhood and adolescence, leading to reduced resilience and poorer coping mechanisms in the long term. However, early intervention through life skills programs may help individuals in the community develop better coping strategies.

Respondents from Odisha highlighted the need for government and police helplines to provide emergency support to the most vulnerable members of the LGBTQ community. They emphasized the value of awareness and counseling to help prevent suicide and support those who may be struggling.

To cite few responses:

-Bisexual Mumbai, 23 years old: After work people see us differently, do many nasty things to uswhich we suffer silently. We can't even tell in our family. We feel helpless and think of suicide.

-Transgender Mumbai: Any other person can easily relax in a bar or beach after a bad day. For us, we have to constantly hide or feel threatened. If a trans-person goes there then they are called for sex or teased .We have no place to be on our own and relax.

-Gay Mumbai: Under extreme stress my mind stops working, i don't feel the point of living any more, life seems meaningless. Sometimes I feel like doing drugs or committing suicide.

-Transgender Mumbai: As a kid you just cry and are helpless. But once you go to college, the body changes and so many things are there. We can't seek help. Struggle starts there and then you think of suicide.

- Gay Lucknow: We can't tell at home because they won't accept us. So often the thought of suicide comes to mind.

-TG Lucknow: Due to living in such stress and depression all the time, suicide seems an easier option

6.7.2 Substance use in the community

Respondents from various centers reported that marginalized communities commonly use substances such as tobacco, alcohol, brown sugar, and cannabis. They view substance use as a result of chronic discrimination, injustice, exploitative jobs, and micro aggressions that create a sense of frustration and poor mental health. Lack of support and a cohesive atmosphere further exacerbates the emotional pain, leading to substance use as a coping mechanism. This creates a vicious cycle of addiction and mental health outcomes within these communities, which is worsened by seclusion and isolation. Additionally, community members often do not share their specific adverse issues with family, leading to the use of substances to ease emotional pain, resulting in financial loss and depression. Apart from self-realization about orientation or gender, which itself is a stressful period, community members face implications following disclosure, too. After disclosure, the social circle is restricted as people following a social boycott. They are likely to go into addiction that leads to further isolation and loss of job.

Most of the transgender addicted to substance abuse because of the insult they face in this society. For example if they go for begging for their livelihood, there were people who don't Immediately give money but rather insult and ask them to leave the place. These insults push

them to consume alcohol, use tobacco products or marijuana etc.

Furthermore, they attributed the use of the substances to a lack of fulfilling long-term relationships, loneliness, and breakups with romantic partners. These are the risky timelines for initiating substance use. Peer modeling during stressful times also makes substance use a preferred coping mechanism. Interestingly, individuals who did not take substances viewed it as a personal responsibility and a bad habit. The use of substances not only causes financial loss but also pushes individuals further down the social ladder. Behavioral and physical changes under intoxication can be embarrassing, inviting stigma for the families of such individuals. Addiction-related behaviors such as stealing and aggression at home are difficult to control, highlighting the minds hijacked by addiction. Moreover, high-risk sexual behavior under intoxication, when individuals forget to use condoms while engaging in sex with random partners, was a concern shared by them. Many lost their close friends to HIV as well, which they feel was secondary to rampant sexual activity under intoxication. Participants mentioned the negative impact of substance use, especially on the behavior of individuals under its influence. In one instance, a respondent from Mumbai reported using substances to cope with distress after realizing their bisexual status but experienced negative effects such as lethargy and loss of motivation to work. The detrimental impact on mental health was also acknowledged by some participants. Substance use can lead to further isolation within the LGBTQIA+ community and society at large. During intoxication, individuals are more vulnerable to exploitation, as reported by a few respondents. Additionally, substance use can lead to loss of reputation, social stigma, and social isolation, which can also affect the LGBTQIA+ individual's family. It can cause rupture of relationships, loss of social affirmation, and collateral stigma towards the family of the LGBTQIA+ person. The respondents also highlighted that many were aware of the ill effects, esp. the behavioral effects of intoxication among their peers. People often address them as "Bewada/ nasheda".

One respondent from Mumbai stated that the community is aware of the negative outcomes. For example, one witnessed a friend who developed depression subsequent to his substance use andis now under psychiatric treatment. And one member completed suicide because of it.

According to the respondents, substance use may initially provide a relaxing effect but can lead to harmful consequences later on. Breakups are a common trigger for substance use, increasing the risk of falling into addiction. Individuals struggling with substance use often get into financial debt to procure drugs, which impact their jobs and health, leading to additional expenses. The community members express concern that this trend is growing, leading to the loss of good friends and sabotaging their social circle. A high rate of being

sacked from a job because of addiction is also common. They said that those who take substances for intoxication behave differently than others; upon consumption, they feel empowered and strong. Often, those kinds of people turn to violence or harm to themselves and others. Those people also reveal those kinds of things which should be kept secret from others.

Substance use for many, as reported by the Gay participants from Odisha, is a learned and eventually automated response to difficult and stressful situations. Substance-based coping over powers all existing support systems when an individual is extremely stressed. However, members remind themselves of the adverse outcome of it and refrain from it.

(It is pertinent to note that in many FGDs from Odisha, the participants were quiet and giggled among themselves when the issue of substance use was raised and laughingly pointed fingers at each other)*

To quote a few responses:

-TG, 30 years: I drink to relax myself. I have problems in education, job, rental house, transport etc. To get rid of everything and to sleep peacefully, I drink. To tolerate the pain during sex and to forget the insult I drink.

-Gay: When some people are depressed, they are into alcohol and rampant sex with many partners. They even forget condoms. I have lost couple of friends to HIV.

-TG, 28 years: Yes, sometimes when I feel stressed or a bit of low mood, I consume tobacco and have a few drinks. Sex work gives me satisfaction. It's in my habit. I can get upset if I don't get it in the time of need.

-TG, 23 years: We take alcohol to forget the pains given by family, society and loved partners

-TG, 34 years: If we are under the influence of alcohol or other tobacco substances, we can somehow tolerate the insult. Hence, we do so.

-TG, 28 years: Most transgender people are addicted to substance abuse because of the insult they face in this society. For example, if they go for begging for their livelihood, there were people who immediately give money, insult and ask them to leave the place, shout at them, make us wait for longer periods and say no money, etc.; these insults push us to consume alcohol, use tobacco products or marijuana etc., To forget all those insults we choose substance abuse to forget the pain we have.

-Gay Mumbai: Community is aware of the negative outcomes of drugs. Still do it. I have witnessed a friend who developed depression subsequent to his substance use and now under psychiatric treatment, and one member completed suicide because of it.

-Bisexual, 20 years: When I realized I am bisexual, it was difficult. I started doing drugs despite people warning me. It got worse and started affecting my near ones and my job.
-Gay Lucknow: I have many friends who smoke when they are depressed. Many friends also takedrugs.
-TG Lucknow: People drink when they are in tension. Some smoke cigarettes and joints also

6.7.3 Challenges faced by LGBTQIA+ community

a) Family non-acceptance, hostility and withdrawal of support

Non-acceptance by the family after disclosure is a main event in this population, which results in the rupture of various needs, putting an individual in significant anxiety, insecurity, and uncertainty around making a living. Families often have a misunderstanding/misconception of their status as an illness acquired by being in the company of transgender. Some community people receive inhuman treatment and "shock treatment" to change their gender or sexual orientation. Odisha respondents revealed that often, the community members feel that their interaction or presence within the family brings societal shame, and the family is being blamed for their identities. This might further rupture the relationship with the family and ultimately seize the support system from the family.
Transwomen from Mumbai reported that they are born male, and hence there are a lot of expectations from the parents that they must be the primary bread earners of the family. They are also expected to marry and spread their family roots further. However, some respondents also reported the positive aspects of the family. Some families are supportive, which plays an important role in a positive mental health outcome in the community. Respondents reported a positive aspect of family support, especially during crisis.
Some examples are given below:
- One member of Mumbai narrated his ordal as he had to identify as a woman but had to disclose when the pressure of marriage started building up. The family did not accept it, and the individual was considering suicide. However, he chose to leave his family and start living independently.
- TG Puducherry: We can visibly see discrimination in the home from the food itself. If a maleand female child is there, they will give more food to their male child. When it comes to us, they won't give us food itself. They will give 3 fish to a male child, one to a female child, and none to us.
- TG Puducherry: When my mom and uncle came to know, my uncle beat me up a lot. For

3months, I was locked up in my room. My mom beat me up regularly and said its better if I die rather than being a transgender

- TG Odisha: They feel ashamed of us when we go outside, because people outside blame them for our behavior.

- TG Odisha: My family supports me in my decisions and gives me emotional support as well.

- TG Puducherry: Since LGBTQIA+ is a minority community; our issues are not even addressed properly. We can write a lot about them and speak about them too. But the change happening is very minimal here. How the SC/ST suffers in this society, likewise we were also suffering. But the protection they get was not given to us. We are not accepted by our own family members itself.

b. Challenges in education fulfillment

One of the recurrent themes in the various center participants was the issue of early dropout from education. A big hurdle is discrimination and non-acceptance on the educational front. Poor academic achievement decides the further life trajectory of these individuals. As per the respondents, retention in education and achieving basic essential qualifications was an important aspect of having better job opportunities and financial security. Following dropping out of school and the withdrawal of family support, the young members become more vulnerable to exploitation and life adversities. They quickly have to choose the option of begging or sex work for survival. Many schools/colleges don't allow T people to take admission and force them to wear uniforms designed for boys and also appear like them by cutting hair. Teachers should make children aware of Transgender people as well. The respondents also suggested the need to sensitize school authorities and children regarding the existence of other sexual or gender minorities to foster a more inclusive and conducive environment. The respondents highlighted the role of family and school in forming a supportive buffer if they want the community children to pursue education. The community faces discrimination from schoolteachers, too. However, some schoolmates do make them feel better despite the discrimination, which creates a sense of loneliness.

Some examples are given below:

- TG Odisha: The worst phase comes after dropping from school, like lack of family support and taking up risky jobs. At least in school we don't face much of the reality. Till schooling, we didn't think of suicide too.

-TG Mumbai: There is discrimination everywhere; school, college, workplace and family. We

are forced to opt for wrong choices such as drugs, self-harm or bad company. It affects our mental health a lot.

- TG Odisha: Education is a main challenge. Whatever other boys and girls do, we can do the same. But we don't get enough scope.

- TG Mumbai: I was teased at school for my manly dressing. When I came out and opted for a haircut, family told me "you are a girl. This much studying is enough for you" They stopped my education.

-TG Odisha: Government has not done much. Even to enter any job, 12th std. is minimum requirement, which most of us don't have.

-Gay Mumbai: I was very lonely in the school as I didn't know what was happening. A friend of mine and my own brother gave me comfort.

-Lesbian Mumbai: I never had any teacher who was supportive. I had a teacher in my college who always questioned my dressing, talking and walking. This has a huge impact on education. I went through a lot of stress.

-TG Odisha: Teachers and students should be made aware about us, so that we feel comfortable at school and don't drop out.

c. Work and employment related challenges

Lack of job opportunities

Even though many of them wanted to pursue better careers, they found companies still functioning in a gender binary way and not promoting inclusivity for the LGBTQIA+ community despite their qualifications in some cases. The stigma and discrimination flavored by prejudices often make the member's entry into a job very difficult. Even if some states are promoting inclusivity, it is still very rare. For e.g., a Mumbai respondent reported feeling surprised that in a small town of Maharashtra, a TG was recruited into the police force, but that doesn't happen in metros like Mumbai, which seems more evolved and accommodative on the surface. Also, due to low economic status, most people are unable to start a business of their own. The respondents from Odisha also reported that TG people are getting employed in a few jobs by the government, such as ticket collectors in municipal parking lots, sweepers and cleaners, trash van drivers, etc. But many of them remain unemployed.

- TG Puducherry: I applied to a private hotel for training. After I disclosed that I was transgender, they rejected me. They told me the hotel's reputation would spoil, guests won't come, organization culture will not be good etc."

- Bisexual Mumbai: I feel he is a human being. He can do anything. I used to work in many fields as a welder, customer office, artistic manager, housekeeping and management at diff places. Every kind of work is important for us. We can do anything.

Restricted and exploitative jobs

While being out casted by society and family, they tend to be supported by their community. Begging in trains or sex work was often the vocations they would pick up mainly so in TG community. This was a common practice seen among the TGs from Odisha. Even these job roles make the members prone to many kinds of exploitations and harassment. Moreover, those in sex work reported that sex work is one of the challenges faced by LGBTQIA+ community. Though it's by their choice and they earn through it, sex work is associated with stress and tension. Most often, they don't get time to relax and sleep stress-free.

Community members' restrictive choices of job roles are largely based on internal biases and self-limiting ideologies as suggested by some members. If members reflect confidence and assertiveness, employers may choose them for diverse job roles involving skilled communication skills and manual hard work. However, the members restrict themselves to jobs requiring soft skills. On the contrary, they can do any kind of work. The internalized limitation of self can translate to public perception of the fact that the community is meant for very selective job roles. This will indirectly restrict job diversity and inclusivity in various jobs.

- TG Puducherry: When we go for begging, they will ask us why you don't work. Aren't you ashamed tobeg like that? To be frank, the truth is we don't get jobs. I tried in 2 companies before I joined this. One company told, we will not provide job to transgender, other company supervisor told, sleep with me, I will provide job. If no one comes forward to provide jobs, then what else we can do apart from begging.

-Bisexual Mumbai: Nowadays many multinational companies are there. There is soft work vs. hardwork. The community itself should embrace hard work too like plumbing, house work, computer repairing. Restricting job choices are inbuilt limitation of an individual. E.g. I am a gay, I can softenmy voice and work in call center, but I should be open for any other hard work with confidence, then only employers will trust me. In that too, I have to prove them.

-TG Puducherry: If we make products out of our efforts that is not accepted by this society for its genuine selling price. If the other gender sells the same product, they accept it for Rs.

100, but if we make the same product, they will ask for Rs. 80 only. I really wonder what makes them judge us like that.

-TG Puducherry, 28 yrs: If disabled or old age men beg, people will put money to them, but if they come across as transgender, they will not. Either they will be abusive or advise them. Very few give money.

Prejudices and biases of employers and workplace discrimination

The respondents perceived the prejudice of employers towards the community members during job interviews. Feminine voices or certain gestures were subtle identifiers of their belonging to the community. Social biases regarding the restricted job choices of the LGBTQIA+ community so far make employers prejudiced. Even if selected for a certain job role, the community members often get a position much lower than their competencies despite these barriers. Despite being employable, various discrimination and micro aggression, bullying, sexualized remarks, and boundary violations take place at the workplace. A higher qualification does not translate to a higher position in jobs as experienced by many community members. They are often given low or medium cadre roles and never leadership roles. One reason is the judgmental attitude and age-old stereotypes defining the community members. Rather than focusing on one's competencies employers often are opinionated by certain characteristics like a feminine voice. Protracted marginalization and portrayal of the community in a stereotyped manner has led to stigma, undermining their potential, and leading to self-scrutiny and depression. However, one respondent (TG) in Odisha reported a positive workplace experience, as a similar experience was reported by a participant from Mumbai (BS).

- Gay Mumbai: It's not that we don't know how to work. Give us feedback based on our work, butnot based on our voice or demeanor. They see us in a dirty way. We want to take steps a head butpeople pull us back with such remarks, don't know what to do. We don't have many job options left.

- TG Odisha age 30 yrs: We are as capable as they are, but due to public pressure and indifferent treatment from others LGBTQIA+ people feel mentally ill. Due to which a person's interests in his workgets declined gradually. Due to constant scrutiny and criticism from others a person feels heartbroken and depressed to work.

- TG Odisha: I have been treated well and with equality at workplace, my colleagues liked me and my work despite knowing about my sexual orientation. I have been treated well and

worked with dignity.

- Gay Mumbai: Some work colleagues esp. women find more safe and confident in our company. This stand for bisexuals and gays too as we feel more safe and accepted among females.

Disclosure at workplace

Regarding the issue of disclosure at the workplace, these respondents had differing viewpoints. The study participants from Mumbai were exposed to corporate culture more than any other center. Some members described the positive outcome of disclosure at the workplace and actively advocated for the community by spreading awareness in the workplace. On the other hand, some members disclosed it after a hiatus of 15 years and felt it neutral. Most of them were uncomfortable with disclosure, expecting a negative aftermath. However, they highlighted the importance of professionalism and boundaries at the workplace. He had to be extra careful in their demeanor to avoid being identified.

-Bisexual Mumbai: Keeping professional boundaries at workplace helps. Many don't want to disclose, keeping boundaries regarding personal information sharing helps in such situation.

-Bisexual Mumbai: We can face bullying and discrimination on disclosure in job place. Many prefer not to disclose.

-TG Odisha: Yes, at first, I was hesitant to reveal my sexual orientation to others at work. Society was not accepting it before. Family members were also against me but now everything has changed since then. I disclosed my sexual orientation to colleagues only at the age of 45 some 15 years before.

-Bisexual Mumbai: Recently coming out from the outset has been a positive experience, encouraged by motivational speakers and philosophy of highest value to human life, and respect towards human. Now the workplace is very positive as well as inquisitive to know the inner life of sexual minorities.

Workplace harassment

The respondents from Mumbai spoke about sexual harassment, discrimination, and issues of forced unpaid labor at the workplace.

- Gay Mumbai: I was told to cut short my hair at a coffee shop where I was working. Despite that the other employees who were men used to touch me inappropriately and drag me to

washroom, when I reported to our senior, she fired me without giving my due salary
-TG Lucknow: I am often bullied and teased at my office. People have even misbehaved with me and tried to take advantage of me.

Grievances redressal systems at workplace

The respondents who had worked or are currently working in corporate sectors, some of them activists in promoting LGBTQIA+ rights, have suggested a grievance addressal system handled by a mature person in office. The solutions should be quick, with transparent communication of the complaint in a reasonable time frame. The workplace issues faced by community members can be addressed in a cordial dialogue. Indirectly, the community person should get to know that his issues are heard and discussed, too. Community people should give suggestions or grievances to the addressal system. Only then will the employer be aware of any existing issues.

-Bisexual Mumbai: There should be a complain portal led by a confident and mature person. Our grievances should be heard and solutions given. People should know what it is about us.

d. Challenges at the societal and broader policy levels

The LGBTQIA+ community faces various challenges, such as lack of family support, discrimination and inequality in educational institutions and workplaces, and negative experiences, such as exploitation and micro aggressions. This can lead to poor living conditions and increased vulnerability to diseases, as well as a higher risk of abuse and harassment. Social prejudices and media misrepresentations further exacerbate the situation and can create an aversive attitude towards the community.

TG Puducherry: In the case of transgender involved in crime, they will not mention the particular name of transgender, and they will mention it as if all of them from this community indulge in these kinds of activities which are problematic to society.

6.7.4 Religiosity

The interconnectedness of life experiences, stressors and mental health esp. cruising though difficulties and yet finding a reason to survive is often connected to the religious belief system the members uphold. Religious events provide a sense of unity and solidarity, bringing together members from various regions of India. During such events, such as when

they pray to ‘Murgi Mata’. ‘Murgi Mata’ is a deity followed all over India by the community. Annually the members of the community esp. the transgender observe this ritual gathering at one place. As per them, this is a time of the year where no one follows any hierarchy or regionalism. This also fosters a high sense unity and mental positivity in them. Many members of the community take blessings from the deity to start major life changes. Additionally, some members believe that God provides indications for them to undergo gender reassignment surgery, leading to a positive mindset. The process of undergoing SRS is accompanied by step-wise rituals that help individuals endure the phases of reconstructive surgeries. Similarly, the Pondicherry group discussed how many community members pay a visit to the Azhagar temple near Embalam. It is a way of networking and collectively offering prayers to God. While addressing the issue of suicide, some respondents equated human life to the supreme creation of God, which no one has a right to end prematurely. Religious beliefs and spirituality were discussed as protective factors against suicide in the community, too. About self-identity, some respondents gave the analogy of certain cultures ascribing a Godly stature to LGBTQIA+, e.g., Jogata/ devmanus (Karnataka/Maharashtra). The mythological characters (Shikhandi) help in some degree of normalization of their identities. These analogies preserve a sense of normality despite the hurdles.

TG Odisha: We celebrate festivals with a lot of joy and affection towards God. God is very important, and all are treated equally in front of God. Like other people, no specific bias towards the LGBTIA+ community exists at religious places.

6.7.5 Coping strategies employed by LGBTQIA+ members in face of challenges

Self-reliance and advocacy was highlighted as a way to educate young people and indirectly improve inclusivity. This was suggested by the NGOs working for the community. They said that despite government aids and measures for improving their status, the LGBTQIA+ individual should also step up and promote advocacy.

They also emphasized the importance of self-acceptance, and disclosure, to be vocal about the community challenges to get any sort of help and recognition /acceptance.

Another coping strategy discussed esp. by Transgender respondent was the perceived communitycohesion. Despite these challenges, the TG community displays strong unity and supports its members. Important to note is the Guru and Chela system followed, esp. in the Odisha and Lucknow centers, where the Guru plays a pivotal role in the member's life; he or she is usually more educated, socially connected, and has a good leadership role. Many times,

following Guru's directives only, the members embrace name change and initiate the Sex reversal surgery process. Many a times these Gurus help them for acquiring government documents like TG card, voter ID, opening a bank account etc. The followers of the community have a strong faith in the Guru's decision and feel protected and well-guided in their lives.

Despite a community support system, many cope with individual difficulties by indulging in self-care (e.g., going to the beach or driving), discussing with peers, and using humor to alleviate the emotional pain from difficult situations. Some initiate substance use at crucial time points in their life.

Varied coping strategies are used by the community members as cited below:

-TG Odisha: I don't get any support from my family. I depend on myself only for my needs. But for TG people, there is community support from their groups. Only recently, since 2014, have some initiatives been taken to support the community. That has made hardly any difference yet because mostof the initiatives are only on paper and the ones that are implemented are slow and not in enough hnumbers considering the large population.

-TG Puducherry: My community people only supported us when I was depressed. They motivate meto achieve in life. They provide solutions to our problems and guide us. They help us to get Ration card, voter id, health care, pension, gazette name change, schemes application, educational support etc.

-TG Puducherry: I get peace out of spirituality. Every Monday I go to Azhagar temple near Embalam. Most of my community comes there; we speak to each other, share our problems, relax and get to know each other

- Bisexual Mumbai: Advocacy is must and should be done. We need to put out our challenge so therwise no one will hear us out.

-TG Odisha: One can seek medical attention, it depends on one's will. If someone wants, they can control themselves of taking substance intoxication. Having sex makes me happy and releases me from stress. I meet with my peers and share my feelings with them. I also take part in many community events to get support from others. My family also supports me in my decisions and gives me emotional support as well.

6.7.6 Suggestions and future scopes

The following are the few responses upon asking for suggestions and scope for improvement:

- As per the community members, at the family level, it is crucial to educate and understand individuals from childhood about gender non-conforming identities. Parents should accept and support their children for who they are without discriminating or forcing them to conform to societal norms. This will help prevent transgender individuals from resorting to begging or sex work as a means of survival.
- Special centers should be established for transgender individuals to seek counseling, and there must be awareness campaigns to sensitize corporate and hospitals about the challenges faced by this community. Substance abuse is prevalent among them, with alcohol being the most common, and drugs also being used to alleviate depression and stress caused by trauma, discrimination, and harassment. Rehabilitation centers and counseling services can help with addiction and emotional healing.
- Transgender individuals often have low self-esteem and confidence, which they cope with by creating humor. Therefore, it is essential to provide them with a supportive environment where they can pursue their education and career goals, obtain appropriate documents with their preferred name and pronoun, and achieve financial independence.
- LGBTQIA+ community is given more preferences in screening for STDs (ease of seeking STD services. After Sec 377 was scrapped, superficially, awareness increased, but not in the true sense; still, public acceptance is not there. Movies based on LGBTQIA+ rights and health are welcomed.
- The government has taken various initiatives to support the LGBTQIA+ community, such as providing Aadhaar cards, voter cards, and e-ration cards. However, to fully benefit from these provisions, community members need to be aware of them and take proactive steps to avail them. Collaboration within the community is essential to achieve the common goal of growth and progress.
- The legal framework in India has become more LGBTQIA+ friendly after the NALSA bill, and the community is more assertive and aware of its rights. Discrimination and stigma towards the community have reduced, and interactions have better dignity. There is also a growing understanding of the importance of education and career planning.
- The community is working towards achieving marriage and adoption rights, and family acceptance and support are crucial for a better future. Many NGOs actively

support the community, and community members themselves take self-led initiatives to bring about further positive changes towards equality.

- The Puducherry Government provide pension of Rs. 1500 to transgenders who have Aadhar card sand other documents.
- The LGBTQIA+ community requires support in terms of job opportunities, employability, and up skilling as their needs are increasing. Similar to women's quotas, job reservations should be made to improve self-dependency among the LGBTQIA+ population. Due to poor job retention, they are often removed from their jobs once their employers become aware of their sexuality or gender status .Therefore, better job retention and employment opportunities that accommodate their identity are necessary.
- Retention of education is crucial, as diversion to restricted and exploitative jobs is common.
- Family acceptance is also vital. The government should include chapters in the educational curriculum about human rights issues of the LGBT community to improve inclusivity among the youth of India. For instance, while the recruitment of transgender members in the police force in Kolhapur is a welcome move, it has not happened in Mumbai so far, indicating the need for uniform implementation across states and demonstrating the inequality in availability.
- Equality, inclusivity, equal opportunities, and treatment at educational centers and health services are needed to facilitate basic education. Promoting skills that the community already excels in should be encouraged rather than just focusing on jobs. The government has started some good schemes like Bachat Ghar, which provides funding to the government in terms of giving loans to set up small-scale businesses and entrepreneurial ventures like salons, tiffin services, tailoring, and art like rangoli. These initiatives can help empower the community and improve their financial independence.

6.7.7 PERSPECTIVES OF PARTICIPANTS FROM NGOs

As per the NGOs consisting of either straight members or members from the community who were in NGOs helped by Governmental organizations, the various responses were in line with the actual struggles faced by this community. Out of the many challenges, they highlighted sex work being the most exploitative, which some individuals choose as a means

of earning a living. This occupation comes with inherent stress and vulnerability, leaving them traumatized and violated, affecting their mental health to a huge extent.

NGO (SAI Office, Odisha): Sex work is one of the challenges faced by LGBT community. Though it's by their choice and they earn through it, sex work is associated with stress and tension. Most often they don't get time to relax and sleep stress free."

Stigma and discrimination are also complex issues that the LGBT community encounters. They have been eternally marginalized by the society. This constant feeling of being judged and rejected takes a toll on their mental health, leading to emotional struggles and a sense of detachment from others. Mental health problems are a significant concern within the community. Substance use is often used as a means of coping with stress and emotional distress. Furthermore, unstable relationships and lack of support from partners can lead to feelings of depression and isolation. Unlike the usual marriage system, this community may not be in a safe social sphere and are often deprived of inheritance rights. Unable to have offspring often leaves them worried about their old age support system. Challenges in disclosing their sexual orientation due to past experiences of societal rejection led to fear of discrimination and negative repercussions. Additionally, accessing SRS remains difficult for many individuals due to the high cost, hindering their ability to align with their gender identity fully. Suicidal thoughts and behaviors are a concerning issue, with personal milestones like gender identification, disclosure, and acceptance influencing the risk. To address these challenges, fostering self-reliance, independence, and belief in oneself are recommended as preventive measures to promote mental well-being within the LGBTQIA+ community.

Economic instability further creates a vicious cycle for the LGBTQIA+ community. Uncertainty about financial security and livelihood turns some individuals toward substance abuse as a coping mechanism. Turning to alcohol and other substances provides temporary relief from stress, but it can also exacerbate mental health issues, leading to depression and dependency. However, the LGBT community also exhibits remarkable resilience and has developed coping mechanisms to navigate these challenges. Peer support plays a vital role, with individuals finding solace and understanding by sharing their experiences with others who share similar struggles. Additionally, some receive emotional support from their families, a crucial aspect in managing mental health and building self-esteem. Community events and programs provide support and foster a sense of belonging and connection with

others.

As per the NGOs working to uplift their social status, societal attitudes have recently been evolving positively, and there is a growing acceptance of the LGBTQIA+ community. Many individuals report receiving more support and understanding from society than in the past. As per them, Government initiatives and policies have contributed to better job opportunities and increased acceptance, leading to improved mental well-being for some members of the community. For, e.g., in Odisha, the Government has been forth coming in issuing them many facilities. With a TG card, they can avail the Madhubabu Pension scheme, housing, etc. Of late, they have been employed in the Bhubaneswar Municipal Corporation-led parking slots for vehicles where they collect tickets. In many cases, they have experienced better response from public which do not involve differential treatment of LGBTQIA+ individuals. This encouraging environment contributes to a positive sense of self and fosters a sense of inclusivity in various professional settings.

In conclusion, the LGBT community in India faces several challenges that impact their mental health. While societal attitudes are gradually evolving to be more inclusive, much work must be done to eliminate stigma, discrimination, and economic instability. Strengthening social support, increasing awareness, and promoting acceptance are essential steps toward creating a more supportive and inclusive environment for the LGBT community.

7. RECOMMENDATIONS

1. Mental illnesses like anxiety and depression, and substance use disorders are prevalent in the Indian general population. However, the rates are much higher in certain populations, including the LGBTQIA+ community. This high rate of mental morbidity has been attributed to the minority stress model. This is especially true for transgender people as compared to other sexual and gender minority communities. Transgender people have significant mental health issues, poor quality of life, and poor perceived social support than other gender minority communities, and they also constitute a substantial chunk of gender minority communities. Regular prevalence data regarding trends and patterns of these morbidities are required to develop better treatment services. However, as of now, national surveys for mental illnesses are not regularly conducted. Although data are available for the general population from the NMHS 2016, they do not provide data for high-risk groups like LGBTQIA+ (Murthy R.S., 2017). Considering the high prevalence rates of these mental morbidities from our study, regular and high-quality data from a nationally representative sample of the LGBTQIA+ community is the need of the hour. As several social welfare schemes have been recently introduced across India, a regular framework of monitoring these illnesses over the years may provide beneficial information about the overall effect of social welfare aspects on the mental health of the LGBTQIA+ community.

2. This is also equally true for substance use. The rates of substance use (tobacco, alcohol, and cannabis) are much higher than the general population estimates provided by the Magnitude of Substance Use in India Survey 2019 conducted by the Ministry of Social Justice and Empowerment (Ambekar et al., 2020). LGBTQIA+ who use substances are considered a unique population of substance users with specific issues. Their patterns of substance use are considered distinct from the general adult population. For example, a phenomenon of chemsex has been reported worldwide among MSM to describe intentional sex under the influence of drugs (Maxwell et al., 2019). Generally, GHB, GBL, methamphetamine, etc., are consumed in such settings. This population (who engage in chemsex) is especially at a higher risk of developing HIV due to higher rates of high-risk behaviors, involvement in group sex, and due to multiple partners. However, just like

mental illnesses, we do not have nationally representative data on this population's various substances of use. Similarly, the data on changes in substance use patterns over the period is almost negligible. Our study results indicate a need for a better monitoring system for substance use in this population.

3. In India, the treatment gap for mental illnesses and substance use disorders is amongst the highest. The treatment gap is as high as 90%. This is especially true for the LGBTQIA+ community. LGBTQIA+ individuals with mental illness/substance use problems face a double whammy effect of stigma (both due to being from the community and the stigma of mental illness). This hampers their treatment-seeking. Further, clinician-related factors such as discrimination in healthcare settings are significant barriers to seeking treatment. In such a scenario, we propose the need for dedicated online treatment services for the LGBTQIA+ community. Recently, the Indian Government has rolled out the TELE–MANAS program for providing telepsychiatry services at the national level. Liaising with TELE-MANAS and other social welfare schemes of central and state governments may be considered for better treatment seeking. Enhancing online consultation portals like E-Sanjeevani and improving awareness of this portal among the LGBTQIA+ community to provide them with mental health support also may be considered. This will improve the mental health help-seeking behavior among the LGBTQIA+ community, where they can seek consultation. This approach can potentially overcome some of the barriers faced by the LGBTQIA+ community. The use of online modes of consultation bypasses the stigma associated with mental illness treatment. Telepsychiatry services may allow these individuals to discuss with their treatment providers more freely. Finally, this may facilitate treatment with a queer-affirmative mental health provider, strengthening the client-therapist relationship.

4. Health Insurance is another important aspect of improving health status. As is seen, most of the participants in our study are from lower socio-economic strata of society. Many of them are employed in unskilled work, including begging. The provision of comprehensive insurance coverage that includes mental health and substance use-related illnesses may help in improving treatment seeking. In this regard, the AB-PMJAY scheme by the Government of India may become an important tool. AB-PMJAY includes covers related to mental health as well as gender reaffirmation surgery. Similar provisions are also included under certain state government welfare schemes. Efforts should be targeted to include more beneficiaries under these schemes.

5. Our study suggested that almost one out of 10 LGBTQIA+ individuals suffer severe suicidal ideations. This is an alarming number. Thus, there is an urgent requirement to scale up the mental health helpline in general and suicide prevention helplines in particular. We propose to develop a queer affirmative counseling helpline that can specifically handle this community's mental health and social issues sensitively.

6. One of the reasons mental health issues are under diagnosed and undertreated in this population is that mental health professionals are not adequately trained to treat vulnerable groups like the LGBTQIA+ population in our country. Without such training, the professionals may even make the mistake of viewing gender and sexual nonconformity as illnesses. This may further damage the psychological health of the community members. LGBTQIA+ community members may likely feel more comfortable with LGBTQIA+-friendly mental health professionals. Thus, better training of medical doctors in the cultural-competency curricula also includes material about this community. In this regard, a recently introduced curriculum by the National Medical Commission aims to make it more "gender-sensitive." **(NMC, 2020).** It may be assumed that training to deal with third-gender-specific issues shall be included in such a curriculum. Finally, opening special clinics that may address the issues specific to this community may be introduced.

7. In our study, stress, anxiety, and depression were negatively correlated with perceived social support. This implies that those with good social support have lesser stress, anxiety, and depression. It is important to note that almost one-third of our study participants were staying alone. Previous studies have also established that developing social connections is a protective factor against mental health issues. Thus, the government should conduct regular workshops and seminars to emphasize the need for social support and family relations and to provide them with practical strategies to improve their social ties. Regular workshops that focus on social skills training may further help. In this manner, self-help groups also play an essential role. Many state governments are assisting various welfare schemes to develop self-help groups of transgender people. This is a laudable step. The same should be encouraged further and should be implemented across the country. The SMILE scheme under the MoSJE, the Government of India, provides skill training and shelter homes to transgender people. Currently, there are 12 Garima Greh – Shelter Homes in the country. This should be up scaled further to have at least one home in every state.

8. The LGBTQIA+ community members suffer from much physical and psychological morbidity, such as depression, anxiety, substance use, and HIV, among many others. On the other hand, they have limited awareness of the various health services and social welfare schemes directed towards them. Regular education campaigns should be incorporated into this population's various state-level and central schemes. A specific portal dedicated to the LGBTQIA+ community should be developed, including details of nearby health facilities relevant to their needs and the availability of social welfare schemes in their region. Separate mobile apps may be created for this purpose. The development of the "*myScheme"* portal by the central government is a laudable step that contains details of various government schemes for different population groups. However, many recent social welfare schemes are not updated on the same (at the time of writing this draft). The government should ensure that such dashboards are regularly updated to provide up-to-date information about the available facilities. This would ensure proper utilization of the services.

9. Transgender people constitute one of the high-risk groups for HIV under the National AIDS Control Program, along with People Who Inject Drugs (PWID), Men who have sex with men (MSM), and Female Sex Workers (FSW). Recently, because of the various vulnerabilities of PWID, the National AIDS Control Organization has come up with a model of integrated service delivery where the PWID can receive multiple services such as opioid substitution therapy (OST), drug treatment, mental health counseling, and treatment, ART for HIV, pre-exposure and post-exposure prophylaxis, HCV treatment, and TB treatment **(NACO,2022)**. Similar models may also be adopted for transgender and MSM communities. The Ministry of Health and Family Welfare may consider developing single window service delivery models for the LGBTQIA+ community that may include services like mental health counseling and treatment, substance use treatment, HIV management, provision of ART, and other specified services as per the vulnerabilities. A liaison may be developed between such centers and social welfare organizations to provide comprehensive services in an integrated manner.

10. During the qualitative interviews, an important aspect was educational difficulties and dropping out of school. Discrimination and not accepting these individuals in educational institutions is a big hurdle. In this regard, we recommend a few steps to improve education in this community. First, there should be written, enumerated policies that identify and list characteristics or traits of students who are more likely to be harassed or

bullied. Such a policy may help schoolteachers and administrators with implementation guidance in case LGBTQIA+ community members are discriminated against or harassed. Also, the training of various school personnel is not up to the mark to support these individuals. They may feel unable to understand their specific needs. A grievance addressal system may be developed at a school level. Unfortunately, as our study shows, many children face discrimination from school teachers. Hence, training of school personnel about LGBTQIA+ identities and their needs for in-service professional development may be carried out regularly. Such training may help develop awareness, self-efficacy, and empathy among schoolteachers. In this regard, the National Education Policy 2020 step to identify transgender children as a "Socio-Economically Disadvantaged" group is an important step forward. (NEP, 2020). The policy has a provision for a "Gender-inclusion fund" to create education more inclusive. Some part of this fund may be earmarked for teacher and school personnel training on LGBTQIA+ sensitivity. Similar provisions may also be adopted in the state social welfare schemes aimed at the LGBTQIA+ community. Further, schools should be encouraged to develop student-led clubs focused on various issues that focus on the LGBTQIA+ community. There is also a provision of scholarships for education under various state government welfare schemes. For example, the Government of Odisha Scheme "Sweekruti" provides pre- and post-metric scholarships for transgender children. Similar scholarships are also available in the Andhra Pradesh welfare scheme for transgenders. Such steps may also be considered by other state governments.

11. Another important area of concern is the work and employment-related issues faced by the LGBTQIA+ community. During our qualitative interviews, many participants reported rejection from jobs due to their transgender status, employment in restricted and exploitative jobs, harassment, and discrimination at the workplace. Despite being employable various discrimination and micro-aggression, bullying, sexualized remarks, and boundary violations take place at the workplace. Thus, there is a need to create a supportive climate at the workplace and to implement policies that explicitly prohibit discrimination against LGBTQIA+ employees. Educating employees about the issues faced by this community and providing them with training may also be considered. It is important to note here that the Transgender Act 2019 explicitly mentions that establishments shall not discriminate against any transgender person. Thus, there is a need to adhere to the law strictly and mechanisms to ensure the same may be enhanced.

The act also mentions designating a specific person to work as a complaint officer to deal with violations of the provisions of the law. However, the act does not explicitly prohibit workplace harassment and discrimination against transgender. Thus, there is a need to provide adequate enforcement mechanisms under the act. Apart from this, transgender may be adequately educated using awareness campaigns about various provisions under social welfare schemes such as financial assistance, counseling services, and legal support. Although free legal aid is available to LGBTQIA+ members through NALSA and under state welfare schemes, very few actually receive those services. As per one estimate, only 1664 transgenders availed of free legal aid at the national level (Jain, 2022). There is an urgent need to identify the barriers to using such services by LGBTQIA+ community members. Passing a comprehensive anti-discrimination law at the workplace that explicitly includes the LGBTQIA+community may be considered. It is important to note here that the Constitution of India forbids discrimination on the grounds of religion, race, *gender*, caste, or place of birth. Thus, transgenders (being a recognized third gender in India) have safeguards against workplace discrimination.

12. Stigma and discrimination towards the LGBTQIA+ community are still prevalent in our country. This was also echoed by our study participants in the qualitative interviews. Thus, there is a need to focus on stigma reduction interventions targeted at the general population as well as key target groups. Although public education is a key component for reducing stigma, it must be substantiated with contact and protest interventions. There should be a focus on vicarious contact interventions, such as improving media portrayal of the LGBTQIA+ community. In this regard, social welfare schemes include various measures that aim to improve the participation of these community members in education and employment. Such interventions help build interpersonal contact. Such interventions can be effective in reducing prejudice and discrimination. Finally, change in policies also helps reduce institutional stigma. In this regard, the Transgender Act 2019 is a landmark law that aims to reduce the stigma and discrimination through institutional mechanisms. Stigma reduction interventions should also target key populations such as healthcare professionals, police personnel, and students.

13. Although many social welfare schemes exist in India, the current utilization of various provisions under the scheme is not up to the mark. For example, as per the SMILE scheme dashboard, a total of 13,312 certificates were issued, while 13,297 ID cards have been issued (at the time of writing this report). A total of 32 states/UTs have participated

in the SMILE scheme. Yet, the distribution of welfare schemes utilization grossly varies. The maximum number of certificates and cards are issued in the states of Maharashtra, Odisha, and Andhra Pradesh, while utilization is minimal in many northeastern states and states like Goa and Himachal Pradesh. There is a need to improve the utilization of schemes across all the states. More public education campaigns focusing on the availability of various social welfare measures is the need of the hour.

14. Our study suggests that the rates of mental health issues, substance use, and suicidality are higher in other LGBTQIA+ communities as well, apart from transgenders. They also suffer from stigma and discrimination on various fronts. However, social welfare schemes are primarily targeted at transgenders. Sexual minority community-specific schemes and laws have received lesser attention from policymakers. There is a need to develop specific ant discriminatory laws which apply to sexual minority populations as well.

15. The community also discussed the importance of religiosity, especially as a conduit for coping with life adversities. This also gave them a platform for building further social networks and achieving a positive psychological state. The analogy of the third gender to respectable mythological characters also played an important role in preserving self-esteem despite the perceived discrimination. More research needs to be done in the Indian community keeping religiosity as the focus to strengthen further resilience. Furthermore, exploring the influence of religion and spirituality on the common public's attitude toward LGBTQIA+ is equally important.

16. Coping: Acknowledging the unique challenges and the limited resources to learn better coping skills, it's essential to encourage a balanced approach to coping strategies. Emotion-focused coping, like acceptance and emotional support, can be helpful but should be complemented by problem-focused techniques such as planning and active coping. As our study participants showed more avoidant and dysfunctional coping patterns like denial and self-blame, specifically the transgender individuals, this can negatively impact their overall well-being and mental health given the varied stressors in their life. They may benefit from additional support and inclusive environments. By fostering healthier coping mechanisms with the help of school, workplace, and various mental health professionals, overall resilience and control over difficult life situations can be navigated better.

8. LIMITATIONS

This study had some important limitations.

- The study was conducted in 4 cities from different regions of India. The sites were chosen purposively. Hence, the findings might not be generalizable to the LGBTQIA+ community of the country or elsewhere. Regional variations in societal attitudes, access to resources, and support networks may not be fully represented. This may lead to skewed insights into the mental health issues faced by LGBTQIA+ individuals. Consequently, the findings may not be applicable to LGBTQIA+ communities residing in rural areas or other urban centers not included in the study.
- The study included participants from transgender, gay, and bisexual communities primarily. We could not include other sexual and gender minority community people, such as queer, intersex, and asexual individuals, despite the best of our efforts. Thus, the findings of the study may not be applicable to these populations. The study's findings may have been impacted by the limited number of participants involved, potentially diminishing the study's ability to identify significant patterns or distinctions among different segments of the LGBTQIA+ community. With a smaller sample size, the study's statistical power to detect associations or differences between groups could have been compromised.
- Some sections of the LGBTQIA+ community, such as those who are less open about their sexual orientation or gender identity or those who experience more intersectional forms of discrimination, may not have been included in the study. Those who are not yet open about their gender or sexual identity may be a different subgroup of this community and may face some unique challenges that may impact their mental health differently.
- As the study only utilized subjective self-reported data using questionnaires and no other objective assessment methods, recall bias is possible, especially in reporting the life experiences during the qualitative interviews. A social desirability bias also cannot be excluded, considering the sensitive nature of the information collected in the study.
- The study employed a cross-sectional study design, so cause-effect relationships cannot be established. Future studies may need longitudinal designs to better understand the trajectories of various mental health problems in this population in India.

- Though we had utilized the validated tools for the purpose of our study, they may fail to capture the unique challenges and experiences of these individuals. More culturally sensitive tools specifically designed for this population may help overcome this issue in future studies.
- Our study did not explicitly utilize and assess the broader social and cultural contexts in which LGBTQIA+ individuals live. Stigma, discrimination, and other social and cultural factors are also important variables that may affect mental health outcomes. This was also evident in our quantitative arm of the study.
- This study employed qualitative interviews to gain an in-depth understanding of participants' experiences. While this approach yielded rich data, the inherent limitations of a small sample size warrant further consideration. It is acknowledged that these findings might not comprehensively represent the spectrum of experiences across the diverse LGBTQIA+ community. To broaden our understanding, future research could benefit from employing larger and more representative samples encompassing this population's multifaceted nature.

9. RESOURCES

1. *Transgender Persons (Protection of Rights) Act - https://en.wikisource.org/wiki/Transgender_Persons_(Protection_of_Rights)_Act,_2019*
2. *State Policy for Transgender Persons in Kerala -http://sjd.kerala.gov.in/beneficiary-info.php?benef_sl=N3NWOHVxUiN2eQ*
3. *TAMIL NADU TRANSGENDER WELFARE BOARD - https://www.tnsocialwelfare.tn.gov.in/en/specilisationstransgenders-welfare/tamil-nadu-transgender-welfare-board*
4. *SWEEKRUTI (A Scheme for Promotion of Transgender Equality & Justice) https://ssepd.gov.in/system/download/Scheme%20for%20TG%20-%20Final.pdf*
5. *State Policy for Transgenders in Karnataka, 2014 (draft) - https://spb.karnataka.gov.in/storage/pdffiles/draft%20State%20Policy%20forTransgenders.pdf*
6. *SHREE centers under Andhra Pradesh State AIDS Control Society - https://apsacs.ap.gov.in/for-lgbtq-community/*
7. *SMILE (Support for Marginalized Individuals for Livelihood and Enterprise) - https://transgender.dosje.gov.in/Applicant/HomeN/Index*
8. *National Council for Transgender Persons in 2020 - n.wikipedia.org/wiki/National_Council_for_Transgender_Persons#:~:text=*
9. *PM-DAKSH-https://pmdaksh.dosje.gov.in/*
10. *PM-JAY -https://setu.pmjay.gov.in/setu/*
11. *TeleMANAS - https://telemanas.mohfw.gov.in/#/home*
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11. ANNEXURES

ANNEXURE 1: SEMI-STRUCTURED QUESTIONNAIRE

1.	Address	
2.	Age in completed years	
3.	LGBTQIA+ Category of Respondent	Lesbian
		Gay
		Bisexual
		Transgender
		Queer
		Intersex
		Asexual
		Others
4.	Marital Status	1. Single
		2. Married
		3. Remarried
		4. Widowed
		5. Divorced
		6. Separated
		7. Others
5.	Education (in years)	
6.	Education of the respondent	1. Not interested to disclose
		2. Illiterate
		3. Primary (up to 5 years formal education)
		4. Middle school (up to 8 years formal education)
		5. Higher school (up to 10 years formal education)
		6. Intermediate or post high school diploma (up to 12 years formal education)
		7. Graduate or Post graduate

		8. Profession or Honors 9. Others (Specify)
7.	Education of the head of the family	1. Profession or Honors 2. Graduate or post graduate 3. Intermediate or diploma 4. High school certificate 5. Middle school certificate 6. Primary school certificate **7.** Illiterate **8.** Not interested to disclose
8.	Occupation of respondent	1. Professionals or semi-professionals 2. Clerical, shop owner, farmer **3.** Skilled Workers **4.** Semi-Skilled worker 5. Unskilled worker 6. Unemployed
9.	Occupation of head of the family	7. Professionals or semi-professionals 8. Clerical, shop owner, farmer **9.** Skilled Workers **10.** Semi-Skilled worker 11. Unskilled worker 12. Unemployed
10	Monthly Income (INR)	1. >=123,322 2. 61,663-123,321 3. 46129-61,662 4. 30,831-46,128 5. 18,497-30,830 6. 6,175-18,496 7. ≤ 6174
11	Monthly Income (INR) of head of family	1. >=123,322 2. 61,663-123,321 3. 46129-61,662

		4. 30,831-46,128 5. 18,497-30,830 6. 6,175-18,496 7. ≤ 6174
12	Religion	1. Hindu 2. Muslim 3. Christian 4. Sikh 5. Others
13	Family Type	1. Nuclear 2. Extended 3. Joint 4. Living alone
14	Locality	1. Urban 2. Semi-urban 3. Rural

ANNEXURE 2: Depression, Anxiety and Stress Scale-21

DASS21

Name: Date:

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **over the past week**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree or a good part of time
3 Applied to me very much or most of the time

1 (s)	I found it hard to wind down	0	1	2	3
2 (a)	I was aware of dryness of my mouth	0	1	2	3
3 (d)	I couldn't seem to experience any positive feeling at all	0	1	2	3
4 (a)	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5 (d)	I found it difficult to work up the initiative to do things	0	1	2	3
6 (s)	I tended to over-react to situations	0	1	2	3
7 (a)	I experienced trembling (e.g. in the hands)	0	1	2	3
8 (s)	I felt that I was using a lot of nervous energy	0	1	2	3
9 (a)	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10 (d)	I felt that I had nothing to look forward to	0	1	2	3
11 (s)	I found myself getting agitated	0	1	2	3
12 (s)	I found it difficult to relax	0	1	2	3
13 (d)	I felt down-hearted and blue	0	1	2	3
14 (s)	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15 (a)	I felt I was close to panic	0	1	2	3
16 (d)	I was unable to become enthusiastic about anything	0	1	2	3
17 (d)	I felt I wasn't worth much as a person	0	1	2	3
18 (s)	I felt that I was rather touchy	0	1	2	3
19 (a)	I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)	0	1	2	3
20 (a)	I felt scared without any good reason	0	1	2	3
21 (d)	I felt that life was meaningless	0	1	2	3

ANNEXURE 3: WHO ASSIST Version 3.0

Question 1

(if completing follow-up please cross check the patient's answers with the answers given for Q1 at baseline. Any differences on this question should be queried)

In your life, which of the following substances have you ever used? ***(NON-MEDICAL USE ONLY)***	**No**	**Yes**
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative:
“Not even when you were in school?”
If "No" to all items, stop interview
If "Yes" to any of these items, ask Question 2 for each substance ever used.

Question 2

In the past three months, how often have you used the substances you mentioned *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Twice	Monthly	Weekly	Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6.

If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for <u>each substance</u> used.

Question 3

During the past three months, how often have you had a strong desire or urge to use *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	**Twice**	Monthly	Weekly	Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

Question 4

During the past three months, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC*) led to health, social, legal or financial problems?	**Never**	**Twice**	Monthly	Weekly	Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the past three months, how often have you failed to do what was normally expected of you because of	nNever	twice	Monthly	Weekly	**Daily**
a. Tobacco products					
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else ever expressed concern about your use of *(FIRST DRUG, SECOND DRUG, ETC.)?*		**...nth s**	**mo nth s**	
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3	
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3	
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3	
d. Cocaine (coke, crack, etc.)	0	6	3	
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3	
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3	
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3	
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3	
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3	
j. Other – specify:	0	6	3	

Question 7

Have you ever tried and failed to control, cut down or stop using ***(FIRST DRUG, SECOND DRUG, ETC.)?***		**hepast3 months**		**epast3 months**
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3	
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3	
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3	
d. Cocaine (coke, crack, etc.)	0	6	3	
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3	
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3	
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3	
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3	
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3	
j. Other – specify:	0	6	3	

Question 8

	No, Never	**Yes, in the past 3 months**	**Yes, but not in the past 3 months**
Have you ever used any drug by injection? ***(NON-MEDICAL USE ONLY)***	0	2	1

IMPORTANT NOTE:

Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

ANNEXURE 3: SCALE FOR SUICIDAL IDEATION

1. Wish to live
   0. Moderate to strong
   1. Weak
   2. None
2. Wish to die
   0. None
   1. Weak
   2. Moderate to strong
3. Reasons for living/dying
   0. For living outweigh for dying
   1. About equal
   2. For dying outweigh for living
4. Desire to make active suicide attempt
   0. None
   1. Weak
   2. Moderate to strong
5. Passive suicidal desire
   0. Would take precautions to save life
   1. Would leave life/death to chance
   2. Would avoid steps necessary to save or maintain life
6. Time dimension: Duration of suicide ideation/wish
   0. Brief, fleeting periods
   1. Longer periods
   2. Continuous (chronic) or almost continuous
7. Time dimension: Frequency of suicide
   0. Rare, occasional
   1. Intermittent
   2. Persistent or continuous
8. Attitude toward ideation/wish
   0. Rejecting
   1. Ambivalent; indifferent
   2. Accepting
9. Control over suicidal action/acting-out wish
   0. Has sense of control
   1. Unsure of control
   2. Has no sense of control
10. Deterrents to active attempt (e.g., family, religion, irreversibility)
    0. Would not attempt because of a deterrent
    1. Some concern about deterrents
    2. Minimal or no concern about deterrents
11. Reason for contemplated attempt
    0. To manipulate the environment; get attention, revenge
    1. Combination of 0 and 2
    2. Escape, surcease, solve problems
12. Method: Specificity/planning of contemplated attempt
    0. Not considered
    1. Considered, but details not worked out
    2. Details worked out/well formulated
13. Method: Availability/opportunity for contemplated attempt
    0. Method not available; no opportunity
    1. Method would take time/effort; opportunity not readily available
    2a. Method and opportunity available
    2b. Future opportunity or availability of method anticipated

14. Sense of "capability" to carry out attempt
    0. No courage, too weak, afraid, incompetent
    1. Unsure of courage, competence
    2. Sure of competence, courage
15. Expectancy/anticipation of actual attempt
    0. No
    1. Uncertain, not sure
    2. Yes
16. Actual preparation for contemplated attempt
    0. None
    1. Partial (e.g., starting to collect pills)
    2. Complete (e.g., had pills, loaded gun)
17. Suicide note
    0. None
    1. Started but not completed; only thought about
    2. Completed
18. Final acts in anticipation of death (e.g., insurance, will)
    0. None
    1. Thought about or made some arrangements
    2. Made definite plans or completed arrangements
19. Deception/concealment of contemplated suicide
    0. Revealed ideas openly
    1. Held back on revealing
    2. Attempted to deceive, conceal, lie

ANNEXURE 4: BRIEF COPE INVENTORY

Brief COPE

We are interested in how people respond when they confront difficult or stressful events in their lives. There are lots of ways to try to deal with stress. This questionnaire asks you to indicate what you generally do and feel, when you experience stressful events. Obviously, different events bring out somewhat different responses, but think about what you usually do when you are under a lot of stress.

Each of us deals with things in different ways; I'm interested in how *you've* tried to deal with things. Each item says something about a particular way of coping. I want to know to what extent you've been doing what the item says. *How much or how frequently.*

Don't answer on the basis of whether it seems to be working or not—just whether or not you're doing it. Try to rate each item separately in your mind from the others. Make your answers as true FOR YOU as you can. *This information is confidential/belongs to you*; you may share if you choose.

There are no "right" or "wrong" answers! We're looking for a general pattern, not a specific "score"

1	2	3	4
Not at all	Little bit	Medium amount	Doing a lot

1 = I haven't been doing this at all
2 = I've been doing this a little bit
3 = I've been doing this a medium amount
4 = I've been doing this a lot

Using this scale, respond to the following:

1. I've been turning to work or other activities to take my mind off things.
2. I've been concentrating my efforts on doing something about the situation I'm in.
3. I've been saying to myself "this isn't real."
4. I've been using addictive behaviors or substances to make myself feel better.
5. I've been getting emotional support from others.
6. I've been giving up trying to deal with it.
7. I've been taking action to try to make the situation better.
8. I've been refusing to believe that it has happened.
9. I've been saying things to let my unpleasant feelings escape.
10. I've been getting help and advice from other people.

1	2	3	4
Not at all	Little bit	Medium amount	Doing a lot

11. I've been using alcohol or other drugs to help me get through it.
12. I've been trying to see it in a different light, to make it seem more positive.
13. I've been criticizing myself.
14. I've been trying to come up with a strategy about what to do.
15. I've been getting comfort and understanding from someone.
16. I've been giving up the attempt to cope.
17. I've been looking for something good in what is happening.
18. I've been making jokes about it.
19. I've been doing something to think about it less, such as going to movies, watching TV, reading, daydreaming, sleeping, or shopping.
20. I've been accepting the reality of the fact that it has happened.
21. I've been expressing my negative feelings.
22. I've been trying to find comfort in my religion or spiritual beliefs.
23. I've been trying to get advice or help from other people about what to do.
24. I've been learning to live with it.
25. I've been thinking hard about what steps to take.
26. I've been blaming myself for things that happened.
27. I've been praying or meditating.
28. I've been making fun of the situation.

ANNEXURE 5: MULTIDIMENSIONAL SCALE OF PERCIEVED SOCIAL SUPPORT

Instructions: We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

Circle the "1" if you **Very Strongly Disagree**
Circle the "2" if you **Strongly Disagree**
Circle the "3" if you **Mildly Disagree**
Circle the "4" if you are **Neutral**
Circle the "5" if you **Mildly Agree**
Circle the "6" if you **Strongly Agree**
Circle the "7" if you **Very Strongly Agree**

1. There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2. There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3. My family really tries to help me.	1	2	3	4	5	6	7
4. I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5. I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6. My friends really try to help me.	1	2	3	4	5	6	7
7. I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8. I can talk about my problems with							

my family.	1	2	3	4	5	6	7
9. I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10. There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11. My family is willing to help me make decisions.	1	2	3	4	5	6	7
12. I can talk about my problems with my friends.	1	2	3	4	5	6	7

ANNEXURE 6: WHO WELL-BEING INDEX

WHO-5 Well-being Index

Please respond to each item by marking one box per row, regarding how you felt in the last two weeks.		All of the time	Most of the time	More than half the time	Less than half the time	Some of the time	At no time
WHO 1	I have felt cheerful in good spirits.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
WHO 2	I have felt calm and relaxed.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
WHO 3	I have felt active and vigorous.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
WHO 4	I woke up feeling fresh and rested.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
WHO 5	My daily life has been filled with things that interest me.	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

Scoring:
The raw score is calculated by totaling the figures of the five answers. The raw score ranges from 0 to 25, 0 representing worst possible and 25 representing best possible quality of life.

To obtain a percentage score ranging from 0 to 100, the raw score is multiplied by 4. A percentage score of 0 represents worst possible, whereas a score of 100 represents best possible quality of life.

ANNEXURE 7: RELIGIOUS COPING SCALE

Positive Religious Coping Subscale Items	
1.	Looked for a stronger connection with God.
2.	Sought God's love and care.
3.	Sought help from God in letting go of my anger.
4.	Tried to put my plans into action together with God.
5.	Tried to see how God might be trying to strengthen me in this situation.
6.	Asked forgiveness for my sins.
7.	Focused on religion to stop worrying about my problems.
Negative Religious Coping Subscale Items	
8.	Wondered whether God had abandoned me.
9.	Felt punished by God for my lack of devotion.
10.	Wondered what I did for God to punish me.
11.	Questioned God's love for me.
12.	Wondered whether my church had abandoned me.
13.	Decided the devil made this happen.
14.	Questioned the power of God.

ANNEXURE 8: Focus Group Discussion Guide

Mental Health Issues and Substance Use Disorders:

1. Can you share some common mental health issues that affect the LGBT community?
2. In your observation, how does having a mental health issue /substance use affect the functioning of a LGBT community member?
3. What do you think could be done to improve the mental health situation of LGBT community in India?

Stress and Coping

1. What are the common coping techniques used?
2. What impact do you think stress can affect mental health/ substance use (or do you think that the effect will be neutral or negative)?

Perceived Social Support:

1. How would you describe the social support system available to the LGBT community?
2. How are the psychosocial needs of LGBT changing and how are they likely to change in the future?
3. What can be done to better support these changing needs?

Occupational functioning / Religiosity

1. HowdoyouthinkyourLGBTstatusisaffectingyouroccupationalfunctioning (or religious views)?
2. How do you feel, has the world evolved today, to accommodate the LGBT community?

—----------

ANNEXURE 9: In Depth Interview Guide

1. What are the various challenges under which the LGBT community lives in India? Please list.
2. What are the various issues the people face: At home (parents/ spouse/ siblings), at work (workplace efficiency and productivity, Leaves, gender disparity in salary
3. Structure) or with peers? Please explain.
4. What are the various mental health issues that surround the LGBT community?
5. Have you ever experienced any of those mental health issues?
6. How did you deal with such issues, if they did arise?
7. What were some barriers, if any, that you encountered? Stigma/ Lack of key support/ Lack of awareness and MHPs?
8. How did you overcome the barrier(s)?
9. What kind of support systems exists to support the LGBT Community? (ex-family/community / government support)
10. How effective are these support systems in helping the cause?
11. What recommendations do you have to improve the Quality of Life of the LGBT community?

WORKPLACE

1. What are the various occupations /employment LGBT community is engaged with?
2. What do you wish to do?
3. Do you think there is a significant restriction in occupational choices for LGBT, if so what are the various reasons for such restricted choices?
4. What is your understanding of importance of workplace
5. How do you understand the gender non-conforming roles and workplace issues in what way the gender non-conforming roles in the workplace affect you?
6. What is your experiences about non LGBT colleagues understanding and biases towards your work performance specifically with your gender what is your experiencehow have you been treated by common men at workplace

7. What are the various factors affecting your choice of workplace?
8. What are the various workplace/work related hazards experienced in the commonly sorted occupation by the LGBT community.
9. What are the differences within L/G/B/T as a potential to be employed?
10. What are the various struggles an LGBT individual faces at workplace enumerate the scope of recent inclusion of third gender reservation "in the workplace.
11. What are the various means kept in situ by the employer at the workplace to enhance workplace productivity?
12. How is the family or community support in place for workplace related stress. What do you suggest to overcome the issue?
13. What hinders/ facilitates you from declaring your gender comfortably at the workplace.
14. In what way undergoing SRS is helpful or not the helpful?
15. What are the existing safeguards and reddressal systems against such incidents at your workplace?
16. How do you perceive the grievances redressal systems specific to LGBT issues in your workplace
17. InyouropinionwhatarethescopesofimprovementtosafeguardLGBTindividualsagainst such experiences.
18. What is your experience with regards to differential treatment of LGBT vs. Non LGBT employees at workplace with regards to
    - Discrimination; selection for a particular role or job allocation including job roles, pay role, promotion ,leaves ,perks ,
    - Bullying,
    - Physical or sexual harassment
    - Cyber bullying
    - Gas lighting (Gas lighting refers to acts of manipulation that are meant to make victims doubt their reality for the benefit of their perpetrators.,
    - Stigma
    - Micro aggression. (Micro aggressions are subtle but harmful actions directed at targeted groups. Micro-aggressions may be verbal, behavioral,

or environmental. Those targeted include people of color, females, those with disabilities, religious minorities, and lesbian, gay, bisexual, and transgender people.)

19. As per you, what are organizational policies, infrastructure (e.g. toilets, lock rooms, and gender neutral dress codes, gender neutral communications between colleagues, acceptance and inclusion) practices employed at your workplace?
20. enabling and discouraging factors at workplace ;
    - colleagues,
    - Employers
    - Sociopolitical and policy level
21. howdoyouseethescopeofinclusionLGBTcommunityinthediverseworkforceinour country
22. In what way living in/ marriage / cohabiting with a partner or being single is helpful vs. unhelpful in managing workplace stress?

MENTALHEALTH

1. What is your understanding regarding health?
    - Mental health
    - Physical health
    - Interaction of both
2. How do you see the mental health issues in the LGBT community?
3. What are your experiences of mental health issues in major personal milestones (e.g., childhood, schooling , adolescence ,relationship , jobs)
4. Also what is your understanding of various mental health issues during the journey of identification, understanding, acceptance and disclosure of the gender related issues from childhood to adulthood?
5. In your opinion, what are the various factors which positively and negatively affect the mental health of LGBT community?

6. Effect on mental health, how you perceive this across many subtypes of gender fluidity.
    - In your opinion what are the various factors (
    - Individual
    - Community
    - And health care services) which positively preserve /safeguard themental health of LGBT community
7. What is your perception regarding the differences of mental health and physical health issues and outcomes in general vs. LGBT community.
8. In your experience what may be the various factors hindering help seeking for mental health issues; individual/community/health system
9. What are the various coping mechanisms specifically utilized by and LGBT individual and the LGBT community in large
10. In your experience family acceptance, early childhood, peer interaction and education shaped your mental health.
11. How would you perceive the impact of disclosure on self and others, discrimination and bullying on the mental health of LGBT people.
12. What is your perception regarding the current social acceptance, media and socio-political modifications towards LGBTin fostering a positive mental health.
13. What is your understanding of social circumstances in India vs.Western countries specifically to LGBT issues? (Acceptance, disclosure, freedom for a quality life and queer friendly health /mental health services.
14. WhatisyourunderstandingabouttheimpactofSexreversalSurgeriesinLGBT.Howdoes it impact your

- Identity expression,
- social acceptance ,
- expectation vs. reality pertaining to SRS related mental health outcome
- and finally your mental health

- What is your perception regarding the support or ease by the non LGBT in the eventual social adjustments after SRS . Do you perceive any scope of improvement in the social /community's role in making transition smooth and inclusive
- How far the health care system are equipped in your experience in supporting LGBTin this transition
- Scope of betterment in health services to smoothen this transition.

2. What are your experiences of existing health services regarding their service provision towards the LGBT community?

3. What is the scope of these services to be more LGBT friendly esp. addressing inclusion, participation, sensitizing public, promoting physical and mental health for LGBT individuals?

LGBTAND SUICIDE

1. Have you lost any close ones ; in the LGBT community to suicide
2. How does the LGBT community at large thinks about suicide
3. What would you say could prevent suicidal thoughts and/or behavior in LGBT people? What do you understand by the contributing factors for suicide
    - Individual factors
    - Societal factors
    - Factors specific to LGBT status
    - Policies
4. in your understanding what are the various personal milestones where in there is a risk of suicide /contemplating suicide by LGBT individuals (childhood, gender identification /disclosure, acceptance, schooling, difficult life experiences, jobs)
5. In your experience the specific issues of acceptance and disclosure to society; how does it play any role in suicidal thoughts?
6. In your understanding how the stigma , isolation parental maltreatment or abuse and day to day micro-aggressions impact suicidal behavior
7. Do you perceive any differences in suicidality between various categories of LGBT
    - AGE RANGE
    - SRS
    - LGBT vs. Non LGBT individuals and what could be the possible reasons.