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The Scottish Health Survey

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CHAPTER 1: METHODOLOGY AND RESPONSE

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1.1 INTRODUCTION

1.1.1 The Scottish Health Survey series

The Scottish Health Survey (SHeS) series was established in 1995 to provide data about the health of the population living in private households in Scotland. It was repeated in 1998 and 2003 and has been carried out annually since 2008.

The 2018-2023 surveys are being conducted by ScotCen Social Research in collaboration with the Office for National statistics (ONS), the Social and Public Health Sciences Unit (MRC/CSO SPHSU) at the University of Glasgow, the Centre for Population Health Sciences at the University of Edinburgh and the Public Health Nutrition Research Group at the University of Aberdeen[1].

Fieldwork for the 2020 and 2021 surveys were significantly affected by the COVID-19 pandemic. Fieldwork for SHeS 2020 was suspended in March 2020. Data for some of the key measures from SHeS was collected via a telephone survey in August and September 2020. Due to the testing of a new methodology for the SHeS survey within the context of the COVID-19 pandemic, the survey results for 2020 were presented as experimental statistics. These results have not been included in Volume 1 of this report.

1.1.2 The SHeS 2021 Fieldwork

There were two phases of fieldwork for SHeS 2021. During Phase 1, potential participants were contacted by letter and asked to opt-in to taking part in an interview conducted over the phone. This phase began in April, with new invites being sent out each month until September 2021. The survey itself was more comprehensive than 2020, with similar content to earlier survey years, and unlike 2020, interviews with or on behalf of children were also conducted.

Phase 2 began at the end of October, with new sample issued across three months. Potential respondents were again contacted by letter, but then recruited to participate by interviewers knocking on their door, in what is termed a ‘knock-to-nudge’ methodology. Interviews were still conducted by telephone, as for Phase 1. This second phase only began once COVID-19 restrictions in Scotland had been lifted to the extent that Scottish Government ministers and the Chief Medical Officer gave permission for such doorstep contact to recommence on Scottish Government surveys. The shift to a knock-to-nudge approach significantly increased levels of response to the survey.

Participants from the child boost sample were invited to opt in via letter for the entire fieldwork period.

The telephone survey methods differed from those used prior to 2020 in the SHeS series. While the 2021 survey includes most of the questions and key indicators from the face-to-face surveys, the change in mode of administration, along with the different approach to sampling, is likely to have impacted the responses received and thus comparability with the previous SHeS data. See sections 1.1.5, 1.1.7 and 1.2 for more information.

1.1.3 Aims of the Scottish Health Survey

The purpose of SHeS is to provide information at national level about the health of the population and the ways in which lifestyle factors are associated with health. This level of information is not available from administrative or operational databases, as hospitals and GPs are not able to collect detailed information about peoples' lifestyles and health-related behaviours. In addition, it is crucial that the Scottish Government has information about the health of the population, including people who do not access health services regularly.

The specific aims of SHeS are:

- To estimate the prevalence of particular health conditions in Scotland.
- To estimate the prevalence of certain risk factors associated with these health conditions and to document the pattern of related health behaviours.
- To look at differences between regions and between subgroups of the population in the extent of their having these particular health conditions or risk factors, and to make comparisons with other national statistics for Scotland and England.
- To monitor trends in the population's health and health related behaviour over time.
- To make a major contribution to monitoring progress towards health targets.

Each survey in the SHeS series has a set of core questions and measurements (height and weight and, if applicable, blood pressure, waist circumference, and saliva samples), plus modules of questions on specific health conditions and health risk factors that vary from year to year. Each year the main sample has been augmented by an additional boosted sample for children.

The purpose of the SHeS 2021 survey was to provide this same information at national level in the context of the developing COVID-19 pandemic. The SHeS series now has trend data going back 26 years and providing this time series is an important function of the survey.

1.1.4 Key changes to the survey methodology in 2018

A number of changes were introduced in light of the 2017 Scottish Government review of the Scottish Surveys Core Questions[2] (a set of harmonised core questions asked across the three major Scottish Government household surveys), and following the 2016 Scottish Government consultation on the Scottish Health Survey questionnaire content[3]. The key changes implemented in 2018 for the 2018-2021 surveys include:

- Increased sample size allowing for analysis at Local Authority level by 2021.
- Removal of local police force, contraception and cosmetic procedures questions.
- Removal of urine sample from the biological module.
- A number of modules will no longer appear in the questionnaire each year, but will appear approximately every 2 or 4 years: gambling, problem drinking, dental health services, parental history, respiratory health, CPR training and use of health services.
- New questions introduced asked about satisfaction with key public services, Nicotine Replacement Therapy (NRT), asthma, type of diabetes and gender identity.
- Additional topics were introduced in 2019 and 2021.

These changes are discussed in greater detail in section 1.3 below and also in the Scottish Health Survey Report of Questionnaire Changes from 2018[4].

1.1.5 The 2021 survey

The 2021 Scottish Health Survey was designed to provide data at national level about the population living in private households in Scotland. The survey covered all ages.

The target sample size for the 2021 survey was the same as that for 2018 and 2019. Because of the requirement for telephone interviewing, with no doorstep recruitment allowed until the end of October, the issued sample was much larger than in previous years.

An initial sample of 64,523 addresses was drawn from the Postcode Address File (PAF) in 2021 on the basis of the survey being conducted by opt-in. These addresses comprised three sample types: main (core) sample version A, main (core) sample version B and the child boost screening sample. This sample was split into 9 monthly waves of fieldwork, from April to December. For the core samples, only the first 6 months were issued, as the sample was superseded by a smaller knock-to-nudge sample for the final three months (the sample for knock-to-nudge was smaller due to higher expected levels of response for this approach). The child boost sample was used for the whole 9 months.

Replacement core sample (3,839 addresses) was drawn for the last three months of 2021 to be issued as knock-to-nudge.

For Phase 1 of the survey, participants were asked to opt-in using an online portal, or by contacting the NatCen freephone team. They were asked to leave a telephone number on which an interviewer would call them back. Addresses were only assigned to interviewers after the household had opted into the survey. Assignments comprised up to 10 addresses and a mix of all sample types.

For Phase 2 of the survey, the 3,839 addresses were grouped into 134 interviewer assignments, with around 44 assignments being issued to interviewers each month between October and December 2021.

ScotCen Social Research enlisted the Office for National Statistics (ONS) to assist with the interviewing for the duration of the 2018-2023 contract. ONS interviewers were only used for the knock-to-nudge element of the 2021 survey. As a result, ONS were allocated approximately 30% of the sampled knock-to-nudge addresses.

The table below shows the total number of addresses (mainstage and additional) issued for each sample type and the people eligible for interview within each sample type.

Table 1: Number of addresses and people eligible for interview, 2021

Sample type	Number of addresses issued in 2021	Eligible for interview
Core version A	13,859 opt-in 2,290 K2N	Max of 10 adults (age 16+) and 2 children (age 0-15)
Core version B	9,253 opt-in 1,549 K2N	Max of 10 adults (age 16+) and 2 children (age 0-15)
Child boost	29,833 opt-in	Only households containing children aged 0-15 were eligible to participate (up to two children at these households were eligible to be interviewed)
Total	*56,784*	

Data collection involved a main computer assisted telephone interview (CATI), and online or paper self-completion questionnaire.

As interviews were conducted by telephone, no height and weight measurements or biological measures could be taken. Participants were asked to estimate their own height and weight during the interview. In previous years, the core version B sample completed a biological module, and these addresses were only assigned to trained bio interviewers. For 2021, as no biological measurement could be taken the only real differences between the core version A and version

B interviews were a slightly longer telephone interview for version A to cover the rotating modules and a slightly longer self-completion for version B to cover the depression, anxiety, self-harm and attempted suicide questions which are included in the biological module.

Participants aged 16 and above were also invited to complete an online recall using Intake24 (https://intake24.org/). Participants were asked to provide verbal consent, which was recorded in CAPI. Respondents were also sent a leaflet with some key information about Intake24 included. If the respondent indicated to the interviewer that they had not read the Intake24 information leaflet (sent with their advance letter), the interviewer read out key information from this before obtaining consent. Those who agreed were invited to complete two dietary recalls, either independently or via a phone call with Cambridge University. Further information about Intake24 is provided in sections 1.3.7, 1.6.5, 1.7.7 and 1.8.4.

1.1.6 The 2021 SHeS annual report

The 2021 report consists of two volumes, published as a set under 'The Scottish Health Survey 2021'. Volume 1 presents results for adults and children on a variety of health topics. This report (Volume 2) provides methodological information and survey documentation. Both volumes are available on the Scottish Government's website along with a short summary report of the key findings from the 2021 survey (Scottish Health Survey). Supplementary web tables are also available on this website. These provide a large number of breakdowns by age group, deprivation, income and limiting long-term conditions. An interactive dashboard is also available presenting key indicators for Scotland, NHS Boards and local authority areas.

1.1.7 Comparisons with previous surveys in the SHeS series

In the 2021 report comparisons are made with data collected earlier in the series (1998-2019 for children and 2003-2019 for adults). However, it should be noted that, due to the difference in method for 2021, caution should be applied when comparing results from this survey year to those for previous years. Caution is advised due to:

- The use of an opt-in approach resulting in a lower proportion of respondent households in the most deprived areas and a lower proportion of respondents in the youngest age group than in previous survey years. Interviews achieved as part of the knock-to-nudge sample brought the overall achieved sample a bit closer to the profile in previous years. The weighting strategy adjusted the results to be representative of the household population as a whole as far as possible.
- Changes in the mode of survey administration to telephone with knock-to-nudge recruitment including:
    - Reduced opportunity to build interviewer rapport

    - Changes to the way the respondents answer some questions including the potential for greater honesty when providing potentially sensitive information
- The use of self-reported height and weight data in place of objective measurements taken by interviewers. Whilst for adults an adjustment has been made for this, the mode of data collection requires the continued use of caution when interpreting such data.
- Changes to the sampling approach such as the use of an unclustered sample during phase 1 of fieldwork.

In addition, this report includes analysis from some combined datasets: one for the years 2017 to 2021 combined and one for the years 2019 and 2021 combined to aid analysis of small subsamples of the population and/or for questions which are included in the survey every second year. Combining data across years in this way allows for a more detailed analysis of subgroups in the sample and allows for analysis of questions with small sample sizes in one survey year.

1.1.8 Health Board and local authority level analysis

Since 2008, the SHeS sample has been designed to be representative of adults at Health Board level (for all Health Boards) following four years of data collection and in 2018 the sample size was increased to allow analysis by local authority. Analysis of the 2017 to 2021 data by NHS Health Board and by local authority is published at the same time as this report, and is available on the SHeS website (Scottish Health Survey). Areas with larger samples may be able to analyse data at their area level based on fewer years of data collection and users should consult the SHeS website for further guidance on sub-geographies analysis.

Changes in the sample design for the 2012 survey mean that users are not advised to combine data for periods spanning 2011 and 2012. Since 2012, however, the sample has been designed to be representative of the population of Scotland at Health Board level for every four-year period. Hence the survey can be analysed using combined data from 2012 to 2015, 2013 to 2016, 2014 to 2017, 2015 to 2018, 2016 to 2019 or 2017 to 2021. It should be noted that no data for 2020 is available by Health Board.

1.1.9 Access to SHeS data

Data from the 2021 survey will be deposited at the UK Data Service along with a combined 2017-2021 dataset and a combined 2019/2021 dataset. Datasets from earlier years in the series are also deposited here (www.ukdataservice.ac.uk).

1.2 SAMPLE DESIGN

1.2.1 Requirements

The sample specification for the 2021 SHeS was designed by the Scottish Government. The design was coordinated with the designs for the Scottish Household Survey (SHS) and the Scottish Crime and Justice Survey (SCJS) to improve survey efficiency and to allow the samples of the three surveys to be pooled for further analysis[5].

There were two elements to the SHeS sample in 2021:

1) Main adult sample - to allow annual reporting of Scotland level results and results at Health Board and local authority level using the 2017, 2018, 2019 and 2021 data combined. This required an annual interview target of 5,112 adults for Scotland as a whole and a minimum of 125 for each local authority. There was an additional requirement for a minimum of 1,000 adults to complete each biological measure each year.

2) Child sample boost – overall there was a requirement for 2,031 child interviews for Scotland. As the main sample was only expected to yield 1,026 child interviews, a further 1,005 interviews were required from a separate boost sample.

1.2.2 Sample design and assumptions

In 2021, the opt-in and knock-to-nudge samples utilised different sampling approaches. The opt-in approach did not require clustering as participants were not visited on the doorstep and interviews could be undertaken by interviewers located throughout Scotland.

For knock-to-nudge, the usual two-stage clustered sample design with intermediate geographies randomly selected at the first stage and address points at the second stage, was used. With the exception of Orkney, Shetland and Na h-Eileanan Siar councils, the sample was clustered by intermediate geographies (IG) with one quarter of IGs selected for each year of fieldwork. In Orkney, Shetland and Na h-Eileanan Siar the sample was clustered by data zone.

1.2.3 Main sample

As stated above, the annual sample size for Scotland was 5,112 adults with a minimum local authority sample size of 125 adults. These sample sizes were the minimum required to allow effective reporting of Scotland-level results annually and Health Board and local authority results with four years of data combined. An iterative approach was taken to efficiently allocate the sample across all Health Boards and local authorities. For the first iteration 4,000 adult interviews were allocated across local authorities in proportion to the adult population. Any local authorities allocated fewer than 125 adult interviews had their allocation increased to 125.

The remaining sample was then allocated over the remaining local authorities. Where allocations were not whole numbers the number was rounded up. This resulted in a total target of 5,112 adult interviews. The results of the allocation are shown in Table 2.

Table 2: SHeS target annual adult interviews, 2021, by Health Board

Health Board	Target Annual Adult Interviews
Ayrshire and Arran	375
Borders	125
Dumfries and Galloway	125
Fife	271
Forth Valley	375
Grampian	488
Greater Glasgow and Clyde	1,075
Highland	297
Lanarkshire	482
Lothian	749
Orkney	125
Shetland	125
Tayside	375
Western Isles	125
Total	**5,112**

To allow for reporting at local authority level over a four-year period (2017/2018/2019/2021) and coordination with the sample selection of the SHS and SCJS, the required sample sizes were set at local authority level. This was done by allocating the target Health Board samples to local authorities proportionate to population.

The number of addresses selected in order to provide the target number of interviews for the opt-in part of the sample was calculated by:

1) Estimating the number of productive adult interviews per co-operating household. Considering response data from the shorter 2020 telephone survey, it was estimated that there would be an average of 1.3 interviews per co-operating households in each local authority.

2) Allocation of the target interviews and associated estimate of co-operating households to local authority strata proportionate to population.

3) The response rate assumptions for local authorities for 2021 were then estimated based on the variation across local authorities in response to the 2020 telephone survey and the 2018 and 2019 face-to-face surveys.

4) The final step was to estimate the level of ineligible addresses. As for previous survey years, the estimates were calculated at local authority level and based on the average level of ineligible addresses from previous years of SHeS, SHS and the SCJS.

For the knock-to-nudge part of the sample, a similar process was followed adjusting to account for a higher assumed response rate and a shorter period of fieldwork.

Tables 4 and 5 show the number of selected addresses used for the main sample in 2021 for opt-in and knock-to-nudge.

1.2.4 Child boost sample

For the 2021 survey, 2,031 child interviews were required. It was estimated that the opt-in and knock-to-nudge main sample would provide 1,026 child interviews, therefore, to reach the target number of child interviews, a child boost sample was required to yield a further 1,005 interviews.

The process for calculating the number of addresses to select for the child boost sample was as follows:

1) The child boost sample of 1,005 child interviews was allocated proportionally to local authorities based on the child (under 16) population. If the number expected from the child boost was less than 10, then the local authority boost target was set to zero. The following table shows the target sample sizes for the main sample and child boost sample by Health Board.

Table 3: Target annual child interviews, 2021, by Health Board

	Expected child interviews from main sample	Child interviews from boost	Total child interviews
Ayrshire and Arran	75	70	149
Borders	25	21	50
Dumfries and Galloway	25	27	50
Fife	54	71	108
Forth Valley	75	60	149
Grampian	97	110	194
Greater Glasgow and Clyde	219	216	427
Highland	60	59	118
Lanarkshire	97	131	191
Lothian	149	163	298
Orkney	25	0	50
Shetland	25	0	50
Tayside	75	77	149
Western Isles	25	0	50
Total	**1,026**	**1,005**	**2,031**

2) The number of co-operating households with children required in each Health Board for the child boost sample was estimated using the performance of the child boost samples in the surveys between 2013 and 2015.

3) To estimate the proportion of child-less households, data from child boost samples between 2012 and 2015 was used. As there was little variation across different areas a Scotland level estimate of households without children (80%) was used.

4) The assumptions made on ineligible addresses for the main sample were applied to the address calculations for the child boost sample.

The total numbers of addresses issued for the child boost sample are shown in Table 4.

Table 4: Selected addresses issued by strata in 2021 – opt-in sample (April to September 2021)

Sample strata	Main sample (inc. additional)	Child boost	Total sample
Aberdeen City	621	877	1498
Aberdeenshire	727	1317	2044
Angus	557	631	1188
Argyll & Bute	573	444	1017
Clackmannanshire	467	241	708
Dumfries & Galloway	490	680	1170
Dundee City	736	1026	1762
East Ayrshire	515	636	1151
East Dunbartonshire	449	486	935
East Lothian	467	504	971
East Renfrewshire	449	486	935
Edinburgh, City of	1385	2059	3444
Eilean Siar	513	0	513
Falkirk	458	755	1213
Fife	1231	2091	3322
Glasgow City	2849	4471	7320
Highland	721	1195	1916
Inverclyde	879	678	1557
Midlothian	453	445	898
Moray	478	467	945
North Ayrshire	489	656	1145
North Lanarkshire	1220	2228	3448
Orkney Islands	503	0	503
Perth & Kinross	594	856	1450
Renfrewshire	677	1117	1794
Scottish Borders	476	517	993
Shetland Islands	486	0	486
South Ayrshire	478	494	972
South Lanarkshire	1276	2168	3444
Stirling	464	429	893
West Dunbartonshire	869	806	1675
West Lothian	562	1073	1635
Total	**23,112**	**29,833**	**52,945**

Table 5: Selected addresses issued by strata in 2021 – K2N sample (adults only)

Sample strata	Main adult sample
Aberdeen City	121
Aberdeenshire	132
Angus	92
Argyll & Bute	108
Clackmannanshire	87
Dumfries & Galloway	94
Dundee City	97
East Ayrshire	86
East Dunbartonshire	89
East Lothian	96
East Renfrewshire	88
Edinburgh, City of	279
Eilean Siar	93
Falkirk	84
Fife	208
Glasgow City	370
Highland	149
Inverclyde	103
Midlothian	82
Moray	86
North Ayrshire	93
North Lanarkshire	187
Orkney Islands	88
Perth & Kinross	97
Renfrewshire	106
Scottish Borders	84
Shetland Islands	87
South Ayrshire	93
South Lanarkshire	174
Stirling	85
West Dunbartonshire	100
West Lothian	101
Total	**3,839**

1.2.5 Sample Selection

The Royal Mail's small user Postcode Address File (PAF) was used as the sample frame for the address selection. The advantages of using the PAF are as follows:

- It has previously been used as the sample frame for Scottish Government surveys so previously recorded levels of ineligible addresses can be used to inform assumptions for 2021 sample design.
- It has excellent coverage of addresses in Scotland.
- The small user version excludes the majority of businesses.

The PAF does still include a number of ineligible addresses, such as small businesses, second homes, holiday rental accommodation and vacant properties. A review of the previous performance of individual surveys found that they each recorded fairly consistent levels of ineligible address for each local authority. This meant that robust assumptions could be made for the expected levels of ineligible addresses in the sample size calculations.

As the samples for the SHS, SHeS and SCJS have all been selected by the Scottish Government since 2012, addresses selected for any of the surveys are removed from the sample frame so that they cannot be re-sampled for another survey. This helps to reduce respondent burden. The addresses are removed from the sample frame for a minimum of four years.

The sample design specified in Section 1.2 for opt-in was implemented in two stages:

1. The required numbers of addresses for the main and child boost samples were combined to give an overall total of addresses to sample for each stratum (local authorities). The required number of addresses for each stratum was then sampled from the sample frame of addresses. Systematic random sampling was used with addresses within PSUs ordered by urban-rural classification, SIMD rank and postcode.

2. Once the overall sample was selected, each address was randomly allocated to the main or the child boost sample. Also, one quarter of the target main adult sample was required to complete the biological module. To guard against a lower response rate to the different elements of the biological module, and to correct for inaccurate response assumptions in previous years, a proportion higher than the required one quarter of the main adult sample (40% in 2021) were allocated to the biological module.

The sample design specified in Section 1.2 for knock-to-nudge was implemented in three stages:

1. All primary sampling units (data zones on the islands, intermediate geographies elsewhere) were randomly allocated to one of four sets. One of these sets will be used in each in each year of fieldwork. This means that the sample is drawn from one quarter of PSUs each year. The sets were updated ahead of the 2021 sampling and this ensures that over four years of fieldwork (2021 to 2024) all addresses will have a non-zero probability of selection.

Table 6: Primary sampling units selected in 2021 knock-to-nudge sample

Health Board	PSUs in 2021 Sample	Total PSUs
Ayrshire and Arran	24	93
Borders	7	30
Dumfries and Galloway	10	40
Fife	26	104
Forth Valley	20	78
Grampian	33	132
Greater Glasgow and Clyde	64	257
Highland	20	79
Lanarkshire	40	160
Lothian	48	192
Orkney	7	29
Shetland	7	30
Tayside	23	92
Western Isles	9	36
Total	**338**	**1,352**

2. As there was no child boost for the knock-to-nudge part of the sample, the required numbers of addresses for the main sample gave an overall total of addresses to sample for each stratum (local authorities). The required number of addresses for each stratum was then sampled from the sample frame of addresses in active PSUs. Systematic random sampling was used with addresses within PSUs ordered by urban-rural classification, SIMD rank and postcode.

3. Once the overall sample was selected, a proportion of the main sample addresses were randomly allocated to the biological module. One quarter of the target main adult sample was required to complete the biological module. To guard against a lower response rate to the different elements of the biological module, and to correct for inaccurate response assumptions in previous years, a proportion higher than the required one quarter of the adult sample (40% in 2021) were allocated to the biological module.

1.2.6 Selecting individuals within households

For the main sample, all adults aged 16 and over in responding households were eligible for interview. To ease respondent burden, for child interviews for both the main and the child boost samples a maximum of two children were interviewed at each household. If a household contained more than two children, then two were randomly selected for interview.

1.3 TOPIC COVERAGE

1.3.1 Introduction

Topics covered in the 2018 to 2021 surveys were agreed following a consultation carried out in 2016[6]. Many of the topics and questions included in earlier years of the survey were included again to continue the time series, questions on long Covid were included for the first time. The 2021 survey included the same rotating topics as the 2019 and 2017 surveys (see sections 1.3.3 and 1.3.4), with the exception that the adverse childhood experience questions (ACES) were not asked in 2021 and questions on drug use were included for the first time. As with previous years, the 2021 survey had a focus on cardiovascular disease (CVD) and its associated risk factors.

The outcome of a public consultation about the content of the survey from 2018 is available from http://www.gov.scot/Resource/0053/00537370.pdf. This report outlines key changes to be made to the 2018-2021 surveys and other topics which would be considered if space became available.

1.3.2 Documentation

Copies of all the documents used in data collection are included in Appendix A. Full copies of the questionnaire documentation used in the main interview and biological module are also available at Scottish Health Survey. A summary of the main interview content and the content of the biological module is provided below.

1.3.3 Main interview

Information was collected at both the household and individual level. Table 7 below summarises the content of the individual level interviews for all participants. The topics a participant was asked depended both on their age and the sample type to which their address had been allocated. The age criteria for each topic are included in brackets following the topic name.

Table 7: Content of the 2021 Interview

Main interview (asked of everyone)	
Household questionnaire including household composition	
General health including caring (0+)	
Respiratory symptoms, cardiovascular disease and use of services (16+)	
Asthma (0+)	
COVID-19 (0+)	
Physical activity adults (16+) and children (2-15)	
Eating habits children (2-15)	
Fruit and vegetables consumption (2-15)	
Vitamins and supplements (0+)	
Smoking (18+)	
Passive smoking (0+)	
Drinking (18+)	
Dental health (16+)	
CPR training (16+)	
Employment and economic activity (16+)	
Education (16+)	
Self-reported measurements (0+)	
Ethnic background, religion and country of birth (0+)	
Parental history/Family health (16+)	
Accidents (0+)	Asked in version A of two thirds of the adult sample and Child Boost
Dental services (16+)	Asked in version A of two thirds of the sample only
Discrimination and harassment (16+)	Asked in version A of two thirds of the sample only
Stress at work (16+)	Asked in version A of two thirds of the sample only
Intake24 (16+)	Asked of those who agreed to take part in this follow up module

Table 8 Overview of topics included in SHeS adult self-completions

Self-completion – Adults aged 18+
Annual topics
Mental wellbeing
Loneliness
Sexual orientation
Gender identity
Veterans
Depression, anxiety, self-harm and suicide (only asked of those assigned to Version B – approximately a third of adults)
Non annual topics
Problem drinking
Drug use
Food insecurity
Social capital

Table 9. Overview of topics included in SHeS young adult self-completion booklets

Self-completion - Young adults
Annual topics
Mental wellbeing
Alcohol
Smoking
Loneliness
Sexual orientation
Gender identity
Depression, anxiety, self-harm and suicide (only asked of those assigned to Version B – approximately a third of adults)
Veterans
Non annual topics
Drug use
Problem drinking
Food insecurity
Social capital

Table 10. Overview of topics included in 13–15-year-olds self-completion booklets

Self-completion - 13–15-year-olds
Annual topic
Mental wellbeing

Table 11. Overview of topics included in 4–12-year-olds self-completion booklets

Self-completion - Parents of 4–12-year-olds
Annual topic
Strengths and difficulties questionnaire (SDQ)

Version A households accounted for 60% of the main (core) sample. At these households the questionnaire included the core questions and the questions included in the Version A rotating module. In 2021, the topics included in the Version A rotating module were: accidents, dental services, discrimination and harassment, stress at work, parental history and family health.

Version B households accounted for the remaining 40% of the main (core) sample. At these addresses, participants were asked the core questions during the main interview, with a slightly longer self-completion module that included depression, anxiety, self-harm and attempted suicide questions.

A significant number of changes were made to the questionnaire content in advance of the 2018 survey based on the consultation that took place in Autumn 2016, with a summary of responses published in Spring 2017[7]. These changes are discussed below and in the Scottish Health Survey: Report of Questionnaire Changes from 2018[8].

From 2018, a number of modules were made less frequent and are no longer asked on an annual basis in the main interview but are asked biennially instead. These questions include those on family health and parental history, CPR training and use of health services.

There were also a few new questions added to the main interview in 2018. These include a question for those who have used a form of Nicotine Replacement Therapy (NRT) to aid smoking cessation, two questions concerning asthma; firstly, school absence due to asthma and secondly, treatment received for asthma, a question establishing whether respondents with diabetes have Type 1 or Type 2, and finally questions on respondents' satisfaction with local services (for example local health services, local schools, refuse collection, public transport, council libraries, etc.).

A number of small amendments were also made to survey questions from 2018 (for example, updates to education qualifications). For full details of these please see the Scottish Health Survey: Report of Questionnaire Changes from 2018[8].

Significant changes were made to the child physical activity questions in 2017. These changes were designed to measure the activity guidelines of being physically active for at least 60 minutes per day for each day of the week (children aged 5 and over). This involved amending the questions. Previously, children were asked for the *number* of days on which they did physical activity and for the *average* amount of time this was for overall. The revised questions ask *which* days they did physical activity and the amount of time spent on *each* of those days (more information is provided in the Physical Activity chapter of the Main Report). These questions remained as they were for 2018.

Analysis of the 2017 data showed that it was not possible to derive a variable which would allow comparison between 2017 data (using the revised questions) and previous years of data (using the previous questions). For this reason, there is no trend analysis for children's physical activity in 2017 or 2018. The question module used prior to 2017 was reinstated in the 2019 survey.

In 2021, questions on COVID-19 vaccinations and long COVID were included to monitor the continued effects of the pandemic on the health of those living in Scotland.

The full question wording of all the questions used in 2021 can be found at Scottish Health Survey.

1.3.4 Self-completion questionnaire

Participants aged 13 and over and parents of participants aged between 4 and 12 were asked to fill in a self-completion booklet during the interview. In all, four different booklets were administered. The version completed was dependent on the age of the participant.

The booklet for young adults aged 16-17 included questions on smoking and drinking behaviour (instead of these being asked as part of the CAPI interview). Interviewers also had the option of administering this young adults self-completion for those aged 18-19 if they felt that it would be more appropriate.

From 2018, some changes were made to self-completion booklets. Questions on contraception and cosmetic procedures were removed indefinitely from both the young adult and adult self-completion. Questions on problem drinking and gambling are now asked less frequently, with problem drinking questions asked biennially and gambling questions asked every few years. New questions on Adverse Childhood Experience were included in 2019 and questions on drug use were included for the first time in 2021.

From 2018, a new question on gender identity was added to the self-completion booklet. This question was added to both the young adult and adult self-completion booklets. For the wording of the questions in full, see the adult or young adult self-completion booklet listed at Scottish Health Survey .

Paper questionnaire booklets contained the following topics in the 2021 survey:

Adults	(Versions A & B) General Health Questionnaire (GHQ12), Warwick Edinburgh Mental Well-being scale (WEMWBS), food insecurity, problem drinking (AUDIT), drug use, gambling, social capital, food insecurity, loneliness, sexual orientation, and gender identity. (Additional questions in version B) - depression, anxiety, self-harm and attempted suicide.
Young adults	Smoking (including use of e-cigarettes), drinking, problem drinking (AUDIT), drug use, gambling, GHQ12, WEMWBS, social capital, food insecurity, loneliness, sexual orientation and gender identity.
13-15 year olds	GHQ12 and WEMWBS.
Parents of 4-12 year olds	Strengths and Difficulties questionnaire (SDQ) (designed to detect behavioural, emotional and relationship difficulties in children).

1.3.5 Height and weight

Due to the restrictions in place at the time of the 2021 fieldwork, self-reported height and weight data was collected for participants aged 2 and over, with their consent.

1.3.6 Biological module

As highlighted previously, at a sub-sample (around 40%) of main core sample addresses, adults (aged 16 and over) were selected to complete the biological module. Since 2012, specially trained interviewers have been collecting the measurements and samples which were collected by nurses in previous years (1995 to 2011). This was not possible in 2021, therefore, no objective biological measurements were collected.

Participants in this sample were asked a set of questions about depression, anxiety, suicide attempts and self-harm (taken from the Adult Psychiatric Morbidity Survey) as part of their self-completion questionnaire. These questions were previously completed by the respondent using a computer-assisted self-completion approach (CASI) directly on to the interviewer's laptop.

1.3.7 Intake24 dietary recalls

Respondents who consented to take part in Intake24 were invited to undertake dietary recalls on two separate occasions where they input details of their food and beverage consumption for the previous day. Two recalls, rather than a single recall, were requested to get a better understanding of an individual's typical diet.

1.4 FIELDWORK PROCEDURES

1.4.1 Advance letters

Each sampled address was sent an advance letter that introduced the survey and for the knock-to-nudge sample, to let the resident know that an interviewer would be calling to seek permission to interview. A number of versions of the advance letter were used in 2021; one for the core version A addresses, one for core version B addresses (with the biological module), and one for child boost addresses. There was a version of each of these letters for each organisation conducting interviews (ScotCen Social Research and ONS), as well as for the opt-in and knock-to-nudge samples. A copy of the survey leaflet was included with every advance letter. The survey leaflet introduced the survey, described its purpose in more detail and included some summary findings from previous surveys.

For copies of the advance letters and survey leaflet, see the documents listed in Appendix A.

1.4.2 Making contact

Initial contact for both samples was made via the advance letter. For the opt-in sample, this letter provided instructions for taking part which involved contacting us via an online opt-in portal, the survey email address and/or the survey freephone number. Additional information was then sent by post to participants who opted in, which was followed

by interviewer telephone contact to arrange a time to complete the interview.

The knock-to-nudge approach differed in that interviewers were able to visit respondent's homes to attempt to obtain gain agreement to participate in the survey, which continued to be conducted by telephone. At initial contact, the interviewer established the number of dwelling units (DUs) and/or households (HHs) at an address and made any necessary selections (see Section 1.2.7).

The interviewer then attempted to make contact with each household. In the main sample they attempted to interview all adults (up to a maximum of ten) and up to two children aged 0-15 (see Section 1.2) from the household. At child boost sample households, interviewers first screened for children aged 0-15. In those households where children were present up to two children were randomly selected for interview. Interviewers obtained the verbal consent of both the parent/guardian and the child before commencing the interview.

1.4.3 Collecting data

Interviewers used computer assisted telephone interviewing (CATI) for the main SHeS interviews.

At each co-operating eligible household (across all sample types), the interviewer first completed a household questionnaire, with information collected from the household reference person[9] or their partner wherever possible. This questionnaire obtained basic information (including date of birth and relationship to other household members) about all members of the household, regardless of age and whether they were eligible to take part in the interview. The computer assisted personal interviewing (CAPI) program then created individual questionnaires for each eligible participant in the household.

Where possible an individual interview was then conducted with all eligible adults and up to two children in a household. In order to reduce the amount of time spent in the home, interviews could be carried out concurrently.

In addition to an advance letter and general survey leaflet, participants were also given a more detailed leaflet describing the contents and purpose of the interview, and what will happen to information they provide (including a link to the Privacy Notice on the Scottish Government's website).

A separate version of this leaflet was used for children in both main and child boost households. Parents at child boost addresses were also provided with a leaflet containing background information on the survey. Copies of all the participant leaflets used in the survey are included in Appendix A.

Online Intake24 dietary recalls were completed via a link (sent by text or email) sent directly to participants by the interviewer within minutes of giving consent. The second recall was completed within seven days of the initial recall. For participants who requested assistance to complete the recalls the interviewer collected a phone number and arranged an appointment date and time for the first recall for at least 5 days following the SHeS interview. This information was sent securely to the Cambridge University team. Participants opting for telephone assistance were sent a hard-copy food photograph atlas in advance to aid the estimation of portion sizes during completion of the dietary recalls. After the first recall was completed, the date for the second recall was arranged between the respondent and the caller from Cambridge.

1.4.4 Interviewing and measuring children

Children aged 13-15 were interviewed directly by interviewers, after verbal consent had been obtained from both the child and their parent or guardian. Interviewers were instructed to ensure that the child's parent or guardian was present throughout the interview. Information about younger children (aged 0-12) was collected directly from a parent or guardian.

1.5 FIELDWORK QUALITY CONTROL AND ETHICAL CLEARANCE

1.5.1 Training interviewers

Interviewers new to SHeS were fully briefed on the survey's content and procedures. Interviewers were supervised by an interviewer supervisor during the early stages of their work to ensure that interviews were administered correctly, and protocols were followed.

Interviewers that had worked on SHeS in previous years attended a refresher briefing ahead of the launch of the new survey year and were refreshed on the knock-to-nudge process when this was introduced. This ensured that they were aware of changes to survey content and procedures for 2021.

Interviewers interested in administering the biological module were initially screened for suitability. Minimum competency levels were set and only interviewers that met the set criteria were invited to training and accreditation sessions.

Full sets of written instructions, covering both survey procedures and measurement protocols, were provided to interviewers (measurement protocols are available on request from ScotCen Social Research).

1.5.2 Checking interviewer and measurement quality

A large number of quality control measures were built into the survey at the data collection stage and thereafter, to monitor the quality of interviewer performance.

Quality checks were carried out at 10% of productive households. These recalls checked with the participants that interviewers had followed the correct survey procedures when conducting the interview.

In addition to the above quality checking procedure, the computer program used by interviewers had in-built soft checks (which can be suppressed) and hard checks (which cannot be suppressed) associated with particular interview questions. When uncommon or unlikely answers were entered, or answers outside a predetermined range, these checks were triggered and appear as a warning message on the interviewers' laptop. The interviewer is either encouraged to double-check the entered response (a soft-check) or asked to change it (a hard-check). For example, when young children were weighed by having an adult hold them; the weight of the adult on their own was entered into the computer followed by the combined weight of the infant and adult. A hard check was used to ensure that the weight entered for the adult alone did not exceed the weight of the infant and adult combined.

Soft-checks were similar to hard-checks, however they could be suppressed. For example, soft-checks were applied to height measurements; if an interviewer entered a respondent's height to be in excess of 1.93 metres (6 feet 3 inches), a message appeared asking the interviewer to confirm that this entry was correct. The interviewer could suppress the soft-check once they had confirmed that the height entry was not a mistake.

1.5.3 Ethical clearance

Ethical approval for the 2021 survey was obtained from the Health and Care Research Ethics Committee for Wales (REC reference number: 17/WA/0371).

1.6 SURVEY RESPONSE

1.6.1 Introduction

This section presents the fieldwork outcomes for the sampled addresses. Survey response is an important indicator of survey quality as non-response can introduce bias into survey estimates. Standardised outcome codes (based on an updated version of those published in Lynn et al, 2001[10]) for survey fieldwork were applied across the SHeS, SHS and SCJS. This enables consistent reporting of fieldwork performance and effective comparison of performance between the surveys.

1.6.2 Household response

Tables 1.1a and 1.1b show a detailed breakdown of the SHeS response for sampled addresses in 2021, which are reported separately for the opt-in and knock-to-nudge samples. Addresses with unknown eligibility have been allocated as eligible and ineligible proportional to the levels of eligibility for the remainder of the sample. This approach provides a

conservative estimate of the response rate as it estimates a high proportion of eligible cases amongst addresses with unknown eligibility.

At each selected household in the main sample, all adults and a maximum of two children were eligible for interview. When considering the household response rate, households classed as “responding” were those where at least one eligible person opted-in/consented to interview and was interviewed. The tables show that for the main opt-in sample, 9.7% of eligible households were classed as responding whilst for knock-to-nudge households this proportion was 31.1%. All individual interviews were completed at 7.9% of main opt-in and 22.9% of knock-to-nudge households.

For the child boost sample, 11.8% of eligible households contacted opted in. 3.1% of households that opted in were ineligible as they did not contain any children under the age of 16. For eligible households 87.7% were classed as responding, with all individual interviews complete at 87.5% of households.

Table 1.2a shows that across Heath Boards, the percentage of opt-in households where at least one eligible person was interviewed ranged from 8.3% (Lanarkshire) to 12.1% (Lothian). Fully cooperating households were those where all eligible individuals were interviewed. This varied between 6.0% in the Western Isles to 10.1% in the Borders. The definition of a fully cooperating household changed in 2012 and is therefore not comparable with fully cooperating figures prior to this.

Table 1.2b shows the household response rate for eligible addresses in the opt-in child boost sample by Health Board. This varied from 7.0% (Ayrshire and Arran) to 12.7% (Grampian). Note that the bases for child boost response rates were particularly low in a number of areas (for example 4 eligible households in Dumfries and Galloway and 8 in the Borders).

Table 1.2c shows that across Heath Boards, the percentage of knock-to-nudge households where at least one eligible person was interviewed ranged from 13.3% (Shetland Islands) to 44.7% (Forth Valley). Fully cooperating households were those where all eligible individuals were interviewed. This varied between 16.9% in Ayrshire and Arran to 31.0% in the Highlands. The definition of a fully cooperating household changed in 2012 and is therefore not comparable with fully cooperating figures prior to this

Table 1.3a shows that across Local Authorities, the percentage of opt-in households where at least one eligible person was interviewed ranged from 6.7% (North Lanarkshire) to 14.2% (City of Edinburgh). Fully cooperating households varied between 5.2% (North Lanarkshire) and 11.5% (City of Edinburgh).

Table 1.3b shows the household response rate for eligible addresses in the opt-in child boost sample by Local Authority. This varied from 3.2%

(Dumfries and Galloway) to 14.7% (West Lothian). Note that the bases for child boost response rates were particularly low in a number of areas (for example 4 eligible households in Argyll and Bute and Clackmannanshire).

Table 1.3c shows that across Local Authorities, the percentage of knock-to-nudge households where at least one eligible person was interviewed ranged from 12.5% (South Ayrshire) to 61.6% (Stirling). Fully cooperating households varied between 6.8% (South Ayrshire) and 39.7% (Stirling). **Tables 1.1a – 1.3c**

1.6.3 Individual response for adults

Overall, there were 4,557 adult responses (2,984 from the opt-in sample and 1,573 from knock-to-nudge) to SHeS 2021, as detailed in tables 1.4a and 1.4c.

The adult response rate in 2021 was calculated based on the number of eligible households. This was undertaken by dividing the number of individual adult interviews by the number of eligible adults in productive households. The total estimated number of adults from sampled addresses eligible for interview is referred to as the “set” sample. For 2021, the set sample for adults was 3,429 for the opt-in sample and 1,914 for the knock-to-nudge sample.

Table 1.4a shows the adult response rate broken down by area deprivation for the opt-in sample. The adult response rate ranged from 86.3% in Scottish Index of Multiple Deprivation (SIMD) quintile 1 (most deprived) to 87.8% in quintile 2.
Table 1.4c shows the adult response rate broken down by area deprivation for the knock-to-nudge sample. The adult response rate ranged from 79.8% in (SIMD) quintile 4 to 84.4% in quintile 2.

Table 1.5 shows that the age distribution of respondents to the core opt-in sample was generally older than the population as a whole. For men, 23% of core opt-in respondents were in the 55-64 age group and 22% in the 65-74 age group compared with 17% and 13% of the male population as a whole. There were similar but smaller differences for women, with 21% of female respondents aged 55-64 and a further 21% aged 65-74 compared to 17% and 13% respectively of the female population as a whole. The sex/age profile for the knock-to-nudge sample was closer to the profile of the population as a whole but still with a lower proportion of respondents aged 16-34 and a higher proportion aged 55-74. **Tables 1.4a, 1.4c and 1.5**

1.6.4 Individual response for children (0-15)

Interviews were undertaken with 1,600 children aged 0 to 15, with 500 interviews taking place as part of the main opt-in sample, 277 as part of the knock-to-nudge sample and 823 as part of the child boost.

As was the case with the adult sample, in order to calculate the response rate for children, the number of eligible children in households that opted-in was used. Tables 1.4a, 14b and 1.4c show that overall response rates for the main sample, knock-to-nudge sample and child boost sample were similar (94.5% for the main sample, 99.9% for the child boost sample and 88.8% for the knock-to-nudge sample).

Tables 1.4a and 1.4c

1.6.5 Intake24 response

A total of 3,447 SHeS adult participants aged 16 and over completed at least one of the dietary recalls, with 3,042 completing both dietary recalls. Similar proportions of men and women completed both of their recalls (86% and 89% respectively). For those who completed any recalls, full completion generally increased with age, with 90% - 91% of those aged 55 and over completing both recalls, with a fairly even spread across the SIMD quintiles (in the range 86% - 89%). **Table 1.6**

1.7 WEIGHTING THE DATA

1.7.1 Introduction

This section presents information on the weighting procedures applied to the survey data. Since 2012 the weighting for SHeS has been undertaken by the Scottish Government rather than the survey contractor (as had previously been the case), but the methodology applied was largely consistent with that of the 2008 to 2011 sweeps of the survey. The procedures for the implementation of the weighting methodology were developed by the Scottish Government working with the Methodology Advisory Service at the Office for National Statistics[11].

To undertake the calibration weighting the ReGenesees Package for R was used. Within this, to execute the calibration, a raking function was implemented.

1.7.2 Main adult weights

The main adult weight is applicable for all adults interviewed as part of the main sample. There were six steps to calculating the overall adult weights. These were as follows:

1) Address selection weights (w1)

The address selection weights were calculated to compensate for unequal probabilities of selection of addresses in different survey strata, within the opt-in and knock-to-nudge samples. For the main sample there were 32 strata (one for each local authority) for both opt-in and knock-to-nudge.

$$w0 = \frac{\text{Number of PAF addresses in the stratum (opt-in/K2N)}}{\text{Number of addresses selected in the stratum (opt-in/K2N)}}$$

To account for the different response rates in the opt-in and knock-to-nudge samples, this was multiplied by the reciprocal of the response rate for opt-in or knock-to-nudge. The address selection weight for each stratum was calculated as:

$$w1 = w0 * \frac{1}{\text{Stratum response rate (opt-in/K2N)}}$$

2) Dwelling unit selection weights (w2)

The Multiple Occupancy Indicator (MOI) for the PAF was used to ensure that if there were multiple dwelling units at a single address point then they would have the same selection probability as individual addresses. However, there are likely to have been some cases where the MOI was incorrect. In face-to-face fieldwork, interviewers record where an MOI is different from PAF when visiting a property. This is not possible via the telephone survey, therefore, the information provided by PAF was assumed to be correct, therefore w2 is effectively 1 for all households.

3) Household selection weights (w3)

Similarly to w2, within a very small number of dwelling units, fieldworkers usually find multiple households, of which only one is selected for participation. Again, due to data collection via the telephone rather than face-to-face, it is not possible to correct for this, therefore w3 was effectively taken as 1 for all households.

4) Calibrated household weights (w4)

The three selection weights were combined (w1*w2*w3) before the household calibration stage. This combined weight was applied to the survey data to act as entry weights for the calibration. The execution of the calibration step then modified the entry weights so that the weighted total of all members of responding households matched the population totals for Health Boards, Scotland-level population totals for age/sex breakdown, and the population within each SIMD quintile. The population totals that were used were the National Records of Scotland's (NRS) mid-2020 estimates for private households.

5) Adult non-response weights (w5)

All adults within selected households were eligible for interview, but within responding households not all individuals completed an interview. The profiles of household members that did not complete the interview were different from those that did. Information on all individuals within responding households was available through information gathered as part of the household interview. This allowed the differential response rates for individuals within households to be modelled using logistic regression to calculate a probability of responding based on their profiles. The logistic regression was only applicable for households containing more than one adult since households consisting of only one

adult either responded to the household and individual interviews or did not respond at all.

The following variables were considered for inclusion in the model:

- Health Board
- Age/sex
- Number of adults in the household
- Employment status of household reference person
- Presence of a smoker in the household
- Marital status
- Tenure
- Urban/rural classification
- Access to a car
- Located within SIMD15 area
- Frequency of eating meals together

Through running backwards and forwards selection procedures for the logistic regression the following variables were included in the final model:

- Health Board
- Age/sex
- Number of adults in the household
- Located within SIMD15 area
- Marital status
- Frequency of eating meals together
- Urban/rural classification

The final logistic regression model was then used to calculate the probability of response for all individuals that did respond. The adult non-response weight (w5) was then calculated as the reciprocal of this probability:

$$w5 = \frac{1}{\text{Probability of individual's response}}$$

For households of only one adult the non-response weight was one.

6) Individual calibration and final adult weight (int21wt)

The household (w4) and non-response (w5) were combined (w4*w5) and applied to the survey data prior to the final stage of calibration weighting which matched weighted totals for the survey data to the NRS 2020 mid-year population estimates for Health Boards, age/sex distribution at Scotland level and age/sex distribution for the Glasgow and Greater Clyde Health Board.

Table 9: 2020 Mid-year population estimates for private households in Scotland by Health Board

Health Board	Adults	Children	Total
Ayrshire & Arran	302,951	60,401	363,352
Borders	95,527	18,769	114,296
Dumfries & Galloway	123,363	22,982	146,345
Fife	301,015	63,959	364,974
Forth Valley	247,082	51,629	298,711
Grampian	470,673	100,082	570,755
Greater Glasgow & Clyde	957,186	197,309	1,154,495
Highland	262,536	50,752	313,288
Lanarkshire	539,111	117,734	656,845
Lothian	732,061	151,379	883,440
Orkney	18,628	3,526	22,154
Shetland	18,544	4,112	22,656
Tayside	338,590	66,541	405,131
Western Isles	22,014	4,125	26,139
Total	**4,429,281**	**913,300**	**5,342,581**

Table 10: 2020 Mid-year population estimates for private households in Scotland by SIMD Quintile

SIMD Quintile	Total population
1 – 20% most deprived data zones	1,044,389
2	1,037,754
3	1,049,792
4	1,116,429
5 – 20% least deprived data zones	1,094,217
Total	**5,342,581**

Table 11: 2020 Mid-year population estimates for private households in Scotland by age group

Age group	Male	Female	Total
0-4	135,354	127,448	262,802
5-9	152,167	144,604	296,771
10-15	180,396	173,331	353,727
16-24	261,040	246,143	507,183
25-34	365,469	372,353	737,822
35-44	329,126	345,187	674,313
45-54	355,921	383,029	738,950
55-64	361,676	386,210	747,886
65-74	277,797	303,440	581,237
75+	187,561	254,329	441,890
Total	**2,606,507**	**2,736,074**	**5,342,581**

1.7.3 Biological module weights

A similar process was applied to derive the weights for the biological module. This is outlined below.

1) Calibrated household weight (w4)

As there was no Health Board boost, the calibrated household weights (w4) were applied from above.

2) Adjustment for biological module selection (bw5)

40% of the main sample was allocated to the biological module. To incorporate this probability of selection a correction was applied to the calibrated household weight (bw4). The correction was:

$$bw5 = \frac{\text{PAF addresses in stratum (opt-in/K2N)}}{\text{Addresses selected in stratum for bio mod (opt-in/K2N)}} * \frac{1}{w4}$$

3) Application of adult non-response (w5)

For within household non-response, the non-response weight (w5) calculated for all households was also applicable for the biological module. An additional non-response weight was not required for the biological module as this was carried out as part of the telephone interview.

4) Final calibration for biological module (bio21_wt)

The household (w4), biological sample correction (bw5) and adult non-response (w5) weights were combined (w4*bw5*w5) and applied to the survey data.

For the final stage of biological module weighting the weighted totals for the survey data were calibrated to match the NRS 2020 mid-year population estimates for private households for Health Boards, age/sex

distribution at Scotland level. However, due to the low sample size for the module a number of the categories had to be collapsed. In terms of Health Boards, all areas except for Grampian, Greater Glasgow and Clyde, Lanarkshire and Lothian were grouped together. For the age groups, the lowest two age groups were combined as were the highest two age groups.

1.7.4 Non-biological module weights (Version A)

A weight titled “Version A” was calculated for the individual respondents in the main sample that were not selected for the biological module. The following steps were followed to derive the weight:

1) Calibrated household weight (w4)

   As there was no Health Board boost, the calibrated household weights (w4) were applied from above.

2) Adult non-response weight (w5)

   For within household non-response, the non-response weight (w5) calculated for all households was also applicable for the biological module.

3) Final calibration for Version A weight (verA21wt)

   The household (w4) and adult non-response (w5) weights were combined (w4*w5) and applied to the survey data. As was the case with the main adult weight and biological module weight, the weighted totals for the survey data were calibrated to match the NRS 2020 mid-year population estimates for private households for Health Boards, age/sex distribution at Scotland level.

1.7.5 Overall child weights

An overall child weight was derived for child responses from the main sample and from the child boost combined. Separate logistic regression non-response weights were not required for the child samples as the response rate for children within cooperating households was sufficiently high. The weighting steps are shown below. Steps (1) and (2) followed the same process as described in 1.7.2 above.

1) Address selection weight for main sample and child boost combined (cw1)

2) Dwelling unit (cw2) and household (cw3) selection weights

3) Selection of children within each household (cw4)

A maximum of two children were eligible for interview in each household. To ensure that children in larger households were not under-represented in the final sample the following child selection weight was calculated for households with more than two children to compensate for the probability of selection:

$$cw4 = \frac{\text{Number of children in the household}}{2}$$

For households with two or fewer children cw4=1.

4) Calibration for child interview weight (cint21wt)

The address selection (cw1), dwelling unit (cw2), household (cw3) and child selection weights (cw4) were combined (cw1*cw2*cw3*cw4) and applied to the survey data. The weighted totals for the survey data were calibrated to match the NRS 2020 mid-year population estimates for private households for Health Boards, age/sex distribution at Scotland level.

Weights were also created specifically for within household analysis, comparing children's characteristics with those of their parents. As data were only collected with respect to both children and adults in the core sample, these weights were only created for children at core sample addresses. They were created in a similar fashion to that described for the whole of the overall child weights.

1.7.6 Combined weights

A number of different combinations of annual sweeps have been produced to allow the analysis of combined datasets. Due to disruption to the survey at the onset of the pandemic, the survey data collected in 2020 was published as experimental statistics and was not comparable with the time series[12]. This data has not been included in the survey trends or the combined years' analysis.

Weight name	Purpose of combined weight
int17181921wt	For analysis of 2017, 2018, 2019 and 2021 combined adult data
cint17181921wt	For analysis of 2017, 2018, 2019 and 2021 combined child data
cmint17181921wt	For analysis of 2017, 2018, 2019 and 2021 combined child data core sample only (for within household analysis)
int1921wt	For analysis of 2019 and 2021 combined adult data
cint1921wt	For analysis of 2019 and 2021 combined child data
bio1921wt	For analysis of 2019 and 2021 combined depression, anxiety, suicide and self-harm data
vera1921wt	For analysis of 2019 and 2021 combined version A adult module data
cvera1921wt	For analysis of 2019 and 2021 combined version A child module data
vera21wt	For analysis of 2021 version A adult module data

In each case, the calculation of the weights followed the same procedure. The pre-calibration weights which had already been calculated for the individual years (which take into account selection

weighting and (except for the child weights) non-response weighting) were combined and calibrated to Health Board and age/sex 2020 population totals for private households.

1.7.7 Intake24 weights

1) Selection and SHeS non-response

The basis for the Intake24 adult weight was the main adult weight (int21wt), which adjusts for the probability of selection and non-response to the survey. This weight was rescaled to a mean of one for all adult respondents eligible for the Intake24 survey.

2) Intake24 non-response weight

Not all of the adults that were invited to take part in the Intake24 survey responded. Using the information collected for the respondent in the main interview and household interview, the likelihood of responding to the Intake24 survey was modelled with logistic regression.

Through running backwards and forwards selection procedures for the logistic regression the following variables were included in the final model for response to the Intake24 survey:

- Health Board
- Age
- Sex
- Ethnicity
- SIMD Quintile
- Tenure
- Number of adults in the household
- Number of children in the household
- Frequency of eating meals together
- Currently drink alcohol
- Any housework in past 4 weeks
- Gardening/DIY/building work in past 4 weeks
- Whether meets CMO recommendations on activity duration and muscle strengthening
- Whether provide help or care
- Highest qualification held
- Presence of a smoker in the household

The final logistic regression model was then used to estimate the probability of response for all individuals that did respond to the Intake24 survey. The Intake24 non-response weight (intake24_NR) was then calculated as the reciprocal of this probability:

$$\text{intake24\_NR} = \frac{1}{\text{Probability of individual's response to Intake24 survey}}$$

3) Final calibration of Intake 24 adult weights (intake24_wt)

The adult weight (int21wt) and non-response (intake24_NR) were combined (int21wt * intake24_NR) and applied to the data prior to the final stage of calibration weighting which matched weighted totals for the survey data to the NRS 2020 mid-year population estimates for Health Boards, age/sex distribution at Scotland level and age/sex distribution for the Glasgow and Greater Clyde Health Board.

1.8 DATA ANALYSIS AND REPORTING

SHeS is a cross-sectional survey of the population. It examines associations between health status, personal characteristics and behaviour. However, such associations do not necessarily imply causality. In particular, associations between current health status and current behaviour need careful interpretation, as current health may reflect past, rather than present, behaviour. Similarly, current behaviour may be influenced by advice or treatment for particular health conditions.

1.8.1 Reporting age variables

Defining age for data collection

A considerable part of the data collected in SHeS 2021 is age specific, with different questions directed to different age groups. During the interview the participant's date of birth was ascertained. For data collection purposes, a participant's age was defined as their age on their last birthday before the interview.

Age as an analysis variable

Age is a continuous variable, and an exact age variable on the data file expresses it as such (so that, for example, someone whose 24th birthday was on January 1, 2021 and was interviewed on October 1, 2021 would be classified as being aged 24.75).

The presentation of tabular data involves classifying the sample into year bands. This can be done in two ways, age at last birthday and 'rounded age', that is, rounded to the nearest integer. In this report, all references to age are age at last birthday.

Some of the adult data included in the 2021 report have been age-standardised to allow comparisons between groups after adjusting for the effects of any differences in their age distributions. Further information on age standardisation can be found in chapter 2 of this report.

1.8.2 Standard analysis breakdowns

Scottish Index of Multiple Deprivation (SIMD)

The analysis of 2021 data was based on the most recent version of the Scottish Index of Multiple Deprivation (SIMD), published in 2020[13]. It is based on 38 indicators in seven individual domains of current income, employment, housing, health, education, skills and training, geographic

access to services and crime. SIMD is calculated at data zone level, enabling small pockets of deprivation to be identified. The data zones are ranked from most deprived (1) to least deprived (6,976) on the overall SIMD index. The result is a comprehensive picture of relative area deprivation across Scotland. The index was divided into quintiles for the presentation of analysis within this report. The full index is not available on the archived dataset due to concerns about its potential for identifying individual respondents or households.

1.8.3 Design effects and true standard errors

SHeS 2021 used a partially clustered, stratified multi-stage sample design (for the knock-to-nudge element). In addition, weights were applied when obtaining survey estimates. One of the effects of using the complex design and weighting is that standard errors for survey estimates are generally higher than the standard errors that would be derived from an unweighted simple random sample of the same size. The calculations of standard errors shown in tables, and comments on statistical significance throughout the report, have taken the clustering, stratification and weighting into account. The ratio of the standard error of the complex sample to that of a simple random sample of the same size is known as the design factor. Put another way, the design factor (or 'deft') is the factor by which the standard error of an estimate from a simple random sample has to be multiplied to give the true standard error of the complex design. The true standard errors and defts for SHeS 2021 have been calculated using a Taylor Series expansion method. The deft values and true standard errors (which are themselves estimates subject to random sampling error) are shown in Tables 1.10 to 1.19 for selected survey estimates presented in the main report. **Tables 1.6a – 1.15b**

1.8.4 Intake24 analysis and reporting

Food and portion size codes are automatically assigned within Intake24 allowing the system to generate nutrient output at the individual food level. The raw Intake24 output was imported into a bespoke database to facilitate data checks and to assign foods reported as missing to an appropriate food code and portion size, using the original free text search term and missing food details provided by the participant. Checks were carried out on all the data to identify possible 'incomplete recalls'. These included recalls with 10 items or fewer (excluding associated foods i.e. milk with tea), recalls that took 2 minutes or less to complete and recalls that contained less than 400kcal. Case by case decisions were made as to whether recalls could be considered valid and complete, including, for example, checking if the respondent said they ate less than usual e.g. sickness. Three participants had one recall that was deemed to be incomplete and these recalls were removed from the dataset.

At the end of the survey data collection, boxplots were generated to review portion sizes and to identify any extreme outliers within each food group. Extreme outliers were identified from the boxplots as

individual data points separate from the box and whiskers since they were more than 3 x IQR (Inter-quartile range: 75th percentile-25th percentile) from the nearest quartile for that intake (either the 25th or 75th percentile). These were examined on a case-by-case basis and reviewed in the context of the participant's overall consumption. Portion sizes which were considered to be implausible, and potentially the result of errors in portion size selection, were adjusted. Adjustments were carried out in the bespoke dietary database by changing the portion code at the individual recall level.

Finally, boxplots were generated to identify any infeasible/extreme energy and nutrient values. As with portions, extreme outliers were looked at on a case-by-case basis. Extreme intakes that were considered to be the result of errors in portion size or food composition were adjusted, otherwise values were left in the dataset as they were assumed to reflect consumption by participants.

The final dietary dataset includes only those respondents who completed two dietary recalls using Intake24, regardless of the day type (i.e. weekdays or weekend days). For each respondent, food and nutrient intake has been calculated based on an average of the two recalls.

Intakes of fruit and vegetables and red meat and processed meats were calculated using disaggregated variables, that is they include these foods eaten as part of composite dishes, as well as their discrete portions, to provide more accurate estimates of total amounts consumed at an individual food level. For example, carrots may be eaten as an accompaniment to a main meal, but they may also be consumed as an ingredient within a stew, together with additional vegetables such as onions and celery.

References and notes

1 The 1995 and 1998 surveys were carried out by the Joint Health Surveys Unit of the National Centre for Social Research (NatCen Social Research) and the Department of Epidemiology and Public Health University College London Medical School (UCL). The MRC Social and Public Health Sciences Unit at the University of Glasgow (MRC SPHSU) joined the consortium in 2003. ScotCen Social Research (a branch of NatCen Social Research), UCL and MRC SPHSU conducted the 2008-2011 surveys after a decision was made to carry out the survey annually.

2 Scottish Surveys Core Questions 2018-2021 Questionnaire Review: Consultation Outcome Report (2017). Available from https://www.gov.scot/publications/scottish-surveys-core-questions-2017/

3 Questionnaire Content of the Scottish Health Survey (2017): Consultation Analysis Report. Available from https://www.gov.scot/publications/questionnaire-content-scottish-health-survey-consultation-analysis-report-april-2017/

4 Dean, L and McLean, J (eds). The Scottish Health Survey 2018 edition: Volume 2: technical report. Edinburgh: Scottish Government Available from: https://www.gov.scot/publications/scottish-health-survey-2018-volume-2-technical-report/

5 Further information on the sample designs and the methodology used is available here: https://www2.gov.scot/Topics/Statistics/About/SurveyDesigns201215

6 Further information on the 2011 Scottish Health Survey questionnaire review for the 2012-2015 surveys can be found on the Scottish Government SHeS website: https://www2.gov.scot/Topics/Statistics/Browse/Health/scottish-health-survey/questionnairereviewreport

7 Questionnaire Content of the Scottish Health Survey (2017): Consultation Analysis Report. Available from https://consult.gov.scot/population-health/scottish-health-survey/

8 Further information on the 2017 Scottish Health Survey questionnaire review for the 2018-2021 survey can be found on the Scottish Government website: http://www.gov.scot/Resource/0053/00537370.pdf

9 The household reference person (HRP) is defined as the householder (a person in whose name the property is owned or rented) with the highest income. If there is more than one householder and they have equal income, then the household reference person is the eldest.

10 Lynn, Peter, Beerten, Roeland, Laiho, Johanna and Martin, Jean 'Recommended Standard Final Outcome Categories and Standard Definitions of Response Rate for Social Surveys', Working Papers of the Institute for Social and Economic Research, paper 2001-23. Colchester: University of Essex. 2001.

11 A report on the development of the weighting procedures is available here: https://www2.gov.scot/Topics/Statistics/About/Surveys/WeightingProjectReport

12 *Scottish Health Survey – telephone survey – August/September 2020: main report.* Edinburgh, the Scottish Government. Available from: https://www.gov.scot/publications/scottish-health-survey-telephone-survey-august-september-2020-main-report/

13 Where time series SIMD data are presented, the appropriate version of the SIMD is used for each year. More details are provided within the main report and at https://www.gov.scot/publications/?term=SIMD&cat=filter&publicationTypes=statistics&page=1

Chapter 2

Methods and Definitions

CHAPTER 2: METHODS AND DEFINITIONS

Stephen Hinchliffe, Victoria Wilson, Caireen Roberts and Xanthippi Gounari

2.1 GENERAL SURVEY DEFINITIONS

AGE STANDARDISATION

Age standardisation has been used in some analysis in order to enable groups to be compared after adjusting for the effects of any differences in their age distributions.

When different sub-groups are compared in respect of a variable on which age has an important influence, any differences in age distributions between these sub-groups are likely to affect the observed differences in the proportions of interest.

Age standardisation was carried out, using the direct standardisation method. The standard population to which the age distribution of sub-groups was adjusted was the mid-2020 population estimates for Scotland. All age standardisation has been undertaken separately within each sex.

The age-standardised proportion p' was calculated as follows, where p_i is the age specific proportion in age group *i* and N_i is the standard population size in age group *i*:

$$p' = \frac{\sum_i N_i p_i}{\sum_i N_i}$$

Therefore p' can be viewed as a weighted mean of p_i using the weights N_i. Age standardisation was carried out using the age groups: 16-24, 25-34, 35-44, 45-54, 55-64, 65-74 and 75 and over. The variance of the standardised proportion can be estimated by:

$$var(p') = \frac{\sum_i (N_i^2 p_i q_i / n_i)}{(\sum_i N_i)^2}$$

where $q_i = 1 - p_i$.

HOUSEHOLD

A household was defined as one person or a group of people who have the accommodation as their only or main residence and who either share at least one meal a day or share the living accommodation.

HOUSEHOLD REFERENCE PERSON (HRP)

The HRP is defined as the householder (a person in whose name the property is owned or rented) with the highest income. If there is more than one householder and they have equal income, then the household reference person is the oldest.

MEAN

All means in this report are **Arithmetic means** (the sum of the values for cases divided by the number of cases).

MEDIAN

The value of a distribution which divides it into two equal parts such that half the cases have values below the median and half the cases have values above the median.

NHS HEALTH BOARD

The National Health Service (NHS) in Scotland is divided up into 14 geographically based local NHS Boards and a number of National Special Health Boards. Health Boards in this report refers to the 14 local NHS Boards.

PERCENTILE

The value of a distribution which partitions the cases into groups of a specified size. For example, the 20^{th} percentile is the value of the distribution where 20 percent of the cases have values below the 20^{th} percentile and 80 percent have values above it. The 50^{th} percentile is the median.

P VALUE

A p value is the probability of the observed result occurring due to chance alone. A p value of less than 5% is conventionally taken to indicate a statistically significant result ($p<0.05$). It should be noted that the p value is dependent on the sample size, so that with large samples differences or associations which are very small may still be statistically significant. Results should therefore be assessed on the magnitude of the differences or associations as well as on the p value itself. The p values given in this report take into account the clustered sampling design of the survey.

QUINTILE

Quintiles are percentiles which divide a distribution into fifths, i.e., the 20^{th}, 40^{th}, 60^{th} and 80^{th} percentiles.

SCOTTISH INDEX OF MULTIPLE DEPRIVATION (SIMD)

The SIMD is the Scottish Government's official measure of area based multiple deprivation. It is based on 37 indicators across 7 individual domains of current income, employment, housing, health, education, skills and training and geographic access to services and telecommunications. SIMD is calculated at data zone level, enabling small pockets of deprivation to be identified. The data zones are ranked from most deprived (1) to least deprived (6505) on the overall SIMD index. The result is a comprehensive picture of relative area deprivation across Scotland.

This report uses the SIMD 2020 for the 2019 and 2021 data (see Scottish Index of Multiple Deprivation 2020).

SIGNIFICANCE TESTING

Where differences in relation to a particular outcome between two subgroups, such as men and women, are highlighted in the main report, the differences can be considered statistically significant, unless otherwise stated.

Statistical significance is calculated using logistic regression to provide a **p-value** based on a two-tailed significance test. One-tailed tests are used when the difference can only be in one direction. Two-tailed tests should always be used when the difference can theoretically be in either direction. For example, even though previous research has shown a higher prevalence of hazardous levels of alcohol consumption among men than among women, and we may expect this to be true in the most recent survey, a two-tailed test is used to confirm the difference.

STANDARD DEVIATION

The standard deviation is a measure of the extent to which the values within a set of data are dispersed from, or close to, the mean value. In a normally distributed set of data 68% of the cases will lie within one standard deviation of the mean, 95% within two standard deviations and 99% will be within 3 standard deviations. For example, for a mean value of 50 with a standard deviation of 5, 95% of values will lie within the range 40-60.

STANDARD ERROR (OF THE MEAN)

The standard error is a variance estimate that measures the amount of uncertainty (as a result of sampling error) associated with a survey statistic. All data presented in this report in the form of means are presented with their associated standard errors (with the exception of the WEMWBS scores which are also presented with their standard deviations). Confidence intervals are calculated from the standard error; therefore, the larger the standard error, the wider the confidence interval will be.

UNWEIGHTED BASES

The unweighted bases presented in the report tables provide the number of individuals upon which the data in the table is based. This is the number of people that were interviewed as part of SHeS and provided a valid answer to the particular question or set of questions. The unweighted bases show the number of people interviewed in various subgroups including sex, age and Scottish Index of Multiple Deprivation.

WEIGHTED BASES

The weighted bases are adjusted versions of the unweighted bases which involves calculating a weight for each individual so that their representation in the sample reflects their representation in the general population of Scotland living in private households. Categories within the table can be combined by using the weighted bases to calculate weighted averages of the relevant categories.

2.2 CHAPTER DEFINITIONS

2.2.1 CHAPTER 1 – GENERAL HEALTH, CARDIOVASCULAR CONDITIONS, AND CPR TRAINING

GENERAL HEALTH

Long-term conditions & limiting long-term conditions

Long-term conditions were defined as a physical or mental health condition or illness lasting or expected to last 12 months or more. The wording of this question changed in 2012 and is now aligned with the harmonised questions for all large Scottish Government surveys. Long-term conditions were coded into categories defined in the International Classification of Diseases (ICD), but it should be noted that the ICD is used mostly to classify conditions according to the cause, whereas SHeS classifies according to the reported symptoms. A long-term condition was defined as limiting if the respondent reported that it limited their activities in any way.

Self-assessed general health

Each year, participants who are aged 13 and over are asked to rate their health in general with answer options ranging from ‘very good’ to ‘very bad’. For children under the age of 13 the question is answered by the parent or guardian completing the interview on their behalf.

CARDIOVASCULAR CONDITIONS

Blood pressure/hypertension

Participants were defined as having self-reported doctor-diagnosed hypertension if they stated during the interview that they had been told by a doctor or nurse that they had high blood pressure.

Cardiovascular disease (CVD)

Participants were asked whether they had ever suffered from any of the following conditions: diabetes, angina, heart attack, stroke, heart murmur, irregular heart rhythm, or ‘other heart trouble’. If they responded affirmatively to any of these conditions, participants were asked whether they had ever been told they had the condition by a doctor and whether they had experienced the conditions in the previous 12 months. For the purpose of this report, participants were classified as having a particular condition only if they reported that the diagnosis was confirmed by a doctor.

It is important to note that no attempt was made to verify these self-reported diagnoses objectively. It is, therefore, possible that some misclassification may have occurred because some participants may not have remembered (or not remembered correctly, or not known about) diagnoses made by their doctor.

Any CVD condition

Participants were classified as having 'any CVD' if they reported ever having any of the following conditions confirmed by a doctor: angina, heart attack, stroke, heart murmur, abnormal heart rhythm, or 'other heart trouble'1.

Diabetes

Participants were classified as having diabetes if they reported a confirmed doctor diagnosis. Women whose diabetes occurred only during pregnancy were excluded from the classification. In 2018, a new question was introduced asking participants to report if they had been told they had Type 1 or Type 2 diabetes. Prior to 2018 no distinction was made between Type 1 and Type 2 diabetes in the interview.

Any CVD condition or diabetes

A summary measure of the above conditions is presented in the tables as 'any CVD condition or diabetes'.

Ischaemic heart disease (IHD)

IHD is also known as coronary heart disease. Participants were classified as having IHD if they reported ever having angina, a heart attack or heart failure diagnosed by a doctor.

Stroke

Participants were classified as having a stroke if they reported **ever** having had a stroke confirmed by a doctor.

IHD or Stroke

A summary measure of the above conditions is presented in the tables as 'IHD or stroke'.

CARDIOPULMONARY RESUSCITATION (CPR) TRAINING

CPR is an emergency procedure that combines chest compressions with artificial ventilation in an effort to manually preserve brain function in a person who is in cardiac arrest.

Participants were asked whether they had ever had any type of training in CPR or learned CPR either through instructor led sessions or self-instruction using DVD/online instruction. Those who reported they had CPR training were asked to provide details of the time interval since the first training, whether they had attended refresher training and the type of CPR training.

2.2.2 CHAPTER 2 – MENTAL WELLBEING

WARWICK-EDINBURGH MENTAL WELLBEING SCALE (WEMWBS)

The WEMWBS was developed by researchers at the Universities of Warwick and Edinburgh, with funding provided by NHS Health Scotland, to enable the measurement of mental wellbeing of adults in the UK. It was adapted from a 40 item scale originally developed in New Zealand, the Affectometer 2. The WEMWBS scale comprises 14

positively worded statements with a five item scale ranging from ‘1 - None of the time’ to ‘5 - All of the time’. The lowest score possible is therefore 14 and the highest is 70; the tables present mean scores. The 14 items are designed to assess positive affect (optimism, cheerfulness, relaxation); and satisfying interpersonal relationships and positive functioning (energy, clear thinking, self-acceptance, personal development, mastery and autonomy)[2].

The scale was not designed to identify individuals with exceptionally high or low levels of positive mental health, so cut-off points have not been developed[3].

WEMWBS is used to monitor the National Indicator 'mental wellbeing’[4] for adults and the mean WEMWBS score of children aged 13-15 years is included in the mental health indicator set for children[5].

GENERAL HEALTH QUESTIONNAIRE-12 (GHQ-12)

GHQ-12[6] is a scale designed to detect possible psychiatric morbidity in the general population. GHQ-12 is a widely used standard measure of mental distress and mental ill-health consisting of 12 questions on concentration abilities, sleeping patterns, self-esteem, stress, despair, depression, and confidence in the previous few weeks. Responses to each of the GHQ-12 items are scored, with one point allocated each time a particular feeling or type of behaviour is reported to have been experienced 'more than usual' or 'much more than usual' over the previous few weeks.

These scores are combined to create an overall score of between zero and twelve. A score of four or more (referred to as a high GHQ-12 score) has been used here to indicate the presence of a possible psychiatric disorder. A score of zero on the GHQ-12 questionnaire can, in contrast, be considered to be an indicator of psychological wellbeing. GHQ-12 measures deviations from people's usual functioning in the previous few weeks and therefore cannot be used to detect chronic conditions.

REVISED CLINICAL INTERVIEW SCHEDULE (CIS-R)

Depression and anxiety

Details on symptoms of depression and anxiety are collected via a standardised instrument, the CIS-R[7]. The CIS-R is a well-established tool for measuring the prevalence of mental disorders. The complete CIS-R comprises 14 sections, each covering a type of mental health symptom and asks about presence of symptoms in the week preceding the interview. Prevalence of two of these mental illnesses - depression and anxiety - were introduced to the Scottish Health Survey in 2008. Given the potentially sensitive nature of these topics, they were included in the nurse interview part of the survey prior to 2012[8]. Since 2012 the questions have been included in the biological module, with participants completing the questions themselves on the interviewer laptop (CASI). The change in mode of data collection may have

impacted response, and comparisons of 2016/2017 figures and onwards with pre-2012 figures should be interpreted with caution. There is a possibility that any observed changes in prevalence across this period may simply reflect the change in mode rather than any real change in the population.

Questions on depression cover a range of symptoms, including feelings of being sad, miserable, or depressed, and taking less of an interest and getting less enjoyment out of things than usual. Questions on anxiety cover feelings of anxiety, nervousness, and tension, as well as phobias, and the symptoms associated with these.

Suicide attempts and self-harm

In addition to being asked about symptoms of depression and anxiety, participants were also asked whether they had ever attempted to take their own life. The question was worded as follows:

> *Have you ever made an attempt to take your own life, by taking an overdose of tablets or in some other way?*

Those who said yes were asked if this was in 'the last week, in the last year or at some other time?' Note that this question is likely to underestimate the prevalence of very recent attempts, as people might be less likely to agree to take part in a survey immediately after a traumatic life event such as this. Furthermore, suicide attempts will only be captured in a survey among people who do not succeed at their attempt.

Since 2008, participants have also been asked whether they have ever self-harmed in any way but not with the intention of killing themselves. Those who said that they had self-harmed were also asked if this was 'in the last week, last year or at some other time'. The percentage of adults who have self-harmed in the last year is one of the national mental health indicators for adults[9].

Since 2012 these questions have been included in the biological module, with participants completing the questions themselves on the interviewer laptop (CASI). Prior to 2012 they were administered in the nurse interview, and any changes over time need to be interpreted with caution due to the change in mode.

LONELINESS

A question was included in the adult and young adult self-completion questionnaires to measure levels of loneliness experienced in the week prior to being interviewed, with five answer options ranging from 'none or almost none of the time' to 'all or almost all of the time'. This differs from the question used in previous surveys where the period asked about was two weeks.

SOCIAL CAPITAL

Social capital encompasses aspects of social connectedness via friend and kinship networks, trust in others, the ability to draw on support from others, as well as a sense of connectedness to places through involvement in the local community and the ability to influence local decisions. In 2021, these social capital indicators are reported in the supplementary tables only.

2.2.3 CHAPTER 3 – RESPIRATORY CONDITIONS INCLUDING COVID-19

ASTHMA AND RESPIRATORY SYMPTOMS

Participants (including parents of children aged 0-12, and children themselves aged 13-15) were asked if a doctor had ever told them they had asthma. This question was asked in the 1998, 2003, 2008 and 2010 surveys, and has been included every year since 2012. No objective measures were used to confirm these reported diagnoses.

Questions on respiratory symptoms were included in the 1995-2003 surveys, and in all even years since 2008. The symptoms covered were: phlegm production, breathlessness and wheezing or whistling in the chest. Breathlessness was classified as grade 2 if it occurred when hurrying on level ground or walking up a slight hill, or grade 3 (the more severe form) if it occurred when walking with other people of the same age on level ground. The impact of wheezing and whistling symptoms on sleep and people's daily activities was also measured. The Medical Research Council Respiratory Symptom Questionnaire was used to collect some of this information[10].

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

COPD is defined by the World Health Organisation as 'a pulmonary disease characterised by chronic obstruction lung airflow that interferes with normal breathing and is not fully reversible'. It is associated with symptoms and clinical signs that in the past have been called 'chronic bronchitis' and 'emphysema,' including regular cough (at least three consecutive months of the year) and production of phlegm.

Each year since 2008, adult participants have been asked if they had ever had COPD, chronic bronchitis or emphysema and, if so, whether a doctor had told them they had one of these conditions. Those who reported doctor-diagnosed COPD were also asked what treatment or advice they had received. No objective measures were used to confirm these reported diagnoses.

LONG COVID

Questions on whether participants had or thought they had COVID-19 and whether they described themselves as having long COVID. Long COVID was defined by experiencing symptoms more than 4 weeks after they first had COVID-19 that were not explained by something else.

2.2.4 CHAPTER 4 – DIET AND FOOD INSECURITY

Scottish Dietary Goals

The Scottish Dietary Goals (SDG) provide the basis for the diet that will improve and support the health of the Scottish population.[11]

Calories	Reduction in calorie intake by 120 kcal per person per day, and average energy density of the diet to be lowered to 125kcal/100g by reducing intake of high fat and/or sugary products and by replacing with starchy carbohydrates (e.g. bread, pasta, rice and potatoes), fruits and vegetables.
Fruit and vegetables	Average intake of a variety of fruit and vegetables to reach at least five portions per person per day (>400g per day).
Oily fish	Oil rich fish consumption to increase to one portion (140g) per person per week.
Red meat	Average intake of red and red processed meat to be limited to around 70g per person per day. Average intake of the highest consumers of red and red processed meat (90g per person per day) not to increase.
Fats	Average intake of total fat to reduce to no more than 35% of food energy, average intake of saturated fat to reduce to no more than 11% food energy and average intake of trans fatty acids to remain below 1% food energy.
Free sugars	Average intake of free sugars not to exceed 5% of total dietary energy.
Salt	Average intake of salt to reduce to 6g per day for adults.
Fibre	An increase in average intake of dietary fibre to 30g per person per day for adults.
Total carbohydrate	Total carbohydrate to be maintained at an average population intake of approximately 50% of total dietary energy with no more than 5% from free sugars.

INTAKE 24

INTAKE24 is an online 24-hour dietary recall tool. It was originally developed by Newcastle University and Food Standards Scotland. It was updated and further developed prior to introduction into the National Diet and Nutrition Survey Rolling Programme (NDNS RP) in October 2019 and is currently maintained by Cambridge University in collaboration with Newcastle University (Open Lab). Information about the development of the tool, reports and publications and a demo of the tool can be found on the website (https://intake24.org/).

Participants aged 16 and over on SHeS were introduced to INTAKE24 by their interviewer. Following their interview participants logged in online on their computer, laptop, tablet, or smart phone via a secure instant URL. Participants who did not have internet access or who did not feel confident completing the dietary recalls independently could request assistance. This was provided by the Cambridge University team who carried out assisted dietary recalls over the telephone. Participants were asked to record in INTAKE24 everything they ate and drank the previous day. INTAKE24 includes an embedded database of

foods with linked portion sizes and corresponding nutrient composition data taken from the National Diet and Nutrition Survey[12] (NDNS) Nutrient Databank from which dietary intakes are automatically calculated.

INTAKE24 uses a range of different methods to estimate the portion size of foods and drinks including food photographs and household measures such as individual items, different spoon sizes, or small, medium or large servings. Drinks can also be reported by a range of glass, cup and bottle sizes, often including a slider to indicate how much was consumed. There are prompts to remind respondents about common foods and drinks that might have been forgotten (for example, milk and sugar in tea, or sauce on chips), built in checks to detect low reported energy intakes and low intake of drinks and checks for large time gaps between eating occasions. Intake24 includes a custom spell checker which works to correct both phonetic misspellings and typing errors in the free text to enable comprehensive search functionality.

Other features of the system include; a missing foods function to ensure foods that are not in the INTAKE24 database are not missed from the recall, a video tutorial on how to complete a recall, contextual help buttons and a telephone help request function enabling the research team to contact respondents to talk them through issues they may be experiencing.

For all participants who completed two recalls, their average daily intake was calculated to enable comparisons with the SDG and the proportions meeting each SDG were also calculated.

Energy density (kcal/100g/day)

Energy density is based on the energy from foods and milk only (not the energy from other drinks).

Fruit and vegetable consumption (adults)

SHeS has gathered data on fruit and vegetable consumption in adults since 2003 as part of the main interview. However, estimations of portions of fruit and vegetable did not include the contribution from composite dishes, both homemade dishes and manufactured products. In 2021, dietary recall data, adult fruit and vegetables portions were calculated after disaggregation, that is they include these foods eaten as part of composite dishes, as well as their discrete portions, to provide more accurate estimates of total amounts consumed at an individual food level. For example, carrots may be eaten as an accompaniment to a main meal, but they may also be consumed as an ingredient within a stew, together with additional vegetables such as onions and celery.

In previous years, the ‘none’ category was used to include just zero portions whereas in 2021, the ‘none/less than ½ portion’ category includes less than half a portion.

Fruit and vegetable consumption (children)

Data on fruit and vegetable consumption among children was measured using survey questions, as in previous years. It is recommended that children eat at least five portions of fruit and vegetables per day[13].

Free sugars intake

The definition of free sugars includes: all added sugars in any form; all sugars naturally present in fruit and vegetable juices, purées and pastes and similar products in which the structure has been broken down; all sugars in drinks (except for dairy-based drinks); and lactose and galactose added as ingredients. The sugars naturally present in milk and dairy products, fresh and most types of processed fruit and vegetables and in cereal grains, nuts and seeds are excluded from the definition[14].

Red and red processed meat intake

Red and red processed meat after disaggregation i.e. including the contribution from composite dishes, both homemade dishes and manufactured products. For the purpose of the analysis, red meat consumers are defined as those who consumed an average of more than 1g of red and red processed meat per day.

Fibre intake

Fibre is measured by the American Association of Analytical Chemists (AOAC) methods. AOAC fibre includes resistant starch and lignin in the estimation of total fibre in addition to non-starch polysaccharides.

FOOD INSECURITY

Food insecurity is ‘the inability to acquire or consume an adequate quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so’. In their self-completion questionnaire, participants answered three routed questions on food insecurity asking whether they had worried about running out of food, had eaten less than they should have or had actually run out of food in the last 12 months.

2.2.5 CHAPTER 5 - OBESITY

BODY MASS INDEX (BMI)

BMI is a widely accepted measure that allows for differences in weight due to height. It is defined as weight (kg)/square of height (m^2). This has been used as a measure of obesity in SHeS since its inception in 1995. BMI has some limitations and does not, for example, distinguish between mass due to body fat and mass due to muscular physique[15].

In 2021, it was not possible to obtain the standardised height and weight measurements using a telephone approach. Therefore, where they were happy to do so, participants were asked to estimate their height and weight, with these self-reported measures used to calculate estimated BMI. So, while these estimates have been calculated, this

data should be used with caution given the self-reported nature of these measures.

Work undertaken to analyse data from the Health Survey for England (HSE) and Active Lives Surveys found that, on average, participants overestimated their height and underestimated their weight[16]. Adjustments for adults have been made to account for this and while these corrections appear to remove some bias from the estimates, caution is advised in interpreting this data.

Based on their BMI (calculated from self-reported height and weight), adult participants were classified into the following groups based on the World Health Organisation (WHO) classification[17]:

BMI (kg/m^2)	Description
Less than 18.5	Underweight
18.5 to less than 25	Normal
25 to less than 30	Overweight, excluding obesity
30 to less than 40	Obesity, excluding morbid obesity
40+	Morbid obesity

The BMI data presented in the report and the data tables is based on data that has been adjusted according to the formula from this HSE and Active Lives work referenced previously. A comparison of the unadjusted and adjusted weighted data for all adults interviewed as part of the survey is presented in the table below.

BMI (kg/m^2)	Unadjusted	Adjusted
Less than 18.5	3%	1%
18.5 to less than 25	44%	37%
25 to less than 30	32%	35%
30 to less than 40	18%	23%
40+	3%	4%
Mean	26.6	27.7

Based on their BMI (calculated from self-reported height and weight), child participants were classified into the following groups based on the World Health Organisation (WHO) classification[18].

Although the BMI calculation method is the same, there are no fixed BMI cut-off points defining overweight and obesity in children. Instead, overweight and obesity are defined using several other methods

including age and sex specific BMI cut-off points or BMI percentile cut-offs based on reference populations. While the data for adults has been adjusted based on previous comparator analysis, no equivalent analysis was available for children, therefore, these self-report figures have not been adjusted.

Children can be classified into the following groups:

BMI (percentile)	Description
Above 2nd and below 85th	Within healthy range
At or above 2nd, at or above 85th	Outwith healthy range
At or above 85th, below 95th	At risk of overweight
At or above 95th	At risk of obesity

WAIST CIRCUMFERENCE

Waist circumference is a measure of deposition of abdominal fat. It is measured during the biological module. A raised waist circumference has been defined as more than 102cm in men and more than 88cm in women. In 2021, it was not possible to collect accurate information for waist circumference (WC); therefore, this was not included in the survey.

2.2.6 CHAPTER 6 – PHYSICAL ACTIVITY

UK CHIEF MEDICAL OFFICERS' (CMO) PHYSICAL ACTIVITY GUIDELINES (2019)

Age group	Guidelines
Early years – children under 5 years	**Infants (less than 1 year):** Physical activity is recommended several times a day (the more activity the better) in a variety of ways including interactive floor-based activity, e.g. crawling. Where infants are not yet mobile, at least 30 minutes of tummy time spread across the day and while awake is recommended along with movements such as reaching and grasping, pushing and pulling themselves over independently, or rolling over; more is better. **Toddlers (1-2 years):** At least 180 minutes (3 hours) of physical activity of any intensity is recommended for toddlers, including active and outdoor play. **Pre-schoolers (3-4 years):** At least 180 minutes (3 hours) of activity is also recommended for pre-school aged children, including a variety of active and outdoor play physical activities spread throughout the day. For this age group, this

	should include at least 60 minutes of moderate-to-vigorous intensity physical activity.
Children and young people aged 5 to 18	It is recommended that children and young people in this age group engage in moderate-to-vigorous intensity physical activity for an average of at least 60 minutes per day. The activities undertaken include those undertaken in a variety of settings such as school-based physical education, active travel, after school activities, play and sporting activities. Engagement in a range of activities and intensities over the course of a week is recommended in order to develop movement skills, muscular fitness and bone strength. This activity should be accompanied by as minimal an amount of sedentary time as possible, with any long periods of inactivity broken up with some physical activity, even if this is light in nature.
Adults aged 19-64	Daily physical activity is recommended for both physical and mental health benefits - the more the better but any activity is encouraged. This includes activities to develop and strengthen the major muscle groups, which can be achieved through activities such as heavy gardening, carrying heavy shopping, or resistance exercise. It is recommended that muscle strengthening activities are done on at least two days a week, but any strengthening activity is better than none. On a weekly basis, adults should undertake: • at least 150 minutes (2 1/2 hours) of *moderate* intensity activity (such as brisk walking or cycling) • or 75 minutes of *vigorous* intensity activity (such as running) • or even shorter durations of *very* vigorous intensity activity (such as sprinting or stair climbing); • or a *combination of moderate, vigorous and very vigorous* intensity activity. Sedentary time should be minimized as far as possible, breaking this up with at least light physical activity.
Adults aged 65 and over	Daily physical activity is also recommended for older adults for the maintenance of good physical and mental health, wellbeing, and social functioning. Even light activity offers greater health benefits than being sedentary, although the more daily physical activity that is undertaken, the better. Older adults should also undertake activities aimed at improving or maintaining muscle strength, balance and flexibility on at least two days a week, either on

	their own or combined with moderate aerobic activity. This should be accompanied by 150 minutes (two and a half hours) of moderate intensity aerobic activity, building gradually up to this where activity levels are currently lower. Those who are already regularly active can achieve these benefits through: • 75 minutes of vigorous intensity activity • or a combination of moderate and vigorous activity Weight-bearing activities offer additional benefit in helping to maintain bone health. Where physically able, long periods of being sedentary should be broken up with light activity, or at least with standing.

ADULT PHYSICAL ACTIVITY QUESTIONNAIRE

The SHeS questionnaire[19] asks about four main types of physical activity:

- home-based activities (housework, gardening, building work and DIY)
- walking
- sports and exercise
- activity at work

Information is collected on the:

- time spent being active
- intensity of the activities undertaken
- frequency with which activities are performed.

ADHERENCE TO ADULT PHYSICAL ACTIVITY GUIDELINES

The activity guidelines advised adults to accumulate 150 minutes of moderate activity or 75 minutes of vigorous activity per week or an equivalent combination of both, in bouts of 10 minutes or more. These guidelines are referred to as the Moderate or Vigorous Physical Activity guidelines (MVPA). To help assess adherence to this guideline, the intensity level of activities mentioned by participants was estimated.

Activities of low intensity, and activities of less than 10 minutes duration, were not included in the assessment. This allowed the calculation of a measure of whether each SHeS participant adhered to the guideline, referred to in the text and tables as “adult summary activity levels”, see the table overleaf. A more detailed discussion of this calculation is provided in the 2012 report[20].

Adult summary activity levels[a]

Meets MVPA guidelines	Reported 150 mins/week of moderate physical activity or 75 mins vigorous physical activity, or an equivalent combination of these.
Some activity	Reported 60-149 mins/week of moderate physical activity, or 30-74 mins/week vigorous physical activity, or an equivalent combination of these.
Low activity	Reported 30-59 mins/week of moderate physical activity, or 15-29 mins/week vigorous physical activity or an equivalent combination of these.
Very low activity	Reported less than 30 mins/week of moderate physical activity, or less than 15 mins/week vigorous physical activity, or an equivalent combination of these.

[a] Only bouts of 10 minutes or more were included towards the 150 minutes per week guideline.

To avoid overcomplicating the text, where descriptions are provided of the summary activity levels, they tend to refer only to moderate physical activity, although the calculations were based on moderate or vigorous activity as described above.

Muscle strengthening

A second summary measure was calculated for adults, in respect of meeting the guidelines to carry out activities that strengthen muscles on at least 2 days a week to increase bone strength and muscular fitness. Nine different sports were classed as always muscle strengthening, and other sports or exercises were classed as muscle strengthening if the participant reported that the effort was enough to make the muscles feel some tension, shake or feel warm. If the participant carried out such activities for at least 10 minutes on 2 or more days a week, on average, they were deemed to meet the muscle strengthening guideline. As this only includes muscle strengthening through sporting activity, reported levels may be an underestimate.

CHILD PHYSICAL ACTIVITY QUESTIONNAIRE

The questions on child physical activity are slightly less detailed than those for adults[21]. No information on intensity is collected (with the exception of asking those aged 13-15 about their walking pace). The questions cover:

- sports and exercise
- active play including housework and gardening
- walking

2.2.7 CHAPTER 7 - SMOKING

QUESTIONS ON SMOKING BEHAVIOUR

Questions on smoking have been included in SHeS since 1995. Some small changes were made to the questions in 2008 and 2012. These are outlined in the relevant annual reports[22,23].

The current questions in the survey focus on:

- current smoking status
- frequency and pattern of current smoking
- the number of cigarettes smoked by current smokers
- exposure to second-hand smoke
- past smoking behaviour, current and ex-smokers
- quit attempts and desire to give up smoking
- medical advice on giving up smoking
- nicotine replacement therapy (NRT) use (including questions on NRT that led to successful cessation)
- e-cigarette use (including as part of a quit attempt)

Adults aged 20 and over were asked about their smoking behaviour during the telephone interview. For those aged 16 and 17, information was collected in a self-completion questionnaire offering more privacy and reducing the likelihood of concealing behaviour in front of other household members. Those aged 18 and 19 could answer the questions either during the telephone interview or via the self-completion booklet, at the interviewer's discretion.

The self-completion questions were largely similar to those asked in the telephone interview. However, given the age of the participants completing the self-completion questionnaire, questions on past smoking behaviour, desire to give up smoking and medical advice to stop smoking were excluded.

SMOKING STATUS

Smoking status categories reported here are:

- current cigarette smoker
- ex-regular cigarette smoker
- never regular cigarette smoker
- never smoked cigarettes at all

Information on cigar and pipe use is collected in the survey but as prevalence is low these are not considered in the definition of current smoking.

ELECTRONIC CIGARETTES (E-CIGARETTES)

Electronic cigarettes or e-cigarettes are battery-powered handheld devices which heat a liquid that delivers a vapour. The vapour is then inhaled by the user, which is known as 'vaping'. E-cigarettes typically

consist of a battery, an atomiser and a cartridge containing the liquid. Earlier models, often referred to as ‘cigalikes’, were designed to closely resemble cigarettes but there is now a wide variety of product types on the market. The liquid is usually flavoured and may not contain nicotine, although in most cases e-cigarettes are used with nicotine. Unlike conventional or traditional cigarettes, they do not contain tobacco and do not involve combustion (i.e. they are not lit).

SHeS has gathered information on the use of e-cigarettes among the Scottish adult population since 2014, in response to their increased availability and high profile. The questions ask whether participants have ever used an e-cigarette as well as whether they currently use an e-cigarette. The questions about e-cigarettes were amended in 2016 to include the term ‘vaping devices’.

EXPOSURE TO SECOND-HAND SMOKE

In 2021, exposure to second-hand smoke in adults was measured by asking respondents to self-report where they have been exposed to second-hand smoke. In previous years, cotinine levels from saliva samples were used, but this was not possible for the 2021 survey due to COVID-19 restrictions.

Exposure to second-hand smoke for children is measured in two ways in the survey:

- whether there is someone who regularly smokes inside the accommodation where the child lives, and
- parents’ and older children’s (aged 13-15) reports of whether children are exposed to smoke at home.

NICOTINE REPLACEMENT THERAPY (NRT)

The remedial administration of nicotine to the body by means other than tobacco, usually as part of smoking cessation. Common forms of nicotine replacement therapy are nicotine patches and nicotine gum. In 2021, NRT use is reported in the supplementary tables only.

2.2.8 CHAPTER 8 – ALCOHOL AND DRUGS

UK CHIEF MEDICAL OFFICERS’ (CMO) ALCOHOL GUIDELINES

The UK CMO alcohol guidelines consist of three recommendations:

- a weekly guideline on regular drinking;
- advice on single episodes of drinking; and
- a guideline on pregnancy and drinking

According to the weekly guideline, adults are safest not to regularly drink more than 14 units per week, to keep health risks from drinking alcohol to a low level. If you do drink as much as 14 units a week, it is best to spread this evenly over three days or more. On a single episode of drinking, advice is to limit the total amount drunk on any occasion, drink more slowly, drink with food and alternate with water. The

guideline on drinking and pregnancy, or planning a pregnancy, advises that the safest approach is not to drink alcohol at all[24].

QUESTIONS ON ALCOHOL

Questions about drinking alcohol have been included in SHeS since its inception in 1995. Questions are asked either face-to-face via the interviewer or included in the self-completion questionnaire if they are deemed too sensitive for a face-to-face interview (e.g. if being interviewed with a parent). All those aged 16-17 years are asked about their consumption via the self-completion, as are some of those aged 18-19 years, at the interviewers' discretion. The way in which alcohol consumption is estimated in the survey was changed significantly in 2008. A detailed discussion of those revisions can be found in the chapter on alcohol consumption in the 2008 report[25].

In 2021, the SHeS questionnaire covered the following aspects of alcohol consumption:

- usual weekly consumption
- problem drinking

Weekly consumption

Participants (aged 16 years and over) were asked preliminary questions to determine whether they drank alcohol at all. For those who reported that they drank, these were followed by further questions on how often during the past 12 months they had drunk each of six different types of alcoholic drink:

- normal strength beer, lager, stout, cider, and shandy
- strong beer, lager, stout, and cider
- spirits and liqueurs
- sherry and martini
- wine
- alcoholic soft drinks (alcopops)

From these questions, the average number of days per week the participant had drunk each type of drink was estimated. A follow-up question asked how much of each drink type they had usually drunk on each occasion. These data were converted into units of alcohol and multiplied by the amount they said they usually drank on any one day[26].

Problem drinking - Alcohol Use Disorders Identification Test (AUDIT)

Since 2012 the AUDIT questionnaire has been used to assess problem drinking. AUDIT is widely considered to be the best screening tool for detecting problematic alcohol use.

It comprises of ten indicators of problem drinking; three indicators of consumption, four of use of alcohol considered harmful to oneself or others, and three of physical dependency on alcohol. Given the potentially sensitive nature of these questions, they were administered

in self-completion format for all participants. In line with the World Health Organisation guidelines on using the tool, responses to each of the ten AUDIT questions were assigned values of between 0 and 4[27]. Scores for the ten questions were summed to form a scale, from 0 to 40, of alcohol use.

The WHO guidelines[28] for interpreting AUDIT scale scores are as follows:

Score	Category description
0 to 7	low-risk drinking behaviour, or abstinence
8 to 15	medium level of alcohol problems, with increased risk of developing alcohol-related health or social problems (sometimes described as hazardous drinking behaviour)
16-19	high level of alcohol problems, for which counselling is recommended (harmful drinking behaviour)
20 or above	warrants further investigation for possible alcohol dependence

Drinking over 3 units (women) or 4 units (men) per day

Consumption of more than three units (women) or four units (men) on a single day is also reported in the supplementary tables. This allows comparison with previous SHeS reports although these daily amounts of alcohol are no longer included in the most recent guidance from the UK CMOs. Consumption of double this amount (six units for women and eight for men) is also reported.

CALCULATING ALCOHOL CONSUMPTION

The guidelines on lower risk drinking are expressed in terms of units of alcohol consumed. Detailed information on both the volume of alcohol drunk in a typical week and on the heaviest drinking day in the week preceding the survey was collected from participants. The volumes reported were not validated. In the UK, a standard unit of alcohol is 10 millilitres or around 8 grams of ethanol (pure alcohol). In this chapter, alcohol consumption is reported in terms of units of alcohol.

Questions on the quantity of wine drunk were revised in 2008. Since then, participants reporting drinking any wine have been asked what size of glass they drank from: large (250ml), medium (175ml) and small (125ml). In addition, to help participants make more accurate judgements they are also shown a showcard depicting glasses with 125ml, 175ml and 250ml of liquid. Participants also had the option of specifying the quantity of wine drunk in bottles or fractions of a bottle; with a bottle treated as the equivalent of six small (125ml) glasses.

There are numerous challenges associated with calculating units at a population level, not least of which are the variability of alcohol strengths and the fact that these have changed over time. The table below outlines how the volumes of alcohol reported in the survey were

converted into units (the 2008 report provides full information about how this process has changed over time)[29]. Those who drank bottled or canned beer, lager, stout or cider were asked in detail about what they drank, and this information was used to estimate the amount in pints.

Alcohol unit conversion factors

Type of drink	Volume reported	Unit conversion factor
Normal strength beer, lager, stout, cider, shandy (less than 6% Alcohol By Volume (ABV)	Half pint	1.0
	Can or bottle	Amount in pints multiplied by 2.5
	Small can (size unknown)	1.5
	Large can / bottle (size unknown)	2.0
Strong beer, lager, stout, cider, shandy (6% ABV or more)	Half pint	2.0
	Can or bottle	Amount in pints multiplied by 4
	Small can (size unknown)	2.0
	Large can / bottle (size unknown)	3.0
Wine (including champagne and prosecco)	250ml glass	3.0
	175ml glass	2.0
	125ml glass	1.5
	750ml bottle	1.5 x 6
Sherry, vermouth and other fortified wines	Glass	1.0
Spirits	Glass (single measure)	1.0
Alcopops	Small can or bottle	1.5
	Large (700ml) bottle	3.5

DRUG USE

Respondents completing the adult and young adult self-completion questionnaires were presented with 21 drugs and asked to indicate whether they had taken each of these or not in the last 12 months. This list included several substances not regulated under the misuse of drugs act (poppers, solvents and nitric oxide), as well as prescription only painkillers that were not prescribed for them.

The drugs were categorised in the data tables according to their composite group within the Drugs Wheel[30]: cannabinoids, stimulants, opioids, depressants, psychedelics, dissociatives, empathogens, prescription painkillers and an additional category of steroids and by their classification: A, B or C (as defined by the Misuse of Drugs Act 1971[31]), as shown in the table below and overleaf.

Drug	Drugs Wheel Category	Drug Class
Amphetamine (speed, sulph, uppers, Billy, base)	Stimulants	B
Methamphetamine (crystal meth, ice, glass, Tina, yabba, crystal)	Stimulants	A
Cannabis (weed, pot, grass, hash, skunk, ganja, blunt, dope, blow, spliff, smoke, green, edibles, joints, marijuana, oil, resin, pollen, shatter)	Cannabinoids	B
Synthetic cannabis (K2, spice, black mamba, incense, fake weed, Yucatan, genie)	Cannabinoids	B
Cocaine (coke, Charlie, white, flake, ching, posh, petrol)	Stimulants	A
Crack (rock, sand, stone, pebbles, freebase, wash)	Stimulants	A
Ecstasy/MDMA Powder ('E', 'X', eccies, 'XTC', MDMA, swedgerz, pingers, sweeties, pills, Mandy, madman)	Empathogens	A
Heroin (smack, skag, 'H', morphine, fentanyl, brown, junk, gear, kit)	Opioids	A
LSD (acid, tabs, trips, blotters)	Psychedelics	A
Magic mushrooms (mushies, psilocybin, shrooms, liberty caps)	Psychedelics	A
Methadone/Physeptone without prescription (phy, meth, linctus, juice, turtle, green)	Opioids	A
Semeron (sems, 'S')*	N/A	N/A
Anabolic steroids without prescription (steroids, roids)	Steroids	C
Poppers (amyl nitrate, liquid gold, TNT)	Stimulants	NC**
Ketamine (K, special K, KET)	Dissociatives	B
Glues, solvents, gas or aerosols (to sniff or inhale)	Depressants	NC**
Mephedrone (M-Cat, 4MMC, 'bubbles', drone, meph)	Stimulants	B
Tranquilisers: Benzodiazepines without prescription (temazepam, nitrazepam, diazepam, etizolam, Valium, Xanax, blues, yellows, benzos, jellies, scoobies)	Depressants	C

Drug	Drugs Wheel Category	Drug Class
GHB/GBL (G, GINA, LIQUID E, LIQUID X)	Depressants	C
Nitrous Oxide (laughing gas, whippets, NOS)	Dissociatives	NC**
Prescription only painkillers that were not prescribed for you (morphine, codeine, co-codamol, oxycontin, tramadol, gabapentin, pregabalin)	Prescription painkillers	NC**

* Fictitious drug included for quality assurance purposes
** Not classified/class not determined

2.2.9 CHAPTER 9 – GAMBLING

GAMBLING ACTIVITIES

All adult participants (aged 16 and over) were asked to report whether they had spent any money on nineteen different forms of gambling activity in the past 12 months. The activities presented ranged from buying tickets for the National Lottery draw to online betting and gaming. The range of activities presented reflected all forms of commercial gambling currently available in Scotland and included betting or gambling privately with family or friends to capture informal gambling activity.

In this chapter, gambling participation is defined as having participated in any one of these activities in the past 12 months. This definition also includes the requirement that the participant spent his/her own money on the activity. This was to ensure that those occasions where someone else placed bets or purchased lottery tickets with a participant's money were included.

The list of gambling activities and descriptions presented to participants reflected those used in the British Gambling Prevalence Survey (BGPS) 2007 as closely as possible[32]. Exceptions included the addition of 'playing poker in pub or club' and of 'betting on sports activities' (like football) to reflect the growing popularity of these activities since the 2007 study.

As with the BGPS series, questions were asked using a confidential self-completion format. This was to encourage more honest reporting of a (potentially) sensitive activity and to ensure maximum comparability with the BGPS. Everyone who had gambled at least once in the last year was also asked to complete the Problem Gambling Severity Index (PGSI) screening instrument to identify problem or risky gambling behaviour.

PROBLEM GAMBLING

Problem gambling is commonly accepted to involve 'gambling to a degree that compromises, disrupts or damages family, personal or

recreational pursuits'[33]. Despite this, there is no definitive definition of problem gambling and many different instruments or 'screens' exist to identify and measure problem gambling (with over 20 different types in existence)[34]. As yet, there is no agreed 'gold standard' instrument recommended for use in population surveys.

PGSI

In 2021, SHeS used PGSI[35], which was developed for use among the general population rather than within a clinical context and was tested and validated within a general population survey. The instrument consists of nine items ranging from chasing losses to gambling causing health problems and feeling guilty about gambling. Each item is assessed on a four-point scale: never, sometimes, most of the time, almost always. Responses to each item are given the following scores: never = zero; sometimes = one; most of the time = two; almost always = three. Scores for each item are summed to give a total score ranging from zero to 27. A score of eight or over on the PGSI represent problem gambling. This is the threshold recommended by the developers of the PGSI and the threshold used in this report. The PGSI was also developed to give further information on sub-threshold problem gamblers. PGSI scores between three and seven are indicative of 'moderate risk' gambling and scores of one or two are indicative of 'low risk' gambling[36].The PGSI thresholds and scoring mechanisms used in SHeS are the same as those used in the BGPS.

Problem gambling scores

To produce problem gambling prevalence rates among all adults aged 16 and over, all non-gamblers were allocated a score of zero in the PGSI screen. To be included in the final analysis, participants were required to have answered at least four of the PGSI questions. Those who answered less than this were only included in the final analysis if their responses to the answered questions scored them as a problem gambler.

2.2.10 CHAPTER 10 – ACCIDENTS

INJURY AND ACCIDENTS

Although the term 'injury' is now frequently used as a high proportion of these incidents are regarded as being preventable[37], in order to maintain continuity with earlier data in the Scottish Health Survey and for ease of understanding among participants, the 2021 Scottish Health Survey continued to refer to 'accidents', with this covering a very broad range of events from the extremely serious through to the relatively trivial. When referring to data from the Scottish Health Survey the term 'accident' is used, whereas 'injury' is generally used to refer to data from other sources specifically collected as injuries.

The definition of 'accident' used in the Scottish Health Survey is any accidental event which resulted in injury or physical harm where advice

was sought from a doctor, nurse or other health professional, or which caused time to be taken off work or school.

Participants were asked to recall any accidents they had had in the 12 months prior to the interview which fitted this definition. Figures shown within the report, however, are based only on those accidents about which advice was sought from a doctor or which required a visit to hospital.

All those who reported having at least one accident of this kind were then asked detailed questions about the nature and cause of the most recent accident. The reference period of 12 months before the interview was chosen so as to be sufficiently long to generate details of enough accidents for analysis, yet short enough for participants to be able to remember accurate details about their most recent unintentional injury.

Data on accidents was collected in the 1998 and 2003 surveys and biennially from 2009.

COVERAGE OF ACCIDENTS

The survey covers most, but not all, accidents to adults and children. Since SHeS collects data directly from participants, fatal accidents are excluded. In addition, there will be under-representation of accidents that lead to long-term hospitalisation. For these reasons, the accident data presented in this chapter can best be described as non-fatal accident prevalence for the household population. Reported prevalence will most likely slightly under-estimate true accident prevalence because of the exclusions. However, since the great majority of accidents do not lead to long-term stays in hospitals, any downward bias should be small.

CAUSES OF ACCIDENTS

Participants who had at least one accident in the 12 months prior to interview were asked to describe the cause of the most recent accident and interviewers coded responses using the following options:

- hit by a falling object
- fall, slip or trip
- road traffic accident
- sports or recreational accident
- use of tool of implement, or piece of electrical or mechanical equipment
- burn or scald
- animal or insect bite or sting
- caused by another person (e.g. attacked)
- lifting
- other

Some caution is needed in the interpretation of the data on cause of accident derived from this interviewer coding. What is coded in

individual cases will depend firstly upon how the participant describes the accident and secondly on how the interviewer interprets that description. For example, an accident in which a child sprains their ankle when playing football may be described as a fall by one participant (“I fell and sprained my ankle”) or as a sporting accident by another (“I sprained my ankle when I was out playing football”). If the participant describes the accident to the interviewer as “I fell and sprained my ankle” then some interviewers may code this as a fall or slip automatically, whereas others may probe further, establish that the participant was playing football at the time of the fall, and code it as a sports accident. Interviewers were briefed to code more than one cause per accident if appropriate, the intention being to collect as full a description of the accident as possible in order to avoid misclassification. One implication of the ambiguity in coding is that prevalence of accidents cannot be readily derived for different types of accident.

References and notes

[1] Diabetes and high blood pressure are not included in the definition of 'any CVD condition' as they are risk factors for CVD.

[2] Kammann, R. and Flett, R. (1983). Sourcebook for measuring well-being with Affectometer 2. Dunedin, New Zealand: Why Not? Foundation. Information on measuring mental wellbeing using WEMWBS is available online from: **Error! Main Document Only.** Further information about WEMWBS is available at: www.healthscotland.com/scotlands-health/population/Measuring-positive-mental-health.aspx

[3] Stewart-Brown, S and Janmohamed, K (2008). *Warwick-Edinburgh Mental Well-being Scale (WEMWBS). User Guide Version 1*. Warwick and Edinburgh: University of Warwick and NHS Health Scotland. Available at: http://www.healthscotland.com/documents/2702.aspx

[4] See: http://nationalperformance.gov.scot/

[5] NHS Health Scotland (2012) *Establishing a core set of national, sustainable mental health indicators for children and young people in Scotland: Final Report*. [online]. Available at: http://www.healthscotland.com/uploads/documents/18753-C&YP%20Mental%20Health%20Indicators%20FINAL%20Report.pdf

[6] Goldberg, D and Williams, PA (1988). *A User's Guide to the General Health Questionnaire*. Windsor: NFER-Nelson.

[7] Lewis, G. & Pelosi, A. J. (1990). Manual of the Revised Clinical Interview Schedule CIS–R. London: Institute of Psychiatry; Lewis G, Pelosi AJ, Araya R, Dunn G. (1992) Measuring psychiatric disorder in the community; a standardised assessment for use by lay interviewers. *Psychological Medicine*; 22, 465-486.

[8] The nurse interview is conducted with one adult at a time, whereas the main interview can be conducted concurrently with up to four household members present. It was therefore easier to ensure that these questions could be answered in confidence. Nurses were also thought to be better placed to handle very sensitive topics such as these than interviewers conducting a general health survey who would have required additional specialist briefing. A leaflet with various help lines was handed to all participants in the nurse visit. From 2012, these questions have been included in the biological module of the survey, conducted by specially trained interviewers, and will be completed by participants using a self-completion computer aided questionnaire.

[9] See: www.healthscotland.com/scotlands-health/population/mental-health-indicators.aspx

[10] Prior to 2012 a fuller version of the MRC Respiratory Symptoms Questionnaire was included in the 1995-2003 and 2008 and 2010 surveys, alongside questions about wheezing and whistling in the chest that were added to the survey in 1998 as part of the asthma module. To reduce duplication and participant burden, from 2012 onwards the MRC Questionnaire items on wheezing were cut (the questions on phlegm and breathlessness were retained).

[11] See https://www.gov.scot/publications/scottish-dietary-goals-march-2016/

[12] See https://www.gov.uk/government/collections/national-diet-and-nutrition-survey

[13] See https://www.nhs.uk/live-well/eat-well/5-a-day/portion-sizes/#:~:text=Children%20should%20also%20eat%20at,the%20palm%20of%20their%20hand.

[14] See https://www.gov.uk/government/statistics/ndns-time-trend-and-income-analyses-for-years-1-to-9

[15] Romero-Corral, A. et al (2008). Accuracy of body mass index in diagnosing obesity in the adult general population. International Journal of Obesity, 32: 959–966.

[16] See https://fingertips.phe.org.uk/documents/2.12%20Adult%20excess%20weight%20method%20details%202015-16.docx

[17] These cut-offs differ to those used in the previous surveys. In 1995 and 1998 the normal weight range was defined as 20-25 kg/m^2, in 2003 it was changed to 18.5-25 kg/m^2. From 2008 onwards the ranges are defined as set out below. This brings the definition in line with WHO recommendations. The impact of the change of definition is very marginal as very few people have a BMI measurement that is exactly 18.5, 25, 30 or 40 kg/m^2.

	2003	**2008 onwards**
Underweight	18.5 or under	Less than 18.5
Normal weight	Over 18.5 – 25	18.5 to less than 25
Overweight	Over 25 – 30	25 to less than 30
Obese	Over 30 – 40	30 to less than 40
Morbidly obese	Over 40	40+

[18] These cut-offs differ to those used in the previous surveys. In 1995 and 1998 the normal weight range was defined as 20-25 kg/m^2, in 2003 it was changed to 18.5-25 kg/m^2. From 2008 onwards the ranges are defined as set out below. This brings the definition in line with WHO recommendations. The impact of the change of definition is very marginal as very few people have a BMI measurement that is exactly 18.5, 25, 30 or 40 kg/m^2.

	2003	**2008 onwards**
Underweight	18.5 or under	Less than 18.5
Normal weight	Over 18.5 – 25	18.5 to less than 25
Overweight	Over 25 – 30	25 to less than 30
Obese	Over 30 – 40	30 to less than 40
Morbidly obese	Over 40	40+

[19] The questions used in the survey since 1998 are based on the Allied Dunbar National Fitness Survey, a major study of physical activity among the adult population in England carried out in 1990. For further details see: Health Education Authority. Allied Dunbar National Fitness Survey. Health Education Authority and Sports Council, London. 1992

[20] Bromley C. (2013) Chapter 6: Physical Activity. In Rutherford L, Hinchliffe S and Sharp C (eds.) Scottish Health Survey 2012 – Volume 1: Main Report. Edinburgh: Scottish Government. Available at: https://www.gov.scot/publications/scottish-health-survey-2012-volume-1-main-report/pages/10/

[21] The questions on child physical activity included in SHeS since 1998 are based on the 1997 Health Survey for England (HSE) children's physical activity module.

[22] Gray L & Leyland AH (2009). Chapter 4: Smoking. In: Bromley, C., Bradshaw, P. and Given, L. (eds.) *The 2008 Scottish Health Survey – Volume 1: Main Report*. Edinburgh: Scottish Government. 2009. www.gov.scot/Publications/2009/09/28102003/0

[23] Gray L & Leyland AH (2013). Chapter 4: Smoking. In: Rutherford, L., Hinchliffe, S. and Sharp, C. (eds.) *The Scottish Health Survey 2012 – Volume 1: Main Report*. Edinburgh: Scottish Government. Available at: www.gov.scot/Publications/2013/09/3684

[24] See: https://www.drinkaware.co.uk/alcohol-facts/alcoholic-drinks-units/latest-uk-alcohol-unit-guidance/

[25] Reid S (2009). Chapter 3: Alcohol consumption. In: Bromley C, Bradshaw P and Given L. (eds.) *The 2008 Scottish Health Survey – Volume 1: Main Report*. Edinburgh: Scottish Government. 2009. Available at: www.gov.scot/Publications/2009/09/28102003/31

[26] For participants aged 16 and 17, details on alcohol consumption were collected as part of a special smoking and drinking self-completion questionnaire. Some aged 18 and 19 also completed the self-completion if the interviewer felt it was appropriate. For all other adult participants, the information was collected as part of the face-to-face interview. The method of estimating

consumption follows that originally developed for use in the General Household Survey and is also used in the Health Survey for England. For six types of alcoholic drink (normal strength beer/lager/cider/shandy, strong beer/lager/cider, spirits/liqueurs, fortified wines, wine, and alcoholic soft drinks), participants were asked about how often they had drunk each one in the past twelve months, and how much they had usually drunk on any one day. The amount given to the latter question was converted into units of alcohol, with a unit equal to half a pint of normal strength beer/lager/cider/alcoholic soft drink, a single measure of spirits, one glass of wine, or one small glass of fortified wine. A half pint of strong beer/lager/cider was equal to 1.5 units. The number of units was then multiplied by the frequency to give an estimate of weekly consumption of each type of drink. The frequency multipliers were:

Drinking frequency	Multiplying factor
Almost every day	7.0
5 or 6 times a week	5.5
3 or 4 times a week	3.5
Once or twice a week	1.5
Once or twice a month	0.375
One every couple months	0.115
Once or twice a year	0.029

The separate consumption figures for each type of drink were rounded to two decimal places and then added together to give an overall weekly consumption figure.

[27] AUDIT questionnaire

Questions	**0**	**1**	**2**	**3**	**4**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking last year?	No		Yes, but not in the last year		Yes, during the last year

[28] Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B. and Monteiro, M.G (2001). *AUDIT – The Alcohol Use Disorders Identification Test – Guidelines for Use in Primary Care,* Second Edition. Geneva: World Health Organization.

[29] See: https://www.gov.scot/publications/scottish-health-survey-2008/pages/29/

[30] See http://www.thedrugswheel.com/

[31] See https://www.legislation.gov.uk/ukpga/1971/38/contents

[32] The BGPS 1999 and 2007 used a paper self-completion booklet to collect data. In 2010, computer-assisted self-completion was used which allowed the questionnaire to have a more complex structure as more follow-up questions could be asked. As the Scottish Health Survey used a paper self-completion, the questionnaire structure and format of the 1999 and 2007 studies was followed.

[33] Lesieur H.R, Rosenthal M.D. (1991). Pathological gambling: A review of the literature (prepared for the American Psychiatric Association Task Force on DSM-IV Committee on disorders of impulse control not elsewhere classified). *Journal of Gambling Studies* 7, 1, 5-40.

[34] Abbott, M., Volberg., R (2007) The measurement of adult problem and pathological gambling. International Gambling Studies, 6(2); 175-200.

[35] Potenza, M. N., Fiellin, D. A., Heninger, G. R., Rounsaville, B. J. and Mazure, C. M. (2002). Gambling. *Journal of General Internal Medicine* 17: 721–732. doi: 10.1046/j.1525-1497.2002.10812.x

[36] Some researchers have recommended that different (lower) thresholds should be used when identifying problem gamblers using the PGSI. However, these recommendations have not been universally accepted and are not currently endorsed by the original developers of the PGSI instrument. Therefore, this chapter uses the thresholds and categorisation recommended by the original developers and replicates the methods used in the BGPS, also allowing comparisons to be made.

[37] See: www.scotpho.org.uk/health-wellbeing-and-disease/injuries/introduction

Appendix A:

Fieldwork Documents

APPENDIX A: FIELDWORK DOCUMENTS

1. Advance Letter (Child Boost Scotcen) (1)
2. Advance Letter (Child Boost ScotCen) (2)
3. Advance Letter (Version A & B) (1)
4. Advance Letter (Version A & B) (2)
5. Knock-to-nudge ONS Advance Letter – Version A&B (1)
6. Knock-to-nudge ONS Advance Letter – Version A&B (2)
7. Knock-to-nudge ScotCen Advance Letter – Version A&B (1)
8. Knock-to-nudge ScotCen Advance Letter – Version A&B (2)
9. Knock-to-nudge ONS Survey Leaflet – Version A&B (1)
10. Knock-to-nudge ONS Survey Leaflet – Version A&B (2)
11. Knock-to-nudge ScotCen Survey Leaflet – Version A&B (1)
12. Knock-to-nudge ScotCen Survey Leaflet – Version A&B (2)
13. ScotCen Child Survey Leaflet (1)
14. ScotCen Child Survey Leaflet (2)
15. ScotCen Adult Survey Leaflet (1)
16. ScotCen Adult Survey Leaflet (1)
17. Knock-to-nudge self-completion cover letter
18. Knock-to-nudge language translations card
19. Respondent showcards
20. Useful Contact Leaflet
21. Intake24 Leaflet
22. Health Board Map

ScotCen Social Research

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NHS SCOTLAND

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Dear Sir or Madam,

Your household has been chosen to take part in the Scottish Health Survey (Child Interviews), an important annual study used to help improve health services in your area and across Scotland. We rely on the goodwill of the people who take part to make the study a success and need to speak to as many different people as possible. In previous years more than 7,000 people took part – now you have an opportunity to join in as well. We're sure you will find it interesting. We are particularly interested in understanding more about the health of **children and young people aged 0-15** living in Scotland.

We would like to hear from you if you have a child or children aged under 16 living in your household.

Taking part is easy:

Step 1
Get in Touch

Contact us one of these ways:

survey.natcen.ac.uk/shes

scottishhealthsurvey @scotcen.org.uk

0800 652 2704

Step 2
Receive your pack

We'll then send you some additional information and documents.

Step 3
Get a call

A ScotCen interviewer will get in touch by telephone to carry out the interview with your household.

Step 4
Enjoy your thank you!

All children in your household who take part will receive a **£10 Love2Shop gift voucher**.

You will need the 8 digit code at the top of this letter and your contact details

By taking part, you and your child are helping to provide a better understanding of the health and lifestyles of people in Scotland during this challenging time. It is also important to look to the future, and the information you and your child provide will help plan, and improve, health services beyond the pandemic.

Further info

Answers to some questions you may have are on the back of this letter, in the enclosed leaflet and at **www.gov.scot/publications/scottish-health-survey-interviewee-faqs**. If you would like to talk to someone about the study, please phone free on **0800 652 2704**.

Julie Landsberg
Survey Manager, Scottish Government

How did you choose my address?

We chose your address at random from the Postcode Address File. This file is held by the Post Office and is available to the public. Only the addresses chosen have the opportunity to take part. Your address is one of around 64,500 addresses which has been contacted this time. As this household has been selected to increase the number of children taking part, we are only able to include your household if there are any children aged 0 to 15 living there. If there are no children living at your address then please disregard this letter. We will also ask you to confirm that there are children in the household.

Who will we want to speak to?

We can interview up to two children in your household. If you have three or more children, your interviewer will select two of them to take part. Parents or guardians will answer questions on behalf of children aged under 13. Children aged 13-15 can answer the questions themselves but we will need you to answer some questions at the start of the interview. We will also ask for your consent for them to take part. We would like you to be present or within earshot of the interview taking place. You can have the phone on speaker phone so everyone can take part at the same time.

Information for children taking part is in the enclosed survey leaflet, please share this with them in advance.

If you require any assistance to take part in the telephone survey then please contact us by emailing **scottishhealthsurvey@scotcen.org.uk** or phone us free on **0800 652 2704**.

What will happen to any information my child and I give?

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What is the interview about?

The interview covers a range of health topics, including general health and lifestyles.

Where can I find out more?

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Survey Manager, Scottish Government

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What is the interview about?

The interview covers a range of health topics, including general health and lifestyles.

Where can I find out more?

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What's next

An interviewer from ONS will call at your address in the next week or so. They will explain more about the study and arrange a convenient time for you and other members of your household to take part by telephone. Your interviewer will show you a photo ID card, so you know who they are.

Thank you

As a thank you, everyone who takes part in your household will receive a £10 Love2Shop gift voucher, with a further £10 voucher for adults who complete the Intake24 online food diary.

Further info

Answers to some questions you may have are on the back of this letter, in the enclosed leaflet and at **www.gov.scot/collections/scottish-health-survey**. If you would like to talk to someone about the study, please phone free on **0800 298 5313**.

Julie Landsberg
Survey Manager, Scottish Government

How did you choose my address?

We chose your address at random from the Postcode Address File. This file is held by the Post Office and is available to the public. Only the addresses chosen have the opportunity to take part. Your address is one of around 57,000 addresses which has been contacted this time.

Who will we want to speak to?

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If you require any assistance to take part in the telephone survey please discuss with the interviewer when they call at your door.

What will happen to any information I give?

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Who is carrying out the survey?

The Scottish Government has asked ScotCen Social Research (ScotCen) to carry out the survey, in collaboration with the Office for National Statistics (ONS). ScotCen and ONS interviewers are highly trained and regular procedures are in place to monitor the quality of their work.

ScotCen is independent of all government departments and political parties. For more information about ScotCen please visit **www.scotcen.org.uk**. ONS is the UK's independent producer of official statistics. For more information about ONS visit **www.ons.gov.uk/surveys**.

What is the interview about?

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Julie Landsberg
Survey Manager, Scottish Government

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What is the interview about?

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ScotCen Social Research | Office for National Statistics | Scottish Government gov.scot | NHS SCOTLAND

The Resident

Code:

Help improve health services in

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What's next

An interviewer from ScotCen Social Research will call at your address in the next week or so. They will explain more about the study and arrange a convenient time for you and other members of your household to take part by telephone. Your interviewer will show you a photo ID card, so you know who they are.

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The survey asks you to provide your height and weight measurements, but only if you are happy to do so. Some personal details such as age, sex and employment are also included to help us interpret this information.

What happens to the information I provide?

Your answers are treated with care and with full respect for your privacy. The Scottish Government and ScotCen guarantee that the survey results will not be published in a form that can reveal your identity and that they will make no attempt to identify you from your answers. The information collected is used for statistical and research purposes only and will be dealt with in accordance with data protection legislation. The information collected in the survey (but no information that would allow you to be identified) is made available via the UK Data Service for use by researchers and academics.

If you take part in the survey, and agree, some information will be linked to your survey answers from your NHS health records on the following:

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This is done in such a way that no data which can identify you or any other individual is released, and really increases the value of the information you provide. If you wish your survey results not to be linked to your health records, please tell the interviewer when you take part.

If you participate in the online Intake24 part of the survey, your answers will be added to your other Scottish Health Survey answers using an anonymous unique identifier. No information that can identify you will be asked in the Intake24 online diary.

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No. In all our surveys we rely on voluntary co-operation. The success of the survey depends on the goodwill and co-operation of those asked to take part. The more people who do take part, the more useful the results will be. You are free to withdraw from any part of the survey at any time, and you do not have to answer all the questions.

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Who has reviewed the study?

The study has been looked at by an independent group of people called a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This study has been given a favourable opinion by Wales REC 3 on behalf of the NHS. The Public Benefit and Privacy Panel will be reviewing the process for linkage of the survey data with information from the NHS health records.

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Why are you phoning my home?

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You have the right to be informed about how the information about you will be used (see 'If I have any other questions?').

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Mean portions of fruit and vegetables per day

women 3.3 portions per day (mean)

men 3.2 portions per day (mean)

Around one in seven children aged 2–15 met the five-a-day recommendation for consumption of fruit and vegetables

14%

Consumption of 5 or more fruit and veg portions a day

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A Company Limited by Guarantee, Charity No. SC038454
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Why has my household been chosen?

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What happens if I agree to be contacted about further research?

If you give your permission, your name, contact details and relevant survey answers may be passed on to the Scottish Government or research agencies for the purpose of further research among particular groups of people to improve health or health services.

This information will only be released for statistical and research purposes carried out by reputable research organisations and you will not be identifiable in any published results. Any information passed to any other organisation will be treated in accordance with data protection legislation and will not be used for any purposes other than further research about health or health services.

Is the survey compulsory?

No. In all our surveys we rely on voluntary co-operation. The success of the survey depends on the goodwill and co-operation of those asked to take part. The more people who do take part, the more useful the results will be. You are free to withdraw from any part of the survey at any time, and you do not have to answer all the questions.

How will taking part in the survey benefit me?

Benefits from the survey will be indirect and in due course will come from any improvements in health and in health services in Scotland which result from the survey. Everyone in your household will receive a **£10 voucher** for taking part, as a thank you, with a further £10 voucher for adults who complete the Intake24 online food diary.

Who has reviewed the study?

The study has been looked at by an independent group of people called a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This study has been given a favourable opinion by Wales REC 3 on behalf of the NHS. The Public Benefit and Privacy Panel will be reviewing the process for linkage of the survey data with information from the NHS health records.

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Will the answers I give be of help?

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Why are you phoning my home?

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What are my rights

You have the right to be informed about how the information about you will be used (see ‘If I have any other questions?’).

Some findings from the 2019 survey

Mean portions of fruit and vegetables per day

women 3.3 portions per day (mean)

men 3.2 portions per day (mean)

Around one in seven children aged 2–15 met the five-a-day recommendation for consumption of fruit and vegetables

14%

Consumption of 5 or more fruit and veg portions a day

23%
women

21%
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You can see all of the previous Scottish Health Survey reports here:
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[73] - SHeS - ScotCen - Survey Leaflet - Version A&B - 010 - 30.08

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Why take part?

The information you provide will help to develop ways of improving people's health in your area and across Scotland. It will also help improve the services people need at times of ill health.

By taking part, you are helping to provide a better understanding of the health and lifestyles of people in Scotland during these challenging times. The information you provide will also help with planning and improving health services beyond the Covid-19 pandemic.

What is it about?

There will be questions about your general health and wellbeing, physical activity, smoking and drinking. There are some questions about diseases of the heart, lungs and chest, as these remain some of the leading causes of death in Scotland. The survey includes Intake24, a quick and easy way to capture information about your diet. There are also some questions about Covid-19 and the vaccination programme.

The survey asks you to provide your height and weight measurements, but only if you are happy to do so. Some personal details such as age, sex and employment are also included to help us interpret this information.

What happens to the information I provide?

Your answers are treated with care and with full respect for your privacy. The Scottish Government and ScotCen guarantee that the survey results will not be published in a form that can reveal your identity and that they will make no attempt to identify you from your answers. The information collected is used for statistical and research purposes only and will be dealt with in accordance with data protection legislation. The information collected in the survey (but no information that would allow you to be identified) is made available via the UK Data Service for use by researchers and academics.

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- Details about registration with a general practitioner and, if you pass away, the date and cause of death.

This is done in such a way that no data which can identify you or any other individual is released, and really increases the value of the information you provide. If you wish your survey results not to be linked to your health records, please tell the interviewer when you take part.

If you participate in the online Intake24 part of the survey, your answers will be added to your other Scottish Health Survey answers using an anonymous unique identifier. No information that can identify you will be asked in the Intake24 online diary.

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[74] - SHeS - ScotCen - Survey Leaflet - Version A&B - 020 - 30.09

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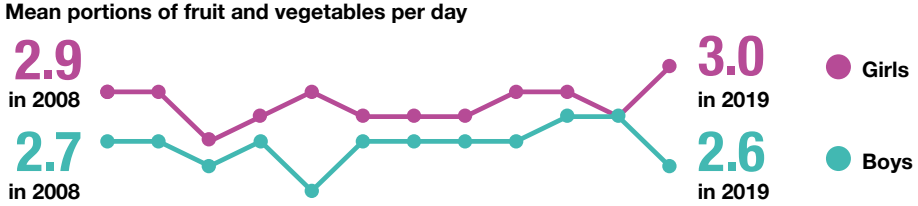
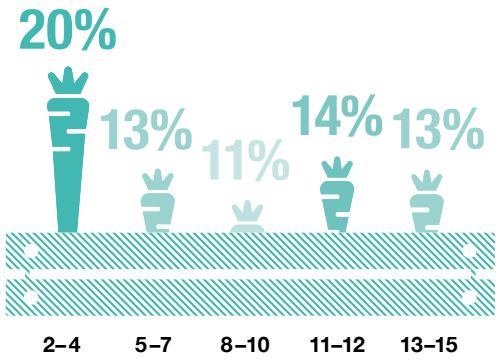
Girls have consumed higher levels of fruit and vegetables per day* than boys in most years since 2008.



* Data based on consumption the day before the interview.

In 2019, children aged 2–4 years were more likely to consume five or more portions of fruit and vegetables on a typical day than older children.



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By taking part, you are helping to provide a better understanding of the health and lifestyles of children in Scotland during these challenging times. The information you provide will also help with planning and improving health services beyond the Covid-19 pandemic.

What is it about?

There will be questions about your child(ren)'s general health and wellbeing, physical activity and eating habits.

The survey asks you to provide your child(ren)'s height and weight measurements, but only if you and they are happy to do so. Some personal details about your household such as the age and sex of each household member, as well as employment details for those aged 16 and over are also included to help us interpret this information.

What happens to the information I /my child(ren) provide?

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Why has my household been chosen?

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STEP 1 Get in touch

Contact us one of these ways:

survey.natcen.ac.uk/shes

scottishhealthsurvey@scotcen.org.uk

0800 652 2704

You will need:

- the 8-digit number in the top right-hand corner of your letter
- your contact details

We will call you back within 10 days to arrange an interview appointment.

STEP 2 Receive your pack

We'll send you additional information and a set of response cards.

STEP 3 Get a Call from an experienced interviewer

A ScotCen interviewer will call you to complete the questionnaire with you and your child (about 30 minutes). Others in your household can take part on the same call or separately. Your interviewer will explain about the self-complete questions.

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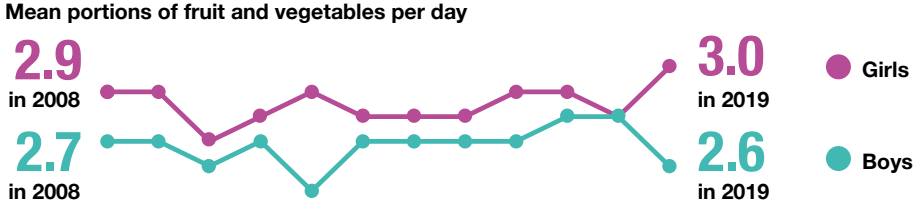

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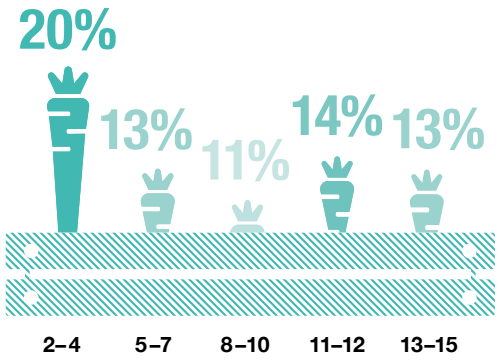

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- Information about diagnosis, treatments and hospital stays for cancer, heart disease, stroke, diabetes and psychiatric episodes.
- Details about registration with a general practitioner and, if they pass away, the date and cause of death.

This is done in such a way that no data which can identify your child(ren) or any other individual is released, and really increases the value of the information you and they provide. If you/they wish for your survey results not to be linked to your/their health records, please tell the interviewer when taking part.

For further information on how the information you provide will be used please see the privacy information on the Scottish Government's website here: **www.gov.scot/publications/scottish-health-survey-interviewee-faqs**

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If there are any children aged 0-15 living in your household, we would like to interview two of them – if there are more than two, your interviewer will select two to take part. Parents or guardians will answer questions on behalf of children aged under 13. We have included information for children at the back of this leaflet which we would like you to share with them in advance of them taking part. After conducting the initial part of the interview with you, the interviewer can then speak directly to any children aged 13-15. The interviewer will ask for your consent to speak to them and we would like you to be in earshot of them.

Why has my household been chosen?

To include every household in Scotland is expensive and time consuming. Instead we select a sample of addresses in such a way that all addresses in the country have a chance of being chosen. Yours is one of those chosen for the 2021 child survey. Your address was chosen at random from the Postcode Address File, a list of every address in the UK, held by the Post Office and available to the public.

What happens if I agree to be contacted about further research?

If you give your permission, your child(ren)'s name, contact details and relevant survey answers may be passed on to the Scottish Government or research agencies for the purpose of further research among particular groups of people to improve health or health services.

This information will only be released for statistical and research purposes carried out by reputable research organisations and your child(ren) will not be identifiable in any published results. Any information passed to any other organisation will be treated in accordance with data protection legislation and will not be used for any purposes other than further research about health or health services.

Is the survey compulsory?

No. In all our surveys we rely on voluntary co-operation. The success of the survey depends on the goodwill and co-operation of those asked to take part. The more people who do take part, the more useful the results will be. You and your child(ren) are free to withdraw from any part of the survey at any time, and you or they do not have to answer all the questions.

How will taking part in the survey benefit me?

Benefits from the survey will be indirect and in due course will come from any improvements in health and in health services in Scotland which result from the survey. All children in your household will receive a **£20 voucher** for taking part, as a thank you.

Who has reviewed the study?

The study has been looked at by an independent group of people called a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This study has been given a favourable opinion by Wales REC 3 on behalf of the NHS. The Public Benefit and Privacy Panel will be reviewing the process for linkage of the survey data with information from the NHS health records.

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Your co-operation is very much appreciated. Thank you very much for your help with this survey.

For further information and advice on healthy living please see the Healthier Scotland website: **www.takelifeon.co.uk**

Information about common health conditions is available here: **www.nhsinform.scot**

How does it work?

If there is a child living in your household we would like you to follow these **4 simple steps**:

STEP 1 Get in touch

Contact us one of these ways:

survey.natcen.ac.uk/shes

scottishhealthsurvey@scotcen.org.uk

0800 652 2704

You will need:

- the 8-digit number in the top right-hand corner of your letter
- your contact details

We will call you back within 10 days to arrange an interview appointment.

STEP 2 Receive your pack

We'll send you additional information and a set of response cards.

STEP 3 **Get a Call** from an experienced interviewer

A ScotCen interviewer will call you to complete the questionnaire with you and your child (about 30 minutes). Others in your household can take part on the same call or separately. Your interviewer will explain about the self-complete questions.

STEP 4 Enjoy your thank you!

As a thank you, all children in your household who take part will receive a **£20 Love2Shop voucher**.

These can be used at over 20,000 shops (including online), restaurants and attractions (www.love2shop.co.uk/where-to-spend).

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Will the answers I give be of help?

Yes, the information you provide could help to make health services better.

What will happen to the answers I give?

The answers you give will be put together with those from other people and will be reported in a way that no one will know that you have taken part.

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Also, if you and the person that looks after you agree, then your name, where you live and your answers could be given to the Scottish Government or other researchers to contact you about other research about your health.

Why are you phoning my home?

To phone every household in Scotland would take too long and cost too much money. Instead we select a small number of addresses and ask the people living there to take part.

What are my rights

You have the right to be informed about how the information about you will be used (see 'If I have any other questions?').

Some findings from the 2019 survey

Mean portions of fruit and vegetables per day

women 3.3 portions per day (mean)

men 3.2 portions per day (mean)

Around one in seven children aged 2–15 met the five-a-day recommendation for consumption of fruit and vegetables

14%

Consumption of 5 or more fruit and veg portions a day

23%
women

21%
men

You can see all of the previous Scottish Health Survey reports here:
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ScotCen Social Research

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NHS SCOTLAND

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[5a] - SHeS - TEL - Survey Leaflet - Version A&B - 010 - V1 - 18.02

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NHS SCOTLAND

The 2021 Scottish Health Survey

The Scottish Health Survey is an annual survey of around 7,000 people in Scotland. It is carried out for the Scottish Government by ScotCen Social Research, the MRC Social and Public Health Sciences Unit at the University of Glasgow and academics from the Universities of Aberdeen and Edinburgh.

Why take part?

The information you provide will help to develop ways of improving people's health in your area and across Scotland. It will also help improve the services people need at times of ill health.

By taking part, you are helping to provide a better understanding of the health and lifestyles of people in Scotland during these challenging times. The information you provide will also help with planning and improving health services beyond the Covid-19 pandemic.

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There will be questions about your general health and wellbeing, physical activity, smoking and drinking. There are some questions about diseases of the heart, lungs and chest, as this remains one of the leading causes of death in Scotland. The survey includes Intake24, a quick and easy way capture information about your diet. There are also some questions about Covid-19 and the vaccination programme.

The survey asks you to provide your height and weight measurements, but only if you are happy to do so. Some personal details such as age, sex and employment are also included to help us interpret this information.

What happens to the information I provide?

Your answers are treated with care and with full respect for your privacy. The Scottish Government and ScotCen guarantee that the survey results will not be published in a form that can reveal your identity and that they will make no attempt to identify you from your answers. The information collected is used for statistical and research purposes only and will be dealt with in accordance with data protection legislation. The information collected in the survey (but no information that would allow you to be identified) is made available via the UK Data Service for use by researchers and academics.

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NHS SCOTLAND

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What are my rights

You have the right to be informed about how the information about you will be used (see 'If I have any other questions?').

The Resident

Code:

Thank you for taking part in the Scottish Health Survey

Dear Household,

Thank you for your participation so far in the Scottish Health Survey. You have helped to provide a better understanding of the health and lifestyles of people in Scotland during this challenging time.

As mentioned during your interview, we would also like everyone to complete and return their self-completion booklet(s). Everyone that agreed to complete a booklet during the interview has been provided with their own booklet with their name on it.

How long it will take to complete will vary depending on which version of the booklet you have received - the booklets for those aged 16+ take between 15 and 25 minutes on average to complete.

If you are a parent of a 4-12 year old, we would like the parent or guardian named on the booklet to complete this.

The instructions in the booklet will help you to complete the questionnaire and you won't need to answer every question. The self-completion booklets are an important part of the Scottish Health Survey and add to the answers already given during the interview.

What is in this envelope?

- Self-completion booklet(s) – there should be enough booklets contained in the pack for everyone who agreed to complete one during the telephone interview
- Blank envelopes have been provided – if there is more than one person in the household completing a booklet we would encourage you to use one of these per questionnaire to help you keep your answers private
- One pre-paid plastic envelope with a NatCen address label on the front for you to send back the self-completion booklet(s)
- One useful contacts leaflet

PLEASE TURN OVER

What do I do next?

1. Fill in the self-completion booklet that has your name on it.
2. Once completed, we would encourage you to place your self-completion booklet in its own blank envelope (if others in your household are also completing booklets)
3. Then place all the envelopes together in the plastic envelope with the NatCen address on the front.
4. Finally, you need to securely close and post the pre-paid envelope back to us. You can post this at a post box or drop it off at your local Post Office. Please do so as soon as possible after receiving this letter.

For more information please visit **Scottish Health Survey - gov.scot (www.gov.scot/collections/scottish-health-survey)** or phone us free on **0800 652 2704**. Hear more about the real difference the study makes at **www.scotcen.org.uk/healthvideo**

Thank you,

Interviewer:

Phone number:

Scottish Health Survey

British Sign Language
Your household has been selected to take part in the Scottish Health Survey. This important study collects information on behalf of the Scottish Government and the National Health Service about the health and lifestyles of people who live in Scotland. If you would you like us to arrange for a BSL interpreter to help conduct the interview, or to explain more about what is involved, please give the person who has called at your address your telephone number so we can arrange this.

Gaelic / Gàidhlig
Chaidh an dachaigh agaibhse a thaghadh airson pàirt a ghabhail ann an Suirbhidh Slàinte na h-Alba. Tha an sgrùdadh cudromach seo a' cruinneachadh fiosrachadh airson Riaghaltas na h-Alba agus Seirbheis Nàiseanta na Slàinte mu dheidhinn slàinte agus caitheamh-beatha muinntir na h-Alba. Ma tha sibh ag iarraidh eadar-theangair a chuidicheas leis an agallamh, no a mhìnicheas dè bhios na lùib, comharraich an cànan a tha sibh a' bruidhinn agus thoiribh an àireamh fòn agaibh don neach a thàinig don taigh gus am faigh sinn air sin a chur air dòigh dhuibh.

Bengali / বাংলা
স্কটিশ হেলথ সার্ভে (Scottish Health Survey) -তে অংশগ্রহণ করার জন্য আপনার পরিবার নির্বাচিত হয়েছে। এই গুরুত্বপূর্ণ অধ্যায়নটি স্কটিশ গভর্ণর (Scottish Government) এবং ন্যাশানাল হেলথ সার্ভিস (National Health Service)-এর পক্ষ স্কটল্যান্ড-এ বসবাসকারী ব্যক্তিদের স্বাস্থ্য এবং জীবনধারা সংক্রান্ত বিষয়ে তথ্য সংগ্রহ করে। আপনি যদি চান যে সাক্ষাৎকারে সহায়তার করতে, অথবা কী কী বিষয় অন্তর্ভুক্ত আছে সে সম্পর্কে আরো ব্যাখ্যা করতে আমরা আপনার জন্য একজন দোভাষীর বন্দোবস্ত করি, তাহলে অনুগ্রহ করে আপনি যে ভাষায় কথা বলেন সেটি নির্দেশ করুন এবং যিনি আপনার ঠিকানায় ফোন করবেন সেই ব্যক্তিকে আপনার ফোন নম্বরটি দিন যাতে করে আমরা এটির বন্দোবস্ত করতে পারি।

Chinese (Cantonese) /中文 (廣東話)
府上已獲選參與《蘇格蘭健康問卷調查》(Scottish Health Survey)。這是一項代表蘇格蘭政府及國民保健服務 (National Health Service) 收集有關居住在蘇格蘭的人士的健康及生活形式的資料的重要研究。如你希望我們爲你安排口譯員以協助進行訪問，或更詳細地解釋當中所涉及的過程，請向到訪府上的問卷調查員指出你所說的語言，並提供你的電話號碼，以便我們作出此安排。

French / Français
Votre foyer a été sélectionné pour participer à l'étude sur la santé en Écosse. Cette importante étude réunit des informations au nom du Gouvernement écossais et du ministère national de la Santé à propos de la santé et du style de vie des habitants de l'Écosse. Si vous aimeriez que nous organisions la présence d'un interprète pour faciliter la conduite de cet entretien ou vous expliquer plus en détail ce qui est impliqué, veuillez indiquer la langue que vous parlez et donner votre numéro de téléphone à la personne qui s'est présentée chez vous pour que nous puissions l'organiser.

Hindi / हिन्दी
आपके परिवार को स्कॉटिश स्वास्थ्य सर्वेक्षण में हिस्सा लेने के लिए चुना गया है। इस महत्वपूर्ण अध्ययन में स्कॉटलैंड सरकार और राष्ट्रीय स्वास्थ्य सेवा की ओर से स्कॉटलैंड में रहने वाले लोगों के स्वास्थ्य और जीवनशैलियों के संबंध में जानकारी एकत्र की जाती है। साक्षात्कार के आयोजन अथवा इसमें शामिल किसी अन्य जानकारी को स्पष्ट करने के लिए यदि आप दुभाषिए (इन्टरप्रेटर) की व्यवस्था चाहते हैं तो आप जो भाषा बोलते हैं उस पर निशान लगाएं तथा आपसे सम्पर्क करने वाले व्यक्ति को अपना टेलीफोन नम्बर दे दें ताकि हम इसका प्रबन्ध कर सकें।

Polish / Polski
Uprzejmie informujemy, że Pana/i gospodarstwo domowe wybrano do wzięcia udziału w ankiecie na temat zdrowia (Scottish Health Survey). Celem tego ważnego badania jest zebranie informacji na temat zdrowia i trybu życia mieszkańców Szkocji. Sondaż przeprowadzamy w imieniu szkockiego rządu i państwowej służby zdrowia (National Health Service). Jeżeli chciał(a)by Pan/i wziąć udział w ankiecie korzystając z pomocy tłumacza bądź uzyskać bliższe informacje na temat badania, proszę wskazać na karcie swój język ojczysty i podać urzędnikowi numer swojego telefonu, by można było umówić spotkanie, podczas którego obecny będzie tłumacz.

Punjabi / ਪੰਜਾਬੀ
ਤੁਹਾਡੇ ਘਰਬਾਰ ਨੂੰ ਸਕੌਟਲੈਂਡ ਦੇ ਸੇਹਤ ਸਰਵੇ ਵਿੱਚ ਭਾਗ ਲੈਣ ਲਈ ਚੁਣਿਆ ਗਿਆ ਹੈ। ਇਹ ਮਹਤੱਵਪੂਰਨ ਅਧਿਐਨ ਸਕੌਟਲੈਂਡ ਦੀ ਸਰਕਾਰ ਅਤੇ ਨੈਸ਼ਨਲ ਹੈਲਥ ਸਰਵਿਸ ਦੀ ਤਰਫੋਂ ਸਕੌਟਲੈਂਡ ਵਿੱਚ ਰਹਿ ਰਹੇ ਲੋਕਾਂ ਦੀ ਸੇਹਤ ਅਤੇ ਰਹਿਣੀ ਬਹਿਣੀ ਬਾਰੇ ਜਾਣਕਾਰੀ ਇਕੱਤਰ ਕਰਦੀ ਹੈ। ਇੰਟਰਵੀਓ ਕਰਨ ਵਿੱਚ ਸਹਾਇਤਾ ਲਈ, ਜਾਂ ਜੋ ਕੁੱਝ ਇਸ ਵਿੱਚ ਸ਼ਾਮਲ ਹੈ ਬਾਰੇ ਵਧੇਰੇ ਜਾਣਕਾਰੀ ਦੇਣ ਲਈ, ਜੇ ਤੁਸੀਂ ਚਾਹੁੰਦੇ ਹੋ ਕਿ ਅਸੀਂ ਦੋਭਾਸ਼ੀਏ ਦਾ ਪ੍ਰਬੰਧ ਕਰੀਏ, ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ ਜਿਹੜੀ ਭਾਸ਼ਾ ਤੁਸੀਂ ਬੋਲਦੇ ਹੋ ਉਸ ਵੱਲ ਇਸ਼ਾਰਾ ਕਰੋ ਅਤੇ ਜਿਹੜਾ ਵਿਅਕਤੀ ਤੁਹਾਡੇ ਘਰ ਆਇਆ ਹੈ ਉਸ ਨੂੰ ਆਪਣਾ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਦਿਓ ਤਾਂ ਕਿ ਅਸੀਂ ਇਸ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕੀਏ।

Turkish / Türkçe
Aileniz İskoç Sağlık Anketi'ne katılmak üzere seçilmiştir. Bu önemli çalışmada, İskoçya Hükümeti ve Ulusal Sağlık Hizmetleri adına, İskoçya'da yaşayan kişilerin sağlık durumları ve yaşam tarzları ile ilgili önemli bilgiler toplanmaktadır. Görüşmelerin yapılabilmesine yardımcı olması veya bu sürece dahil olan diğer noktaları açıklaması için bir tercüman ayarlamamızı istiyorsanız, lütfen konuştuğunuz dili belirtin ve sizi ziyaret eden kişiye telefon numaranızı verin; sizin için gerekli ayarlamaları yapacağız.

Arabic / العربية

لقد وقع الاختيار عليك وعلى عائلتك للمشاركة في استبيان الصحة الاسكتلندي، وتقوم هذه الدراسة الهامة بجمع المعلومات لصالح الحكومة الاسكتلندية وهيئة الصحة الوطنية (NHS) وتتلعق بصحة ونمط وأسلوب حياة القاطنين في اسكتلندة. إذا كنت ترغب منا أن نرتب حضور مترجم لمساعدتك خلال هذه المقابلة أو لتوضيح المزيد عن أهداف ومغزى الاستبيان فالرجاء الإشارة إلى اللغة التي تتكلمها إلى الشخص الذي جاء لمنزلك لإجراء المقابلة واكتب له رقم هاتفك لترتيب إجراء هذه المقابلة بحضور مترجم.

Farsi / فارسی
خانواده شما برای شرکت در نظرسنجی سلامتی و بهداشت اسکاتلند انتخاب شده است. در این تحقیق بسیار مهم از طرف دولت اسکاتلند و سرویس ملی بهداشت، اطلاعاتی درباره سلامتی و شیوه های زندگی مردم ساکن اسکاتلند جمع آوری می شود. اگر مایل هستید برای تان یک مترجم بیاوریم تا در انجام مصاحبه کمک کند، یا اطلاعات بیشتری درباره تحقیق به شما بدهد، لطفاً به نام زبانی که به آن صحبت می کنید اشاره کرده و شماره تلفن خود را به فردی که به آدرس شما مراجعه کرده است بدهید تا ترتیب این کار بدهیم.

Urdu / اردو

سکاٹش ہیلتھ سروے میں حصہ لینے کے لئے آپ کے گھرانے کا انتخاب کیا گیا ہے۔ یہ ضروری تحقیق سکاٹش گورنمنٹ اور نیشنل ہیلتھ سروس کی جانب سے سکاٹ لینڈ میں رہائش پذیر لوگوں کی صحت اور طرز زندگی کے متعلق معلومات جمع کرتی ہے۔ اگر آپ چاہتے ہیں کہ ہم انٹرویو لینے یا اس میں شامل امور کی مزید وضاحت کرنے میں مدد کے لئے ایک انٹرپریٹر (ترجمان) کا انتظام کریں تو براہ مہربانی جو زبان آپ بولتے ہیں اس کی طرف اشارہ کریں اور جو شخص آپ کے گھر تشریف لایا ہے اسے اپنا پتہ اور ٹیلیفون نمبر دے دیں تاکہ ہم اس کا انتظام کرسکیں۔

SCOTTISH HEALTH SURVEY 2021

SHOWCARDS

CARD A1

MARITAL STATUS

1 Never married and never registered a same-sex civil partnership

2 Married

3 In a registered same-sex civil partnership

4 Separated, but still legally married

5 Separated, but still legally in a same-sex civil partnership

6 Divorced

7 Formerly in a same-sex civil partnership which is now legally dissolved

8 Widowed

9 Surviving partner from a same-sex civil partnership

CARD A2

RELATIONSHIP

1 Husband / Wife / Spouse
2 Legally recognised civil partner
3 Partner / Cohabitee

4 Natural child
5 Adopted child
6 Foster child
7 Step-child
8 Child's spouse / civil partner (in law)
9 Natural parent
10 Adoptive parent
11 Foster parent
12 Step-parent / Parent's partner
13 Parent-in-law

14 Natural sibling (i.e. both natural parents the same)
15 Half-sibling (i.e. one natural parent the same)
16 Step-sibling (i.e. no natural parents the same)
17 Adopted sibling
18 Foster sibling
19 Sibling-in-law

20 Grandchild
21 Grandparent

22 Other relative
23 Other non-relative

CARD A3

1 Buying with mortgage / loan

2 Own it outright

3 Part rent / part mortgage

4 Rent (including rents paid by housing benefit)

5 Living here rent free

CARD A4

1 People can smoke anywhere inside this house / flat

2 People can only smoke in certain areas or rooms inside this house / flat (include smoking out of the window and at an open back door)

3 People can only smoke in outdoor areas (e.g. gardens / balconies of this house / flat)

4 People cannot smoke indoors or in outdoor areas of this house / flat

CARD A5

1 Very satisfied

2 Fairly satisfied

3 Neither satisfied nor dissatisfied

4 Fairly dissatisfied

5 Very dissatisfied

6 No opinion

CARD A6

1 Earnings from employment or self-employment (including overtime, tips, bonuses)

2 State retirement pension

3 Pension from former employer

4 Personal pensions

5 Pension Credit

6 Child Benefit

7 Universal Credit

8 Job-Seekers Allowance

9 Income Support

10 Working Tax Credit, Child Tax Credit or any other Tax Credit

11 Housing Benefit

12 Employment and Support Allowance

13 Personal Independence Payments

14 Disability Living Allowance

15 Attendance Allowance

16 Carer's Allowance

17 Other state benefits

18 Student grants and bursaries (but not loans)

19 Interest from savings and investments (eg. stocks and shares)

20 Rent from property (after expenses)

21 Other kinds of regular income (eg. maintenance or grants)

22 No source of income

CARD A7

GROSS INCOME FROM ALL SOURCES

(before any deductions for taxes, National Insurance contributions, health insurance payments, superannuation payments etc.)

WEEKLY		MONTHLY		ANNUAL	
Less than £10	1	Less than £40	1	Less than £520	1
£10 less than £30	2	£40 less than £130	2	£520 less than £1,600	2
£30 less than £50	3	£130 less than £220	3	£1,600 less £2,600	3
£50 less than £70	4	£220 less than £300	4	£2,600 less than £3,600	4
£70 less than £100	5	£300 less than £430	5	£3,600 less than £5,200	5
£100 less than £150	6	£430 less than £650	6	£5,200 less than £7,800	6
£150 less than £200	7	£650 less than £870	7	£7,800 less than £10,400	7
£200 less than £250	8	£870 less than £1,100	8	£10,400 less than £13,000	8
£250 less than £300	9	£1,100 less than £1,300	9	£13,000 less than £15,600	9
£300 less than £350	10	£1,300 less than £1,500	10	£15,600 less than £18,200	10
£350 less than £400	11	£1,500 less than £1,700	11	£18,200 less than £20,800	11
£400 less than £450	12	£1,700 less than £2,000	12	£20,800 less than £23,400	12
£450 less than £500	13	£2,000 less than £2,200	13	£23,400 less than £26,000	13
£500 less than £550	14	£2,200 less than £2,400	14	£26,000 less than £28,600	14
£550 less than £600	15	£2,400 less than £2,600	15	£28,600 less than £31,200	15
£600 less than £650	16	£2,600 less than £2,800	16	£31,200 less than £33,800	16
£650 less than £700	17	£2,800 less than £3,000	17	£33,800 less than £36,400	17
£700 less than £800	18	£3,000 less than £3,500	18	£36,400 less than £41,600	18
£800 less than £900	19	£3,500 less than £3,900	19	£41,600 less than £46,800	19
£900 less than £1,000	20	£3,900 less than £4,300	20	£46,800 less than £52,000	20
£1,000 less than £1,150	21	£4,300 less than £5,000	21	£52,000 less than £60,000	21
£1,150 less than £1,350	22	£5,000 less than £5,800	22	£60,000 less than £70,000	22
£1,350 less than £1,500	23	£5,800 less than £6,500	23	£70,000 less than £78,000	23
£1,500 less than £1,750	24	£6,500 less than £7,500	24	£78,000 less than £90,000	24
£1,750 less than £1,900	25	£7,500 less than £8,300	25	£90,000 less than £100,000	25
£1,900 less than £2,100	26	£8,300 less than £9,200	26	£100,000 less than £110,000	26
£2,100 less than £2,300	27	£9,200 less than £10,000	27	£110,000 less than £120,000	27
£2,300 less than £2,500	28	£10,000 less than £10,800	28	£120,000 less than £130,000	28
£2,500 less than £2,700	29	£10,800 less than £11,700	29	£130,000 less than £140,000	29
£2,700 less than £2,900	30	£11,700 less than £12,500	30	£140,000 less than £150,000	30
£2,900 or more	31	£12,500 or more	31	£150,000 or more	31

CARD A8

1 Working as an employee (or temporarily away)

2 On a Government sponsored training scheme (or temporarily away)

3 Self employed or freelance (or temporarily away)

4 Working unpaid for your own family’s business (or temporarily away)

5 Doing any other kind of paid work

6 None of the above

CARD A9

HOURS SPENT PROVIDING CARE

1 Up to 4 hours a week

2 5 - 19 hours a week

3 20 - 34 hours a week

4 35 - 49 hours a week

5 50 or more hours a week

CARD A10

1 Less than one year

2 One year but less than 5 years

3 5 years but less than 10 years

4 10 years but less than 20 years

5 20 years or more

CARD A11

1 Been unable to take up employment

2 Worked fewer hours

3 Reduced responsibility at work

4 Flexible employment agreed

5 Changed to work at home

6 Reduced opportunities for promotion

7 Took new job

8 Left employment altogether

9 Took early retirement

10 Other (Please say what)

11 Employment not affected/never had a job

CARD A12

1 Short breaks or respite e.g. day time breaks, overnight breaks or emergency respite

2 Advice and information

3 Practical support (e.g. transport, equipment/adaptations)

4 Counselling or emotional support

5 Training and learning

6 Advocacy services

7 Personal assistant/ support worker/ community nurse/ home help

8 Help from family, friends or neighbours

9 Carer's allowance

10 Other (Please say what)

11 Receive no help or support

CARD A13

1 Short breaks or respite e.g. day time breaks, overnight breaks or emergency respite

2 Advice and information

3 Practical things, e.g. putting hand rails in the bathroom, transport to a day centre

4 Talking to someone for support, e.g. family member, friend, counsellor

5 Having a befriender or a peer mentor

6 Advocacy services

7 Personal assistant/ support worker/ community nurse/ home help

8 Help from family, friends or neighbours

9 Help from teachers at school, e.g. talking or extra help with homework

10 Social activities and support, e.g. young carers' groups or day trips

11 Other (Please say what)

12 Receive no help or support

CARD A14

Extremely dissatisfied **Extremely satisfied**

0 1 2 3 4 5 6 7 8 9 10

CARD B2

1 Regular check-up with GP / hospital / clinic

2 Taking medication (tablets / inhalers)

3 Advice or treatment to stop smoking

4 Using oxygen

5 Immunisations against flu / pneumococcus

6 Exercise or physical activity

7 Advice or treatment to lose weight

8 Other (Please say what)

CARD C1

1 A general practitioner (GP)

2 Nurse at GP surgery/Health centre

3 Community, School or District Nurse

4 Hospital casualty/Accident and Emergency department

5 Consultant/Specialist or other doctor at hospital outpatients

6 Consultant/Specialist or other doctor elsewhere

7 Homeopath

8 Acupuncturist

9 Other alternative medicine professional

CARD C2

1 Fever
2 Weakness/tiredness
3 Diarrhoea
4 Loss of smell
5 Shortness of breath
6 Vertigo/dizziness
7 Trouble sleeping
8 Headache
9 Nausea/vomiting
10 Loss of appetite
11 Sore throat
12 Chest pain
13 Worry/anxiety
14 Memory loss or confusion
15 Muscle ache
16 Abdominal pain
17 Loss of taste
18 Cough
19 Palpitations
20 Low mood/not enjoying anything
21 Difficulty concentrating
22 None of these

CARD C3

1 Very likely
2 Fairly likely
3 Neither likely nor unlikely
4 Fairly unlikely
5 Very unlikely

CARD C4

1 I need more information about the safety of the vaccines

2 These are new vaccines so I don’t want to be among the first

3 I have heard that some people don't feel well after being vaccinated

4 I don’t think COVID-19 would be a serious illness for me

5 I don't think I'm at risk of catching Coronavirus

6 I’m concerned about how quickly the vaccines have been developed

7 I’m concerned about how quickly the vaccines have been approved

8 I have a medical history of allergic reactions and am concerned about my reaction to being vaccinated

9 I am concerned about having an allergic reaction, even though I do not have a medical history of allergies

10 I would worry about the risk of catching coronavirus at the place where the vaccines are given

11 I worry about how I will travel to the place where the vaccines are being given

12 I usually choose not to get any vaccines

13 I’m unlikely to have time to get vaccinated

14 I don’t trust vaccines

15 Other (Please say what)

CARD D1

1 On a pavement or a pedestrian area

2 On a road

3 In a home or garden (either your own or someone else's)

4 In a place used for sports, play or recreation (including sports facility at a school or college)

5 In some other part of a school or college

6 In an office, factory, shop, pub, restaurant or other public building

7 Somewhere else (Please say where)

8 Outdoor place of recreation or work otherwise not specified

CARD D2

1. Broken bone
2. Dislocated joints
3. Losing consciousness
4. Straining or twisting a part of the body
5. Cutting, piercing or grazing a part of the body
6. Bruising, pinching or crushing a part of the body
7. Swelling or tenderness in some part of the body
8. Getting something stuck in the eye, throat, ear or other part of the body
9. Burning or scalding
10. Poisoning
11. Other injury to internal parts of the body
12. Animal or insect bite or sting
13. Other (Please say what)

CARD D3

1. Hospital
2. GP/Family Doctor
3. Nurse at GP surgery
4. Nurse at place of work, school or college
5. Doctor at place of work, school or college
6. Other doctor or nurse
7. Ambulance staff
8. Volunteer first aider
9. Chemist or pharmacist
10. Family, friends, colleagues, passers-by
11. Looked after self
12. Other person/s

CARD E1

HOUSEWORK

Done during the last 4 weeks -

Hoovering

Dusting

Ironing

General tidying

Washing floors and paintwork

CARD E2

HEAVY HOUSEWORK

Done during the last 4 weeks -

Moving heavy furniture

Spring cleaning

Walking with heavy shopping
(for more than 5 minutes)

Cleaning windows

Scrubbing floors with a scrubbing brush

CARD E3

GARDENING, DIY AND BUILDING WORK

Done during the last 4 weeks -

Hoeing, weeding, pruning

Mowing with a power mower

Planting flowers/seeds

Decorating

Minor household repairs

Car washing and polishing

Car repairs and maintenance

CARD E4

HEAVY MANUAL WORK

Done during the last 4 weeks -

Digging, clearing rough ground

Building in stone/bricklaying

Mowing large areas with a hand mower

Felling trees, chopping wood

Mixing/laying concrete

Moving heavy loads

Refitting a kitchen or bathroom

CARD E5

Done during the last 4 weeks -

1 Swimming

2 Cycling

3 Workout at a gym / Exercise bike / Weight training

4 Aerobics / Keep fit / Gymnastics / Dance for Fitness

5 Any other type of dancing

6 Running / Jogging

7 Football / Rugby

8 Badminton / Tennis

9 Squash

10 Exercises (e.g. press-ups, sit-ups)

Please also include teaching, coaching and training/practice sessions

CARD E6

1	Bowls
2	Fishing / angling
3	Golf
4	Hillwalking / rambling
5	Snooker / billiards / pool
6	Aqua-robics / aquafit / exercise class in water
7	Yoga / pilates
8	Athletics
9	Basketball
10	Canoeing / Kayaking
11	Climbing
12	Cricket
13	Curling
14	Hockey
15	Horse riding
16	Ice skating
17	Martial arts including Tai Chi
18	Netball
19	Powerboating / jet skiing
20	Rowing
21	Sailing / windsurfing
22	Shinty
23	Skateboarding / inline skating
24	Skiing/ snowboarding
25	Subaqua
26	Surfing / body boarding
27	Table tennis
28	Tenpin bowling
29	Volleyball
30	Waterskiing

0 No – none of these

CARD F1

1 Less than 5 minutes

2 5 minutes, less than 15 minutes

3 15 minutes, less than 30 minutes

4 30 minutes, less than 1 hour

5 1 hour, less than 1 ½ hours

6 1 ½ hours, less than 2 hours

7 2 hours, less than 2 ½ hours

8 2 ½ hours, less than 3 hours

9 3 hours, less than 3 ½ hours

10 3 ½ hours, less than 4 hours

11 4 hours or more (please say how long)

CARD F2

SPORTS AND EXERCISE ACTIVITIES

INCLUDE any sports and exercise activities like:

Playing football, rugby or netball in a team, or any other organised team games

Playing tennis, squash or badminton

→ *include playing in:*
a practice session
a match
a club
out-of-school lesson

Going swimming or swimming lessons

Gymnastics (include Toddler Gym, Tumble Tots etc)

Dance lessons, ballet lessons, ice skating

Horse riding

Disco dancing

Any other organised sports, team sports or exercise activities

CARD F3

Other active things like:

Ride a bike

Kick a ball around

Run about (outdoors or indoors)

Play active games

Jump around

Any other things like these

CARD G1

1 6 a day or more

2 4 or 5 a day

3 2 or 3 a day

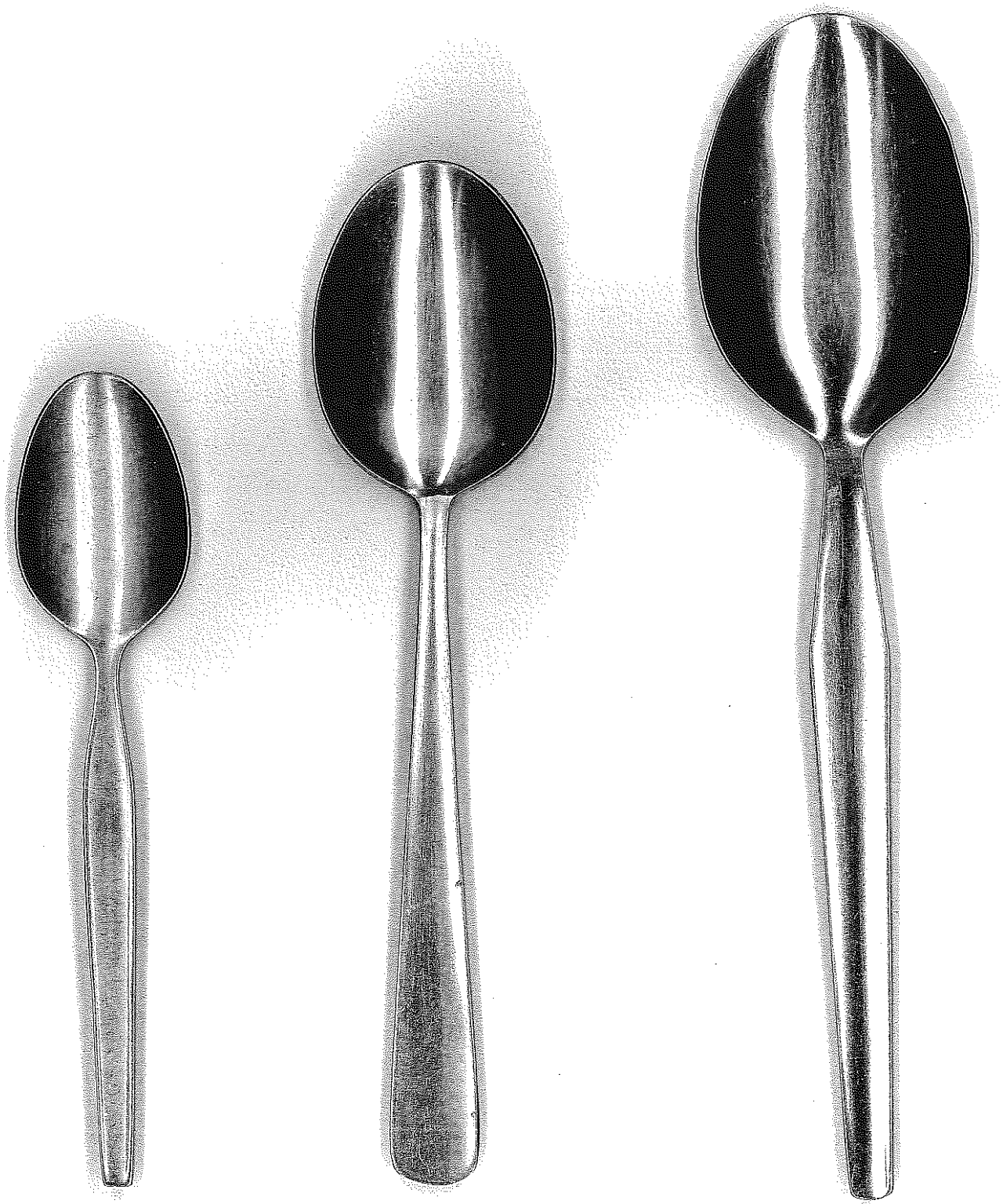
4 One a day

5 Less than one a day

CARD G2

1	6 or more times a day
2	4 or 5 times a day
3	2 or 3 times a day
4	Once a day
5	5 or 6 times a week
6	2 to 4 times a week
7	Once a week
8	1 to 3 times a month
9	Less often or never

CARD G3



Teaspoon

Dessertspoon

Tablespoon

CARD H1

1 Less than a week

2 At least a week but less than a month

3 1 - 3 months

4 4 - 6 months

5 Over 6 months

CARD H2

1 Every day

2 4 - 6 days a week

3 2 – 3 days a week

4 Once a week

5 2 – 3 times in the last 4 weeks

6 Once in the last 4 weeks

7 Not at all in last 4 weeks

CARD H3

1 Every day

2 4 - 6 days a week

3 2 – 3 days a week

4 Once a week

5 2 – 3 times in a 4 week period

6 Once in a 4 week period

7 Less than once in a 4 week period

CARD H4

1 Nicotine gum

2 Nicotine patches that you stick on your skin

3 Nasal spray/nicotine inhaler

4 Lozenge / microtab

5 Champix / Varenicline

6 Zyban / Bupropion

7 Electronic cigarette / vaping device

8 Other (Please say what)

9 No products used

CARD H5

1 At own home

2 At work

3 In other people’s homes

4 In cars, vans etc

5 Outside of buildings (e.g. pubs, shops, hospitals)

6 In other public places

7 No, none of these

CARD J1

1 Almost every day

2 Five or six days a week

3 Three or four days a week

4 Once or twice a week

5 Once or twice a month

6 Once every couple of months

7 Once or twice a year

8 Not at all in the last 12 months

250ml wine glass


175ml
125ml
175ml wine glass
125ml wine glass

CARD J2

1 Normal strength beer / lager / cider / shandy

2 Strong beer / lager / cider

3 Spirits or Liqueurs

4 Sherry, Martini or Buckfast

5 Wine (including Babycham, champagne and prosecco)

6 Alcopops / pre-mixed drinks

7 Other alcoholic drinks

8 Low alcohol drinks only

CARD J3

1 In a pub or bar

2 In a restaurant

3 In a club or disco

4 At a party with friends

5 At my home

6 At someone else's home

7 Out on the street, in a park or other outdoor area

8 Somewhere else (Please say where)

CARD J4

1 My husband or wife / boyfriend or girlfriend / partner

2 Male friends

3 Female friends

4 Male and female friends together

5 Work colleagues

6 Members of my family / relatives

7 Someone else (Please say who)

8 On my own

CARD K1

1 No natural teeth

2 Fewer than 10 natural teeth

3 Between 10 and 19 natural teeth

4 20 or more natural teeth

CARD K2

1 Eating food

2 Speaking clearly

3 Smiling, laughing and showing teeth without embarrassment

4 Emotional stability, for example, becoming more easily upset than usual

5 Enjoying the company of other people such as family, friends, or neighbours

6 None of these

CARD K3

1 Yes, often

2 Yes, occasionally

3 No, never

CARD K4

1 Full upper denture

2 Full lower denture

3 Partial upper denture

4 Partial lower denture

CARD K5

1 Less than a year ago

2 More than 1 year, up to 2 years ago

3 More than 2 years, up to 5 years ago

4 More than 5 years ago

5 Never been to the dentist

CARD K7

1 Difficulty in getting time off work

2 Difficulty in getting an appointment that suits me

3 Dental treatment too expensive

4 Long way to go to the dentist

5 I have not found a dentist I like

6 I cannot get dental treatment under the NHS

7 I have difficulty getting access, e.g. steps, wheelchair access

8 Other (Please say what)

CARD K8

1 Brush my teeth with a fluoride toothpaste

2 Use dental floss

3 Use a mouth rinse

4 Restrict my intake of sugary foods and drinks

5 Clean my dentures (including soaking with a sterilising tablet)

6 Leave my dentures out at night

CARD L1

1 Within the last 12 months

2 One year ago but less than two years ago

3 Two years ago but less than four years ago

4 Four years ago or more

CARD L2

1 Within the last 12 months

2 One year ago but less than two years ago

3 Two years ago but less than four years ago

4 Four years ago or more

5 No refresher training

CARD L3

1 I taught myself from a book, through the internet (e.g. YouTube, other website) or another self-learning tool

2 Training I took primarily because I am a parent or carer

3 Training which was compulsory for me to take as part of my work

4 Training which I opted to take as part of my work

5 Training which was compulsory for me to take as part of my voluntary work or hobby

6 Training which I opted to take as part of my voluntary work or hobby

7 Training I took whilst I was a student as part of my school/college/university work

8 Other form of CPR training (Please say what)

CARD N1

D	Your accent
K	Your ethnicity
W	Your age
T	Your language
G	Your colour
L	Your nationality
B	Your mental ill-health
H	Any other health problems or disability
A	Your sex
I	Sectarian reasons
C	Other religions belief or faith reason
P	Your sexual orientation
E	Where you live
O	Other reason
N	I have not experienced this

CARD P1

1 Working as an employee (or temporarily away)

2 On a Government sponsored training scheme (or temporarily away)

3 Self employed or freelance (or temporarily away)

4 Working unpaid for your own family's business (or temporarily away)

5 Doing any other kind of paid work

6 None of the above

CARD P2

1 Not at all stressful

2 Mildly stressful

3 Moderately stressful

4 Very stressful

5 Extremely stressful

CARD P3

0	Extremely dissatisfied
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	Extremely satisfied

CARD P4

1 Always

2 Often

3 Sometimes

4 Seldom

5 Never

CARD P5

1 Strongly agree

2 Tend to agree

3 Neutral

4 Tend to disagree

5 Strongly disagree

CARD Q1

1 School Leaving Certificate, National Qualification Access Unit

2 O Grade, Standard Grade, GCSE, GCE O Level, CSE, National Qualification Access 3 Cluster, Intermediate 1 or 2, National 4 or 5, Senior Certificate or equivalent

3 GNVQ/GSVQ Foundation or Intermediate, SVQ Level 1 or 2, SCOTVEC / National Certificate Module, City and Guilds Craft, RSA Diploma or equivalent

4 Higher Grade, Advanced Higher, CSYS, A level, AS level, Advanced Senior Certificate or equivalent

5 GNVQ/GSVQ Advanced, SVQ Level 3, ONC, OND, SCOTVEC National Diploma, City and Guilds Advanced Craft, RSA Advanced Diploma or equivalent

6 HNC, HND, SVQ Level 4, RSA Higher Diploma or equivalent

7 First Degree, Higher Degree, SVQ Level 5 or equivalent

8 Professional qualifications e.g. teaching, accountancy

9 Other school examinations not already mentioned

10 Other post-school but pre Higher education examinations not already mentioned

11 Other Higher education qualifications not already mentioned

12 No qualifications

CARD Q2

Choose **ONE** section from A to F, then choose **ONE** option which best describes your ethnic group or background.

A White
Scottish
Other British
Irish
Gypsy/Traveller
Polish
Other white ethnic group (please say what)

B Mixed or multiple ethnic group
Any mixed or multiple ethnic groups (please say what)

C Asian, Asian Scottish or Asian British
Pakistani, Pakistani Scottish or Pakistani British
Indian, Indian Scottish or Indian British
Bangladeshi, Bangladeshi Scottish or Bangladeshi British
Chinese, Chinese Scottish or Chinese British
Other (please say what)

D African
African, African Scottish or African British
Other (please say what)

E Caribbean or Black
Caribbean, Caribbean Scottish or Caribbean British
Black, Black Scottish or Black British
Other (please say what)

F Other ethnic group
Arab, Arab Scottish or Arab British
Other, (please say what)

CARD Q3

1 Self-employed, with a business with 25 or more employees

2 Self-employed, with a business with fewer than 25 employees

3 Self-employed, in a business with no employees

4 A manager of 25 or more staff

5 A manager of fewer than 25 staff

6 Foreman or supervisor

7 An employee, not a manager

CARD Q4

1 High Blood Pressure

2 Angina

3 Heart Attack

4 Stroke

5 Other Heart Trouble

6 Diabetes

Useful Contacts Sheet

This sheet contains some contact details for organisations that you may find useful. A Useful Contacts Sheet has been sent to every household contacted as part of the Scottish Health Survey.

Organisation	Phone number	Website address
NHS 24	111	www.nhs24.scot
NHS Inform (dedicated to Covid-19 at time of issue)	0800 22 44 88	www.nhsinform.scot
NHS Inform (stop smoking)		www.nhsinform.scot/healthy-living/stopping-smoking
Take Life On		www.takelifeon.co.uk
Every Mind Matters		nhs.uk/oneyou/every-mind-matters
Alzheimer Scotland	0808 808 3000	www.alzscot.org
Alcoholics Anonymous	0800 9177 650	www.alcoholics-anonymous.org.uk
Narcotics Anonymous	0300 999 1212	www.ukna.org
Know the Score	0333 230 9468	www.knowthescore.info
Scottish Families Affected by Alcohol and Drugs	08080 10 10 11	https://www.sfad.org.uk/
Gamblers Anonymous Scotland	0370 050 8881	https://gascotland.org
Victim Support line	0800 160 1985	www.victimsupportsco.org.uk
Scotland Domestic Abuse and Forced Marriage Helpline	0800 027 1234	www.sdafmh.org.uk
Refuge (domestic abuse helpline)	0808 2000 247	www.refuge.org.uk
LGBT Helpline Scotland	0300 123 2523	www.lgbthealth.org.uk
The Samaritans	116 123	www.samaritans.org
Breathing Space Scotland	0800 83 85 87	www.breathingspace.scot
NHS Living Life	0800 328 9655	www.nhs24.scot/our-services/living-life
SANE		www.sane.org.uk
Supportline	01708 765 200	www.supportline.org.uk
Childline	0800 1111	www.childline.org.uk/
NSPCC	0808 800 5000	www.nspcc.org.uk
Beat (eating disorders)	0808 801 0677	beateatingdisorders.org.uk
Future Pathways	0808 164 2005	www.future-pathways.co.uk
Relationships Scotland	0345 119 2020	www.relationships-scotland.org.uk
Cruse Bereavement Care Scotland	0808 802 6161	www.crusescotland.org.uk
Parentline Scotland: Children 1st	08000 28 22 33	www.children1st.org.uk
Citizens Advice Scotland	0800 028 1456	www.cas.org.uk
Carers Scotland	0808 808 7777	www.carersuk.org/scotland

Everyone who takes part in the Scottish Health Survey is asked to take part in Intake24.

This leaflet explains Intake24 and answers some of the questions you might have.

What if I get stuck or have any questions?

If you need any help completing the diary, or have any questions about Intake24, please call free on 0800 652 2704 or email Intake24@scotcen.org.uk

Food Standards Scotland

Office for National Statistics

MRC Epidemiology Unit

UNIVERSITY OF CAMBRIDGE

ScotCen Social Research, Scotiabank House, 2nd Floor, 6 South Charlotte Street, Edinburgh, EH2 4AW. Tel. 0800 526 397. A Company Limited by Guarantee, Charity No. SC038454

Person One name:

Username:

Password:

2nd diary day:

Person Two name:

Username:

Password:

2nd diary day:

Person Three name:

Username:

Password:

2nd diary day:

If you do not receive an email or text, please go to: **intake24.org/surveys/SHS** Then enter your username and password. Please only use your own username and password.

[68]_P15381_PIL_INTAKE24 ADULT LEAFLET_V3

ScotCen
Social Research that works for society

INTAKE24
A short introduction

Please retain this leaflet for later use

What is INTAKE24?

It's an online diary that you fill out on a computer, smartphone or tablet. The diary asks you to enter everything you had to eat and drink the day before. It's designed to be quick and easy to use and helps you remember all the foods and drinks you had.

The information will help Food Standards Scotland and the Scottish Government develop better ways of improving the health of people in Scotland.

How do I take part?

We'd like you to do Intake24 on two days over a 8 day period. Your interviewer will let you know when to complete your diary days.

If you have an email address or a smartphone we can send you a link that takes you straight to the diary – no need to type in a password. We'll also be able to send you reminders.

Who will see my answers?

Your answers are treated with care and with full respect for your privacy.

The information collected in Intake24 is used for research only and will be dealt with in accordance with data protection legislation. The results from the project will not be published in a form that can reveal your identity.

Full details about data confidentiality are provided in your Scottish Health Survey information leaflet.

Do I have to take part?

No, not if you don't want to. If you start filling out the diary and want to stop then that's fine too. And if you decide that you no longer want the information you've entered into Intake24 to be used in the survey then we can delete it for you. You just need to let us know before March 2022.

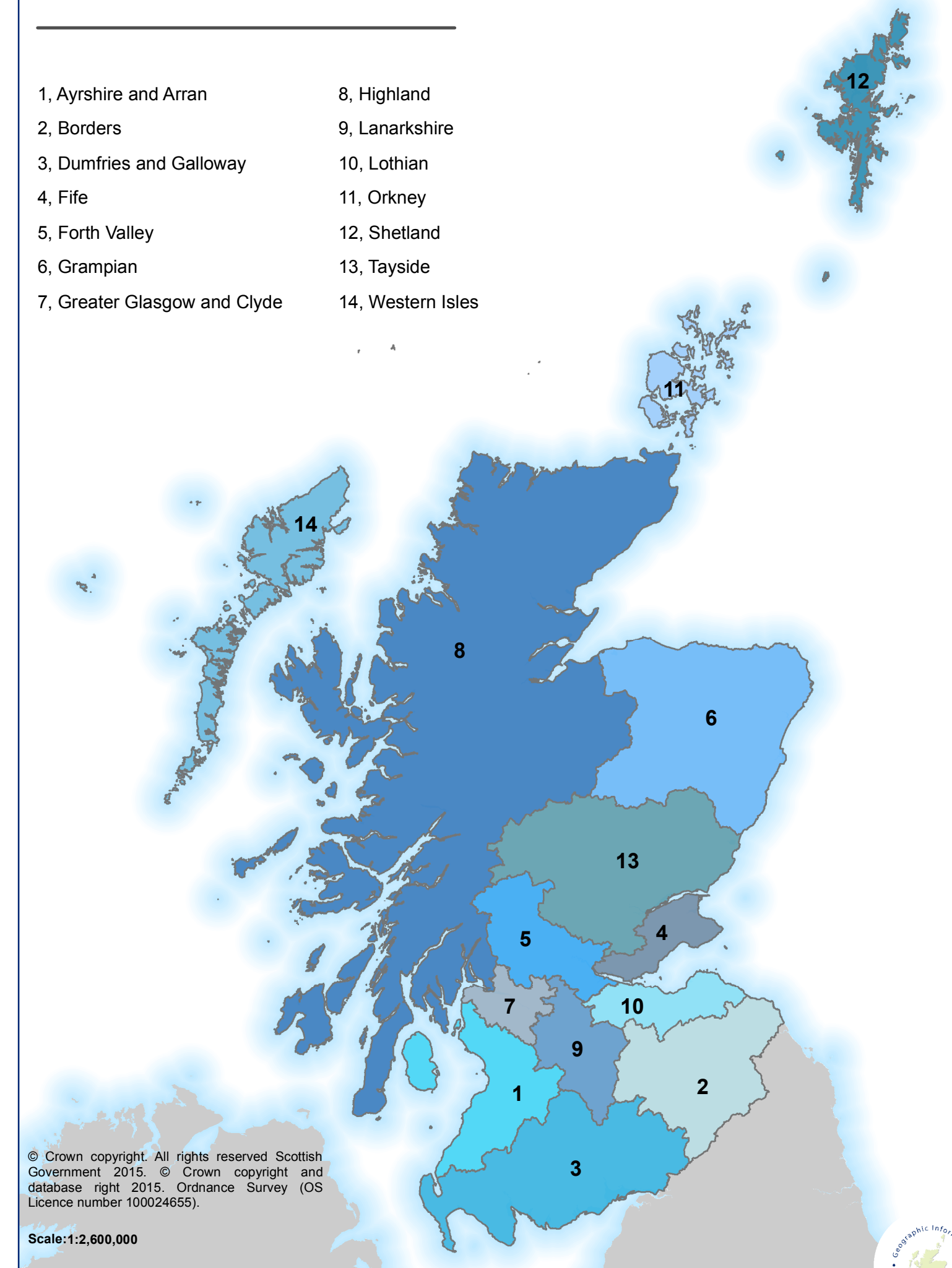
We think you'll enjoy taking part and your information will help develop new ways of improving the health of people in Scotland!

Thank you!

If you complete Intake24 on both days we'll send you a **£10 shopping voucher**. You will also be able to see some feedback on your diet if you like.

NHS Health Board Areas

1, Ayrshire and Arran
2, Borders
3, Dumfries and Galloway
4, Fife
5, Forth Valley
6, Grampian
7, Greater Glasgow and Clyde
8, Highland
9, Lanarkshire
10, Lothian
11, Orkney
12, Shetland
13, Tayside
14, Western Isles



Scale:1:2,600,000

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The United Kingdom Statistics Authority has designated the Scottish Health Survey as National Statistics in January 2010, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics.

Designation can be interpreted to mean that the statistics: meet identified user needs; are produced, managed and disseminated to high standards; and are explained well.

Correspondence and enquiries

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DG Health and Social Care
Telephone: 0131 244 2368
e-mail: scottishealthsurvey@gov.scot

For general enquiries about Scottish Government statistics please contact:
Office of the Chief Statistician, Telephone: 0131 244 0442
e-mail: statistics.enquiries@gov.scot

How to access background or source data

The data collected for the Scottish Health Survey:
☒ are made available via the UK Data Service

☒ may be made available on request, subject to consideration of legal and ethical factors. Please contact scottishealthsurvey@gov.scot for further information.

Further breakdowns of the data:
☒ are available via the Scottish Health Survey website
https://www.gov.scot/collections/scottish-health-survey

Complaints and suggestions

If you are not satisfied with our service or have any comments or suggestions, please write to the Chief Statistician, 3WR, St Andrews House, Edinburgh, EH1 3DG, Telephone: (0131) 244 0302, e-mail statistics.enquiries@gov.scot.

If you would like to be consulted about statistical collections or receive notification of publications, please register your interest at ScotStat Register: guidance

Details of forthcoming publications can be found at
https://www.gov.scot/publications/official-statistics-forthcoming-publications/

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