

Being LGBTQI+ in Ireland



The National Study on the
Mental Health and Wellbeing
of the LGBTQI+ Communities
in Ireland

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FOREWORD

The co-funders of the *Being LGBTQI+ in Ireland* study, warmly welcome the completion of the study, and presentation of comprehensive findings as published in this report. This represents a very timely and definitive follow-up to the *LGBT Ireland Report (2016)* – the first, ground-breaking study of the mental health of LGBTQI+ people in Ireland.

The *Being LGBTQI+ in Ireland* study is another important milestone for researchers, policy makers, service providers, and LGBTQI+ people in Ireland alike. The study has comprehensively considered many inter-connected areas of interest, such as: LGBTQI+ people's mental wellbeing; the prevalence of mental health problems (depression, anxiety, stress, substance misuse, self-harm, suicidality, eating disorders) among LGBTQI+ people; safety and discrimination (in the context of schools and in the media); healthcare utilisation and experiences of healthcare and attitudes on societal acceptance and inclusion.

The experiences shared by participants regarding healthcare practitioners reveal both positive strides and gaps in knowledge and understanding, underscoring the further need for greater awareness and inclusivity across various sectors, from education to healthcare, to ensure the well-being and safety of LGBTQI+ community. The study has further shed light on the multifaceted challenges encountered by transgender and intersex individuals in healthcare settings. These findings are calling for healthcare systems to adopt more informed and supportive approaches, catering to the unique needs of these communities and ensuring equitable access to quality care.

The co-funders of this study would like to emphasise the importance of the striking findings from this study. They are incredibly valuable in influencing wide-ranging policy, practice, health and school settings – and our collective societal attitudes and behaviour toward LGBTQI+ people in Ireland. In particular:

- The HSE National Office for Suicide Prevention (NOSP) works to drive the implementation of *Connecting for Life, Ireland's National Strategy to Reduce Suicide (2015-2024)*. In doing so, the office leads, facilitates and supports a wide range of networks and structures, with multi-sectoral stakeholders that are committed to working to advance the strategy's 69 actions. The strategy sets out a vision of an Ireland where fewer lives are lost through suicide, and where communities and individuals are empowered to improve their mental health and wellbeing. LGBTQI+ people have been shown by long-standing national and international research to have increased risk of suicidal behaviour. Therefore, steadfast commitments remain in *Connecting for Life* – and will remain across our future suicide prevention efforts – to such a significant priority group in Ireland.

- The HSE National Social Inclusion Office (NSIO) holds a remit for promoting health and well-being, improving health outcomes, and enabling access to health services for vulnerable groups and marginalised (socially excluded) communities. The work of the NSIO is informed by a Social Determinants of Health, human rights-based and person-centred approach, with comprehensive national policies and strategies to inform all developments. NSIO works with other HSE partners to implement health actions of the *First National LGBTI+ Inclusion Strategy (2019-2021)*. The vision for this strategy is a safe, fair and inclusive Ireland for LGBTIQ+ people through four thematic pillars: Visible and Included, Treated Equally, Healthy, Safe and Supported. The HSE's responsibilities under the Strategy fall under the thematic pillar Healthy and Include actions focused on training of healthcare providers in LGBTIQ+ awareness and needs, including LGBTIQ+ community's specific needs in health policy, resourcing of Sexual Health Services in the Ireland, educating communities on STIs, testing and support people living with HIV and promoting transgender healthcare access and support. Findings from this study – especially in relation to training development for healthcare staff – will inform future training development, promotion efforts and incorporating lived experiences to ensure more inclusive and effective healthcare practices.
- The Department of Children, Equality, Disability, Integration and Youth (DCEDIY) has oversight responsibility for the National LGBTI+ Inclusion Strategy while implementation of specific actions is the responsibility of relevant line Departments. The Strategy provides for a whole-of-Government framework for identifying and addressing issues, which may prevent LGBTI+ people from enjoying full equality in practice in Irish society. The overall vision informing the Strategy is of a safe, fair and inclusive Ireland where people are supported to flourish and to live inclusive, healthy and fulfilling lives, whatever their sexual orientation, gender identity or expression, or sex characteristics. The Strategy pursues objectives under four thematic pillars providing a vision of an Ireland where LGBTI+ people are visible and included, treated equally, healthy and feel safe and supported. A National LGBTI+ Steering Committee is in place to oversee implementation of the National LGBTI+ Inclusion Strategy, which comprises representatives from key government departments and public bodies along with NGOs, particularly those representing LGBTI+ people. Meetings of the Steering Committee are chaired by the Minister for Children, Equality, Disability, Integration and Youth.

The *Being LGBTIQ+ in Ireland* study is the result of an extensive body of work undertaken by the authors, project leads – Belong To and Trinity College Dublin – and members of the interagency Research Advisory Group. The co-funders of the study would like to take this opportunity to thank them for their tireless work on this project.

In addition, we would like to sincerely thank every person who shared their lived experiences with the researchers, and trusted them. The strength and value of this study – and its ultimate potential to influence change and attitudes – are firmly rooted in the authenticity and honesty in your voices.

HSE National Office for Suicide Prevention

HSE National Social Inclusion Office

Department of Children, Equality, Disability, Integration and Youth

PREFACE

Being LGBTQI+ in Ireland offers an in-depth exploration of the mental health and wellbeing of lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI+) people in Ireland today.

This study continues the historic legacy of the 2016 *LGBTIreland* – a groundbreaking piece of research that has been instrumental in giving voice to and advocating for the lives and needs of the LGBTQI+ population in Ireland.

Being LGBTQI+ in Ireland is the second iteration of the *LGBTIreland* study. This report explores what has changed for LGBTQI+ people since the 2014-2015 data collection of the initial study.

Since this first study, significant policy and legal developments have taken place in Ireland, progressing the social and political lives of the LGBTQI+ individuals.

The findings of this study affirm that the legislative developments of the Marriage Equality Act 2015 and the introduction of the Gender Recognition Act 2015 positively impacted the mental health and wellbeing of the LGBTQI+ community. Alongside legislation, there have been significant efforts made to address LGBTQI+ inequality and promote visibility, health and safety among LGBTQI+ communities namely through two national strategies; the *LGBTI+ National Youth Strategy 2018-2020* (DCYA, 2018), and the *National LGBTI+ Inclusion Strategy 2019-2021* (DCEDIY, 2019).

Despite these major milestones, findings reveal that inequality persists for LGBTQI+ individuals in Ireland and they continue to face challenges in relation to their health and wellbeing. This study finds that LGBTQI+ people in Ireland continue to face high levels self-harm and suicidality with increased levels of depression, anxiety and stress since the 2016 *LGBTIreland* report.

LGBTQI+ people in Ireland continue to face high levels of harassment and violence related to their sexual orientation and/or gender identity as demonstrated through the findings. In addition to experiencing violence and harassment, LGBTQI+ people also experienced anti-LGBTQI+ hate speech across a variety of media. This increase in anti-LGBTQI+ hate speech normalises homophobia and transphobia and increases acceptance of this across society. Facing an environment of growing hate has major impacts on the mental health of the community. It results in worries and fears regarding personal safety, creates concerns that social progress would be influenced and undone and compounds mental health challenges among the LGBTQI+ community.

While the LGBTQI+ community as a whole can face mental health challenges, the findings are harrowing concerning two cohorts: LGBTQ+ young people under 25 and trans individuals.

The study confirmed that LGBTQI+ young people experience elevated levels of suicidal behaviour and self-harm, and experience severe and extremely severe symptoms of stress, anxiety and depression. In addition, LGBTQI+ youth are also at elevated risk in relation to eating disorders and harmful alcohol and drug use. Many factors play a role in influencing the mental health and wellbeing of LGBTQI+ young people including struggles with self-acceptance, bullying and discrimination, familial rejection, fear, confusion, lack of access to services that can meet their needs harassment and increased hate towards LGBTQI+ people in the media. While in recent years, at both a policy and practice level, there has been a movement towards protecting and supporting LGBTQI+ young people at post-primary levels, the findings related to the school experience of LGBTQI+ students reveal that substantial effort is still needed to ensure the full inclusion, safety and belonging of these students.

In addition to LGBTQI+ youth the trans community were also identified as a vulnerable group in relation to their mental health and wellbeing in this study. The trans community face increased stigma, isolation and discrimination in society than other cohorts in the LGBTQI+ community and as a result, have worse mental health outcomes than their cisgender peers. This study finds that the trans community also has significantly reduced access to healthcare that can facilitate medical transitioning. Without access to this life-saving form of healthcare trans people face increased mental health challenges, social isolation and to turn to alternative means of transitioning that pose financial and health-related risks.

The findings of this study show that while Ireland has made significant progress since the 2016 *LGBTIreland* report, more work is still needed to ensure that all LGBTQI+ people are equal, safe, included and valued across Irish society. It also highlights the increasing importance of protecting the existing social inclusion, equality and rights achieved for the community in light of the increased anti-LGBTQI+ hate and harassment. Importantly, this research points to ways LGBTQI+ lives can be improved in Ireland by highlighting protective factors namely supportive relationships; connection to communities; personal awareness and self-acceptance; access to safe and supportive services and spaces; education and awareness within society and positive representation of LGBTQI+ lives within the media. The recommendations informed by this research reflect these rich findings and are grounded in the insight and knowledge of community members.

On behalf of Belong To I would like to express my deep appreciation to the LGBTQI+ people who shared their experiences and stories as part of this research. We are so grateful for your honesty, trust and resilience. In addition, I wish to sincerely thank the support and expert guidance of the Research Advisory Committee who were instrumental at every stage of this project. I also wish to extend my sincere gratitude to the HSE National Office for Suicide Prevention (NOSP), HSE Social Inclusion, and the What Works and Dormant Accounts Fund, Department of Children, Equality, Disability, Integration and

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Moninne Griffith (she/her)

CEO

Belong To – LGBTQ+ Youth Ireland

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We would also like to thank members of the research advisory group who provided invaluable assistance throughout the study. The group's membership was as follows:

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GLOSSARY

Androsexual is a term used to describe someone who experiences attraction to men and/or masculinity and/or male anatomy, regardless of whether the object of one's affection identifies as a man.

Agender is a term used to describe someone who identifies as having no gender or gender identity, or identifies as non-gendered.

AFAB is a term used to describe someone whose sex was assigned as female at birth, typically based on their anatomical and other biological characteristics.

AMAB is a term used to describe someone whose sex was assigned as male when born, typically based on their anatomical and other biological characteristics.

Aromantic is a term used to describe someone who experiences little or no romantic attraction to others.

Asexual or **Ace** is a term used to describe someone who experiences limited or no sexual attraction.

Aroace is short for aromantic asexual and is a term used to describe someone who does not experience romantic or sexual attraction to others.

Bisexual or **Bi** is a term used to describe someone who is sexually and romantically attracted to multiple genders.

Biphobia is a dislike, fear or hatred of bisexual people.

BIPOC is an acronym which stands for black, indigenous, and other people of colour.

Bi-erasure is ignoring, removing, or re-explaining the evidence of bisexuality.

Cisgender or **Cis** is a term used to describe an individual's gender when their experiences of their gender correspond to the sex they were assigned at birth.

Coming out is a process that involves developing an awareness of one's LGBTQI+ identity, accepting one's sexual orientation or gender identity, choosing to share the information with others and building a positive LGBTQI+ identity. It not only involves coming out, but staying out and dealing with the potential challenges that one might encounter as an LGBTQI+ person.

Cyberbullying is bullying with the use of digital technologies.

Demi-girl is someone who only partially (not wholly) identifies as a girl or woman, whatever their assigned sex at birth.

Deadnaming is the act of referring to a transgender or non-binary person by a name they used prior to transitioning, such as their birth name.

Demisexual is a term used to describe someone who feels sexual attraction only to people with whom they have an emotional bond.

Detransition refers to the stopping or reversal of gender transitioning which could be social (gender presentation, pronouns), medical (hormone therapy), surgical, or legal.

DIY HRT (do-it-yourself hormone replacement therapy) is a phenomenon where transgender people obtain and self-administer hormones as part of their medical transition without the guidance of a licensed medical provider.

Doxing or **Doxxing** is short for "dropping dox" and involves finding and sharing the victim's personal information online with the intent to shame or harass.

Families of choice, or '**friendship families**', refer to non-biological social networks, which have been highlighted as playing a larger role in the lives of LGBTQI+ people when compared to heterosexual people.

Female-to-Male (FTM) Transgender refers to a person assigned 'female' at birth but who identifies as male.

Gay is a term traditionally used to describe a man who is sexually and romantically attracted to other men. While the term 'lesbian' is typically used to describe women who are attracted to other women, many women with same-sex attractions self-identify as 'gay'.

GBTQ is an acronym for 'gay, bisexual, transgender, queer/questioning.'

Gender fluid refers to a person who does not feel confined by the binary division of male and female.

Gender identity refers to how a person identifies with a gender category. For example, a person may identify as either a man or woman, or in some cases as neither, both or something else.

Gender identity disorder is a controversial term. Within the medical world it refers to a formal medical diagnosis for the condition in which a person experiences persistent discomfort and disconnect with the biological sex with which they were born. It was included in the Diagnostic and Statistical Manual of Mental Disorders in 1994 as a replacement for the term 'transsexualism'.

Gender non-conforming or **gender diverse** is an umbrella term for the wide variety of gender identities that exist outside of the binary of man or woman and do not conform to traditional gender roles.

Gender affirming surgery refers to a variety of surgical procedures by which the physical appearance and function of existing sexual characteristics and/or genitalia are altered to resemble the person's gender identity.

Gender critical refers to beliefs about sex being biological and unchanging, while also opposing the idea of gender identity and gender identity-based rights.

Genderqueer is a term used to describe someone who possesses identities that fall outside of the widely accepted gender binary.

Gender-neutral language is language that avoids reference towards a particular sex or gender.

Gynosexual is a term used to describe a person, of any gender or gender non-conforming, who is attracted to femininity, regardless of the gender identity of the femme-presenting person they are attracted to.

Hate speech is any kind of communication that attacks or uses pejorative or discriminatory language with reference to a person or a group based on race, ethnicity, religion, sexual orientation, or similar grounds.

Heteroflexible is a term used to describe someone who primarily identifies as heterosexual, or "straight," but is sometimes attracted to the same sex.

Heteronormative, or the '**heterosexual norm**', refers to the assumption that heterosexuality is the only sexual orientation. It is closely related to 'heterosexism' (see definition) and can often cause other sexual orientations to be ignored and excluded.

Heterosexual is a term used to describe someone who is sexually and romantically attracted to a person of the opposite sex.

Heterosexism is the assumption that being heterosexual is the typical and 'normal' sexual orientation, with an underlying assumption that it is the superior sexual orientation. This assumption often results in an insensitivity, exclusion or discrimination towards other sexual orientations and identities, including LGBTQI+.

Homophobia is a dislike, fear or hatred of lesbian and gay people.

Internalised homophobia is the homophobia of a lesbian, gay, or bisexual person towards their own sexual orientation. It has been described as the conscious or unconscious incorporation of society's homophobia into the individual. It can be recognised or unrecognised by the individual but has been found to lead to struggle and tension, sometimes severe, for a person when dealing with their sexual orientation and identity.

Internalised stigma occurs when a person cognitively or emotionally absorbs stigmatising assumptions and stereotypes and comes to believe and apply them to themselves.

Intersex is an umbrella term used to describe a variety of conditions in which a person is born with anatomy or physiology that does not fit societal definitions of female or male (e.g. sexual or reproductive anatomy, chromosomes, and/or hormone production).

Lesbian is a term used to describe a woman who is sexually and romantically attracted to other women.

LGB is an acronym for 'lesbian, gay and bisexual'.

LGBT is an acronym for 'lesbian, gay, bisexual and transgender'.

LGBTI is an acronym for 'lesbian, gay, bisexual, transgender and intersex'.

LGBTQI is an acronym for 'lesbian, gay, bisexual, transgender queer/questioning and intersex'.

LGBTQI+ stands for 'lesbian, gay, bisexual, transgender, queer/questioning and intersex' with the '+' signifying inclusivity to all sexual and gender identities.

LGBTQI+ bullying: Bullying based on prejudice or discrimination towards LGBTQI+ people.

LGBTQI+-friendly refers to services, programmes, groups and activities which recognise, are inclusive of and welcoming to, LGBTQI+ people.

LGBTQI+-specific is a term used to describe services, programmes, groups and activities that are aimed at and cater specifically to LGBTQI+ people.

Mainstream is a term used to describe services, programmes, groups and activities which are not aimed at or do not cater specifically for LGBTQI+ people.

Male-to-Female (MTF) Transgender refers to a person assigned 'male' at birth but who identifies as female.

Microaggressions are brief and often subtle slights or derogatory acts, that may or may not be intentional but communicate negative viewpoints toward a person, for example, making flippant comments that are rooted in a heteronormative viewpoint.

Minority stress is based on the premise that LGBTQI+ people, like members of any minority group, are subject to chronic psychological stress due to their group's stigmatised and marginalised status. While LGBTQI+ people are not inherently any more prone to mental health problems than other groups in society, coping with the effects of minority stress can be detrimental to LGBTQI+ people's mental health.

Misogyny describes dislike of, contempt for, or ingrained prejudice against women.

Misgendering is the act of using the wrong pronouns or gendered language when talking to, or about, someone.

MSM is an abbreviation for men who have sex with men.

Neopronouns are a category of new (neo) pronouns that are increasingly used in place of "she," "he," or "they" when referring to a person. Some examples include: xe/xem/xyr, ze/hir/hirs, and ey/em/eir.

Neurodivergent is a term used to describe someone whose brain functions differently from the typical brain and can include conditions such as autism spectrum disorder (ASD) or other neurological or developmental conditions such as attention-deficit/hyperactivity disorder (ADHD).

Non-binary or **Enby** (plural enbies) is a term used to describe someone whose gender identity is neither exclusively woman or man or is in between or beyond the gender binary.

Omnisexual is a term used to describe someone who is attracted to all genders.

Out/Coming out is a term used to identify the experience of a person first telling someone/others about their orientation and/or gender identity.

Pansexual is sexual or romantic attraction toward people of any sex or gender identity.

Panromantic is a term used to describe romantic attraction towards persons of every gender(s).

PEP (Post Exposure Prophylaxis) is an emergency course of medication that aims to prevent HIV acquisition following a recent possible exposure to HIV.

POC (People Of Colour) is primarily used to describe any person who is not considered "white".

PrEP (Pre Exposure Prophylaxis) is a medication taken by HIV-negative people to reduce the chance of getting HIV from having sex without a condom or from sharing needles or equipment to inject or use drugs.

Queer is an umbrella term used to describe people who are not heterosexual and/or are not cisgender. Queer was used as a slur against the LGBTQ+ community for many years and still can be. However, the word has been reclaimed by LGBTQ+ communities and many now embrace the term as one denoting any gender identity or sexuality that does not fit society's traditional ideas about gender or sexuality. Queer may also be used to indicate people's identification with a politically alternative perspective to what some might see as the more assimilationist perspectives of the LGBTQI+ communities.

Questioning is the process of examining one's sexual orientation and/or gender identity.

SD is an abbreviation for 'standard deviation', a statistical term describing the variation of values around the mean. A low standard deviation means that the values tend to be very close to the mean, whereas a high standard deviation indicates that the data are spread out over a larger range of values.

Self-harm refers to the act of harming oneself in a way that is deliberate but not intended as a means to suicide. Examples of self-harm include cutting, scratching, hitting, or ingesting substances to harm oneself.

Sexual identity refers to how a person identifies in terms of sexual and emotional attraction to others. It includes a wide range of identities, with the most typical being gay, lesbian, bisexual and heterosexual. A person's sexual identity may be different than their sexual behaviours and practices.

Sexism is any expression (act, word, image, gesture) based on the idea that some people, typically females, are inferior because of their sex.

Sexual and gender minority (SGM) is an umbrella term that encompasses populations included in the acronym "LGBTI" (lesbian, gay, bisexual, transgender and intersex), and those whose sexual orientation or gender identity varies.

Sexual orientation refers to an enduring pattern of emotional, romantic or sexual attraction to others. It includes a wide range of attractions and terms, the most common being gay, lesbian, bisexual and heterosexual.

Stealth is a term used to describe transgender people who have transitioned and are living their gender openly but have not informed the people around them about their transgender status.

Swatting refers to giving a false tip to police about the targeted victim committing a serious crime or that a serious crime is in progress. The intended outcome being a large number of law enforcement arriving at the victims address unexpectedly.

Trans Exclusionary Radical Feminism (TERF) or 'TERFs' is a term used to separate feminists who do not support trans people from those who do. TERFs are opposed to the recognition of trans people's genders, particularly trans women as women, opposed to transgender rights, and support the exclusion of trans women from women's spaces. These beliefs are often based on the view that biological sex should determine one's gender.

Transgender is an umbrella term referring to people whose gender identity and/or gender expression differs from conventional expectations based on the sex they were assigned at birth. This can include people who self-identify as trans men, trans women, transsexual, transvestite, cross-dressers, drag performers, genderqueer, and gender variant.

Transmasculine/Transmasc is someone assigned a female sex at birth and who identifies as masculine, but may not identify wholly as a man.

Transfeminine is someone assigned a male sex at birth who identifies as feminine, but may not identify wholly as a woman.

Transphobia is a dislike, fear or hatred of people who are transgender, transsexual, or people whose gender identity or gender expression differs from the traditional binary categories of 'male' and 'female'.

Transsexual is a controversial and contested term. It refers to a person whose gender identity differs from the sex assigned to them at birth. It was removed from the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) in 1994 and replaced with gender identity disorder.

Transitioning is the process through which a person takes steps to live openly as their gender. This can include changing appearance, mannerisms, name/ pronouns, legal documentation, and other personal, social, and legal changes. This may also include undertaking hormone replacement therapy and/or gender affirming surgery.

Xenophobia is a fear of strangers which may express itself in dislike of or prejudice against people from other countries.

EXECUTIVE SUMMARY

Module One

Introduction

The *Being LGBTQI+ in Ireland* study is a sequel to and based on the *LGBTIreland* study (Higgins et al. 2016) which was published in 2016 and was the largest ever study of the mental health and wellbeing of the LGBTI community in Ireland. The original study highlighted that while the majority of LGBTI participants experienced positive wellbeing, there was also a significant number who experienced mental health challenges, a significant number of young LGBTI participants who were subjected to bullying in school and issues related to harassment and safety of LGBTI people in day-to-day life. Given the many developments that have taken place since its publication, it was considered timely to track potential changes in mental health outcomes since 2016. This also offered the opportunity to gain new insights into the mental health and wellbeing of the LGBTQI+ community in Ireland by focusing on under researched areas and subgroups of the LGBTQI+ population.

Module One objectives

The objectives of Module One were to:

- Explore LGBTQI+ people's mental wellbeing (happiness, self-esteem, resilience, comfort/consonance with identity, disclosure, strategies for maintaining wellness), including identifying the prevalence of mental health problems (depression, anxiety, stress, substance misuse, self-harm, suicidality, eating disorders) among the LGBTQI+ community, with specific emphasis on the adolescent and young adult cohort.
- Explore LGBTQI+ people's perspectives on safety and discrimination in the context of school and media, including challenges in accessing and using health care.
- Assess any changes in LGBTI people's mental health and wellbeing since the initial *LGBTIreland* report as well as changes in school outcomes.
- Identify priorities and make recommendations for future service provision and policy developments based on the research evidence, best practice and evidence from Ireland and other jurisdictions.

Research methodology and participant profile

Data for Module One were collected using an online survey comprising 144 questions, including both repeat questions from the *LGBTIreland* survey and new questions. In total, 2,806 people were included in the final sample, of which 70% identified as cisgender. There were 718 participants who identified as

transgender and 31 who identified as intersex or as having an intersex variation. Half of the sample (50%) identified as lesbian or gay. It was predominantly a young sample with 70% aged under 35, with a small proportion aged 60 or older (4%). The mean age of the sample was 31 years (SD=13.4; Range 14-84). The majority of the sample had completed third level education (56%) and were working for payment or profit (54%). Approximately 3% had not told anyone of their LGBTQI+ identity. Around one fifth (22%) of transgender participants did not live openly as their gender¹. The average age of awareness of one's LGBTQI+ identity was 14 years while the average age of disclosure was 19 years. The profile of the study participants in 2016 and 2024 differed with respect to sexual orientation, gender identity, age, ethnicity, education level and employment status (p -value<0.001 for all). These differences were adjusted for in the analysis of changes in outcomes from *LGBTIreland* to *Being LGBTQI+ in Ireland*.

Key findings from Module One

Wellbeing

On average, participants rated their happiness at 6.13 out of 10, roughly one point above the midpoint of 5 and their self-esteem at 26.77 out of 40, which is on the low end of the normal or medium range. Both scores were found to be lower compared to general population scores at national and international levels. Participants rated their resilience at 2.89 out of 5, which is within the 'low resilience' category. While these results signal below general population levels of wellbeing, there were positive findings in terms of participants rating their comfort/consonance with their gender identity (M=8.12) and their sexual orientation (M=8.01) high (0-10 scale with 10 being high comfort/consonance).

Notwithstanding these mixed results, the strength and resilience garnered by participants from being LGBTQI+ was evident in the collective responses the majority gave to a question asking what they liked most about being LGBTQI+. The personal gains received from undertaking a process of self-reflection, gaining awareness of the self and the self in wider society, and in turn respect for oneself and others were clear. Many identified the relief that came with being open, out and proud, and the bolstering received from others' recognition of their LGBTQI+ identity. Being in strong relationships or being attracted to people in ways that aligned with who they were was also a source of happiness and strength. Belonging to the LGBTQI+ communities, friendships developed and being engaged in LGBTQI+ culture and politics were expressed in experiences of togetherness and solidarity, as boosting resilience, and as engendering feelings of joy and pride.

Support for LGBTQI+ identities

Similarly positive was support within people's family and social circles, with high levels of support reported from people with whom they socialised (92%), immediate family (75%), and work/school acquaintances (63%). The LGBTQI+

¹ The Being LGBTQI+ in Ireland survey asked participants who identified as transgender: 'Do you currently live openly in your felt/preferred gender?'

community was mostly viewed positively, with around two-thirds of participants agreeing that they felt welcome (65%), visible (62%), and advocated for (66%). Nonetheless, there was a proportion who felt their identity wasn't given equal recognition (31%), felt isolated and separate (27%), and felt excluded (22%). For people who identified as bisexual and asexual, feeling not equally recognised rose to 45% and 64% respectively highlighting within group differences in terms of community belonging and connection. Qualitative comments suggested that the reasons for a lack of community connection/belonging were related to racism, ageism, ableism, and sexism, thus highlighting the intersectionality of lived experience. Participants highlighted the uniquely positive aspects of being LGBTQI+, such as belonging to a community, and the ways in which they coped with any challenges they encountered, all of which served to highlight the joy, pride and strengths/resiliencies which their identities invoked.

Mental health challenges

The majority of the sample (60%) had sought professional help for a mental health problem in the past five years, with a counsellor/therapist and a GP being accessed the most. Many participants reported that their mental health had worsened since the start of the COVID-19 pandemic rather than improved (48% vs. 18%). On the DASS-42, which is a set of three self-report scales designed to measure the emotional states of depression, anxiety and stress, between approximately two-fifths and one half of participants fell within the moderate/severe/extremely severe categories for symptoms of depression, anxiety, and stress (47%, 50% & 39% respectively)². Lifetime prevalence of self-harm was 52%, with half doing so in the year previous to survey participation. Nearly half (47%) reported that nobody knew about their self-harm. Lifetime prevalence of suicidal thoughts was 65%, with approximately half (51%) having these thoughts within the last year. Lifetime prevalence of suicide attempt was 26%, with around one quarter (26%) attempting it in the year previous to survey participation. A total of 65% reported that someone knew that they had made a suicide attempt while 37% reported that they received medical care from a GP, nurse or at the emergency department for treatment for their most recent attempt. 14 was the most common age of first self-harm and first suicidal thoughts while 15 was the most common age for first suicide attempt. Approximately half of participants reported that their self-harm, suicidal thoughts and suicide attempt were related to their LGBTQI+ identity (58%, 51% and 49% respectively). LGBTQI+ related reasons for self-harm and suicidality included both internal stressors (discomfort, shame, confusion etc.) and external stressors (negative familial/societal attitudes, fears of rejection, bullying, discrimination, homophobia, transphobia etc.) as well as not being able to envision a future and having a sense of hopelessness. In relation to eating disorders, two fifths (41%) of the sample reached the risk threshold for potentially having an eating disorder. Nearly two-fifths (37%) also indicated that they were dissatisfied with their eating patterns and ate in secret. While these two questions are not diagnostic,

² DASS-42 is not a diagnostic tool for depression, anxiety or stress; instead it measures the experiences of symptoms associated with depression, anxiety and stress.

positive answers to both indicate a need for further assessment for bulimia nervosa, a type of eating disorder. There was a pattern in wellbeing and mental health outcomes, with cisgender men and gay participants (most of whom were cisgender men) showing the most positive outcomes, followed by cisgender women and lesbian participants (most of whom were cisgender women). In contrast, transgender and gender non-conforming (TGNC) participants and other sexual identity minorities showed the least positive outcomes. A pattern was also evident in terms of age, with wellbeing and mental health outcomes improving with increasing age.

Substance use

In terms of substance use, 42% scored above 8 on the Alcohol Use Disorders Identification Test (AUDIT) screening tool, indicating harmful or hazardous drinking. For one third, this was categorised as a moderate level of alcohol consumption, and for one-tenth, it was categorised as a high or very high level of alcohol consumption. Lifetime prevalence of drug use was 54% (non-medical use), with over half of those (57%) taking drugs within the last year. Of these, just under one third (30%) scored at a moderate level, with further investigation recommended at this level, and 9% scored at a substantial/severe level, with intensive assessment recommended.

School belonging and bullying

The school findings highlight some of the challenges that LGBTQI+ students encounter (n=1025). Participants gave a relatively low rating for the LGBTQI+ friendliness of school (M=4.79). In terms of belonging and safety, around one third of participants (31%) reported 'not belonging at all' in school and around one half (49%) reported being subjected to homophobic, biphobic or transphobic bullying and avoiding certain places due to feeling unsafe (48%). This had impacts not only on attendance but also on early school leaving for a minority of participants, with 26% reporting that they had missed or skipped school to avoid such bullying and 7% leaving school early due to negative treatment related to being LGBTQI+. As well as potential implications for academic performance and longer term educational outcomes, there was some evidence of poorer wellbeing and mental health outcomes in the cohort who experienced bullying compared to those who hadn't, with statistically significant higher symptoms of depression (M=21.88 vs. M=17.84), anxiety (M=21.02 vs. M=16.04) and stress (M=23.22 vs. M=19.18), and higher rates of self-harm (77% vs. 61%), suicidal thoughts (84% vs. 67%), suicide attempt (46% vs. 22%) and potential eating disorder (65% vs. 46%); and lower happiness (M=4.83 vs. M=5.60), self-esteem (M=22.4 vs. M=24.20), resilience (M=2.46 vs. 2.72) and gender identity comfort (M=6.87 vs. M=7.68). Additionally, transgender and gender non-conforming (TGNC) participants had worse outcomes compared to cisgender participants on several school metrics, including LGBTQI+ friendliness of school, sense of belonging, experiencing LGBT bullying, missing or skipping school due to bullying, and leaving or thinking about leaving school early.

Inclusivity, visibility and support with school

As well as the aforementioned safety issues, inclusivity, visibility and support were lacking in the school environment, with around two-fifths indicating that gender and sexual diversity wasn't addressed in Social, Personal and Health Education (SPHE) (44%), positive statements and representations of LGBTQI+ people weren't included in the curriculum (41%), and that teachers weren't informed about LGBTQI+ identities (42%). More positive than negative however, was the presence of posters and activities related to Pride or Stand-Up Awareness Week against LGBTQI+ bullying reported by 60%, highlighting that visibility at some level was present. For transgender and non-binary participants, the school environment was especially challenging in terms of expressing one's gender identity, with 75% not having access to gender-neutral bathrooms and facilities, 57% not being addressed by the correct name and pronoun(s) and 46% not being free to wear a uniform which aligned with their gender identity. Participant suggestions for improving the school environment were attention to safety and support, equality for LGBTQI+ students, education of staff and students, raising LGBTQI+ visibility and the removal of religious influence.

Harassment, violence and safety in public spaces

Participants faced high levels of LGBTQI+ related harassment and violence, evident in the reported rates of verbal harassment (72%), being threatened with being outed (33%), non-consensual touching (30%), physical attack (24%) and sexual assault (16.5%). Cisgender men and gay participants reported the highest level of physical attacks and non-consensual touching. On all other instances of violence and harassment, TGNC participants reported the highest prevalence. A majority (68%) also experienced someone purposely using wrong pronouns when talking about them. The top three reasons identified for experiencing harassment other than for being LGBTQI+ were: 1) Gender (due to being a woman/misogyny/sexism); 2) Racism/Xenophobia; and 3) Neurodivergence, once again highlighting the intersectionality of lived experience. In terms of a personal sense of safety, the majority of participants would feel unsafe showing affection with a same sex partner in public (53%) and holding hands with a same sex partner in public (45%), while among transgender and non-binary participants, 54% reported feeling unsafe expressing their gender identity in public.

Approximately one third of participants reported either feeling unsafe or would not use public transport (27%), be seen going to or leaving an LGBTQI+ club or venue (31%), or be seen checking an LGBTQI+ website on a public computer (33%).

Media and anti-LGBTQI+ hate speech

Approximately 23% of participants had experienced anti-LGBTQI+ hate speech either online or in public media in the last year, and TGNC and young participants (14-18 years) were more likely to have experienced this. Participants viewed anti-LGBTQI+ hate speech in the media as harmful not only at a personal and

community level, but harmful in terms of the hate it generates and promotes at a societal level. Importantly, the media was also seen as having a positive impact in terms of LGBTQI+ representation and visibility and being a source of education and information both for LGBTQI+ people and wider society. Media also created a space for LGBTQI+ people and allies to experience belonging, inclusion and solidarity. Legal and policing protections against, as well as consequences for, discriminatory acts, and media management and accountability in relation to the reporting and representation of LGBTQI+ lives and related issues were key topics identified for keeping LGBTQI+ people safe.

Healthcare experiences

In terms of participants' experiences of healthcare practitioners, most never experienced healthcare practitioners discriminating against them (83%) or telling them that their LGBTQI+ identity could be changed (91%). Additionally, most participants (79%) never experienced healthcare practitioners asking unnecessary/invasive questions about their identity unrelated to their reason for visiting. However, in relation to practitioners' knowledge, one third (34%) of the sample reported having to educate practitioners about LGBTQI+ identities, with just over one quarter (29%) reporting that healthcare practitioners were knowledgeable about LGBTQI+ identities 'most of the time' or 'always'. This lack of knowledge/awareness of LGBTQI+ identities was reflected in cis-hetero normative practices, with participants reporting that healthcare practitioners made incorrect assumptions about their LGBTQI+ identity 'sometimes' (25%) or 'most of the time'/'always' (17%). Half of participants (50%) reported that services didn't have any posters or information related to LGBTQI+ healthcare, highlighting the lack of visibility of LGBTQI+ identities in healthcare as an issue. Approximately one quarter (27%) never felt comfortable to disclose their LGBTQI+ identity to their healthcare practitioner. For transgender participants, there were particular fears around disclosure, such as being pathologized and not getting the care that they required.

Participants' comments around their experiences of healthcare utilisation highlighted the importance of supportive, respectful, and knowledgeable practitioners. Barriers to accessing mental health care identified by participants included waiting times, cost, stigma and fear of being pathologized due to one's LGBTQI+ identity. The findings in relation to the healthcare experiences of people who identify as intersex or have an intersex variation(s) echoes international literature on this population, with non-consensual medical interventions performed as an infant or child, and hormonal treatment commencing in adolescence.

Accessing healthcare to support medical transition

The findings also illuminated the many issues that transgender and non-binary people face when using healthcare services to medically transition. The length of waiting time, insufficient knowledge of trans healthcare and distance were identified as the top three barriers. These led the majority (69%) of those who had or were in the process of medically transitioning to use services abroad

to support their transition and around one-third (30%) to self-medicate using hormones as part of their medical transition. Consequently, people incurred significant financial cost and ran the risk of poor-quality aftercare when they returned home as well as negative health outcomes from do-it-yourself hormone replacement therapy (DIY-HRT). Where participants did use the National Gender Service in Ireland, negative experiences were recounted, including experiencing consultations that were intrusive, inappropriate, and pathologizing, which made participants feel that access to services was being blocked.

Changes since LGBTIreland

A comparative analysis revealed statistically significant changes in wellbeing, mental health and school outcomes after adjusting for differences in the demographic profile of 2016 and 2024 participant groups. These changes were:

- a 11% relative decrease in the prevalence of being happy
- a 26% relative decrease in high self-esteem
- a 17% relative increase in symptoms of severe/extremely severe depression
- a 30% relative increase in symptoms of severe/extremely severe anxiety
- a 33% relative increase in symptoms of severe/extremely severe stress
- a 19% relative increase in the prevalence of witnessing LGBT bullying in school
- a 24% relative increase in the prevalence of thinking about leaving, or leaving school early due to negative treatment.

Module Two

Introduction

Public attitudes regarding LGBTQI+ people provide an indication of the extent to which they are accepted and included in society. Given that attitudes develop and change overtime, periodical monitoring is necessary to identify how these views are developing. It also enables examination of attitudes to emerging issues that are pertinent to the lives of LGBTQI+ people. As this impacts the LGBTQI+ communities this is an important aspect of this project. For these reasons a repeat of our 2014 survey of attitudes towards LGBTQI+ people was conducted in order to ascertain whether shifts in public opinion have occurred, and if so to what extent, in the years since the publication of the *LGBTIreland* study.

Research methodology and participant profile

An interview-administered telephone survey was conducted to duplicate the *LGBTIreland* study. In addition, an online survey was administered to gain new insights on attitudes towards transgender and intersex people in particular. Some of the questions asked online were the same as in the telephone interviews to allow a comparison to be made between the two methods. Both surveys were conducted by Red C Research and Marketing and undertaken with a nationally representative sample of the Irish public (aged 18+). Each of the samples contained 1,000 participants. Data were weighted across gender, age, region, and social class to ensure a nationally representative sample based on the most recent AIMRO population statistics³.

Key findings from telephone survey results and comparison with 2014 findings

A statistically significant positive change since 2014 in attitudes across 30 of the 39 statements examined was found under the themes of education, discrimination, being in the company of LGBT people, transgender identity, and LGB related belief systems. Some examples include increases in comfort with children having LGB or transgender teachers (+11% & +12% respectively) and a male couple, or a female couple, kissing in public (+23% & +20% respectively). In the main, positive changes were found across all socio-demographic sub-groups explored. Smaller change effects were often due to already high rates of positive attitudes in 2014.

Notwithstanding these positive findings some areas for consideration were evident. There is around one tenth to one fifth of adults who agree with views such as being LGB is a phase (11%), a choice (22%), or not normal (10%), that people can be convinced to 'turn' LGB (15%) and, that accepting transgender people as normal is difficult (19%). Also, there was a statistically significant decline since 2014 (62% to 53%) in agreement with the view that being transgender is something you are born with. Since 2014, a worrying upward trend (+9%) in the view that bullying is a normal part of growing up and schooling was found, and a sizeable minority (8%) still believed that making fun of young people in school because of being LGB is not harmful. There was also an increase in agreement with the statement that 'Learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment' (+8%). Whether people who agreed with this statement perceived this as negative, positive, or neutral is open to debate. Over one third of adults (35%) believed that LGB people can't know their sexual orientation at 12. Also found was a small 4% rise (albeit not statistically significant) since 2014 in the belief that equality has been achieved for LGB people (36%), with 18% expressing uncertainty about this issue. A small (3%) reduction (albeit not statistically significant) was found, from a high base of 71% agreement in 2014, regarding transgender people being able to change their legal documents.

³ AIMRO (Association of Irish Market Research Organisations) population statistics is comprised of CSO population projections and Irish random route surveys.

Although there were significantly more frequent interactions with LGBT people in comparison with 2014, a significant proportion (36%) never had any interaction with people who are transgender.

Key findings from supplementary online survey (administered in 2023 only)

The main focus of the online study was on attitudes to and knowledge of transgender and intersex identities. The results showed that participants were overwhelmingly against discrimination of LGBT people in employment and service provision, and did not accept religion as grounds for discrimination against LGBT people.

On education issues, positive attitudes outweighed the negative across all statements, however a significant minority would not be in favour or comfortable with including education on transgender experiences (28%) and intersex variations (26%) in school. By contrast, there was lower disagreement on including LGB sexualities in the secondary school curriculum (21%). There was a high rate of agreement in the belief (43%) that learning about transgender lives in school might make young people think they are transgender while a significant minority (27%) did not believe that students should be allowed to choose between trousers or a skirt as part of their uniform regardless of gender.

Over half of participants (56%) believed that a young person cannot know they are transgender at the age of 12, and one quarter were undecided/uncertain, a finding that is contrary to many transgender people's own experiences. The majority of participants agreed that there are only two genders (50%); at the same time, more than half (56%) acknowledged that for some people gender is more complex than being male or female.

The majority of participants are accepting of a child born with an intersex variation (71%) and supportive if a family member were to transition (65%). However, comfort about a son or daughter being transgender (44%) was substantially lower. Discomfort with being in the company of non-binary people was higher (25%) compared to discomfort with being in the company of LGB people (11%), and views on bisexuality remain challenging where half expressed discomfort with the idea of their partner being bisexual (51%).

There was a low rate of agreement (30%) to transgender people under 18 years being able to change their legal documents to match their gender identity, even with parental consent. Positive attitudes about transgender people's participation in sport were also low where just one third (33%) agreed that transgender men should be allowed to take part in men's sports, and just one fifth (21%) agreed with transgender women taking part in women's sports. More people agreed than disagreed that transgender men should be able to use the men's bathroom (39% vs. 26%) while slightly more people disagreed than agreed that transgender women should be able to use the women's bathroom (36% vs. 34%). High levels of undecidedness/uncertainty about both issues were found.

On political and equality issues, there was strong support for equal treatment of same sex parents (77%) and that the Government should protect LGBT people against hate crimes and hate speech (73%). More were supportive than not (50% vs. 21%) of LGBT people being granted asylum if being persecuted on these issues in their country of origin. Around one third (29%) of the public disagreed that there are comments in the media calling for violence against LGBT people, with one third undecided/unsure about this statement. There was an even split in terms of those who agreed that Ireland is a safe place for transgender people (29%) and those who disagreed (30%).

Most people reported frequent or occasional interactions with people who are gay or lesbian. Fewer reported interactions with bisexual people and still fewer with transgender people. Those who had frequent interactions with lesbian or gay, bisexual or transgender people were significantly more likely to be positively disposed to the LGBTI issues contained in the survey. Knowledge of LGBTI experiences decreased along a sliding scale from lesbian and gay, to bisexual, transgender and finally intersex.

Key findings from comparisons with metrics included on both telephone and online surveys

Although the outcomes were fundamentally the same in so far as both methods demonstrated that attitudes are mostly positive, the extent of the positive attitudes is somewhat higher in the interview-administered telephone survey. For example, comfort with a male couple kissing was 69% in the telephone survey and 52% in the online survey. Also, comfort if one's child was transgender was 69% in the telephone survey and 44% in the online survey. Social desirability bias may be one reason as to why participants in the telephone survey were more positively disposed to issues compared to the online survey participants.

Recommendations

The *Being LGBTQI+ in Ireland* study indicates that many LGBTQI+ people in Ireland continue to face challenges in relation to their mental health and wellbeing, with LGBTQI+ young people and trans and gender non-conforming people at increased risk and vulnerability. Based on the study's findings, the following recommendations are made to government departments, bodies under their aegis, and state agencies with a view to advancing LGBTQI+ people's mental health and wellbeing, rights and social inclusion in Ireland:

Supporting mental health and reducing risks among LGBTQI+ people

- **Continue** to recognise LGBTQI+ people as a priority group in all future and current state mental health policies including *Sharing the Vision: A mental health policy for everybody* (Government of Ireland, 2020) and *Connecting for Life, Ireland's National Strategy to Reduce Suicide*, (Department of Health, 2015) and invest in targeted initiatives.

- **Invest** in accessible, safe, high-quality, regulated mental health services with improved access which include tailored and specific supports for LGBTQI+ people.

Building LGBTQI+ inclusive and affirmative health care

- **Invest** in LGBTQI+ inclusive community-based mental health supports, and expand supports in educational settings, youth services and community groups.
- **Fund** and implement a new model of gender-affirming care for young people and adults that complies with national and international human rights and medical standards of care and the principles of self-determination and informed consent.
- **Implement** interim harm-reduction interventions in primary care for transgender, non-binary and gender non-conforming people who are self-medicating as a result of a lack of access to gender-affirming care or extensive waiting times.
- **Build** capacity amongst all healthcare personnel currently working with LGBTQI+ individuals by including LGBTQI+ perspectives in ongoing continuing professional development.
- **Integrate** as an accreditation requirement LGBTQI+ awareness and inclusion in health education curricula for undergraduate and postgraduate healthcare practitioners.

Strengthening LGBTQI+ people's rights

- **Implement** the recommendations from the Review of the Gender Recognition Act 2015 and provide legal gender recognition for non-binary people and reform the legal gender recognition system for trans young people.
- **Enhance** the *Equal Status Acts 2000-2018* and the *Employment Equality Acts 1998-2015* to provide explicit protections for all LGBTQI+ people.
- **Introduce** new hate crime and hate speech legislation accompanied by a holistic action plan against hate crimes that includes a reformed Garda response and wrap-around supports for victims.

Creating a supportive school culture for LGBTQI+ people

- **Implement** *Cineáltas: Action Plan on Bullying* (Department of Education, 2022) to ensure the inclusion and safety of LGBTQI+ young people in school.
- **Fund** and support a national rollout of the *LGBTQ+ Quality Mark* (Belong To, 2020) so that all schools can support LGBTQI+ students.

Support LGBTQI+ people to live in safe communities

- Introduce a second *National LGBTI+ Inclusion Strategy* that is actionable, achievable, concrete, measurable and time-bound with enhanced multi-annual funding and additional staff resources. This strategy should take a life cycle approach and incorporate the *National LGBTI+ Youth Strategy*.
- **Fund** regional LGBTQI+ resource centres, community groups, organisations and social spaces to provide access to LGBTQI+ youth work services, supports for parents and family members, the provision of alcohol-free spaces and facilities for LGBTQI+ people.
- **Deliver** a robust regulatory, enforcement and oversight framework for social media platforms through continued resourcing of Coimisiún na Meán (commission for regulating broadcasters and online media).
- **Include** LGBTQI+ visibility within public service broadcasting requirements and make funding available for LGBTQI+ programming.
- **Support** LGBTQI+ people by ensuring that policies, practices, strategies, systems, infrastructure and processes of LGBTQI+ organisations provide inclusive and culturally safe environments, services and supports for all.
- **Fund** a public awareness campaign based on accurate information to inform and raise awareness, support and understanding among the general public towards LGBTQI+ identities.

Advancing the evidence base and evaluating progress

- **Fund** the repetition of the *Being LGBTQI+ in Ireland* study in 2027 to assess progress.
- **Include** new questions to the Census on sexual orientation, gender identity and sex characteristics.
- **Mainstream** LGBTQI+ questions in existing CSO data collection, Government research projects and Government-funded organisations and services.
- **Expand** understanding of the risks and protective factors which impact the mental health of individuals with emerging sexual identities, specifically pansexual and asexual individuals in future research endeavours.
- **Fund** additional research to facilitate comparisons between LGBTQI+ groups and the general population in Ireland.
- **Fund** a review of the needs of the intersex community in healthcare giving specific focus to mental health, reproductive and gynaecological care, bone health, cancer care and gender-affirming healthcare.

Prioritise LGBTQI+ experience and expertise

- **Consult** LGBTQI+ communities on all strategies, policies, programmes legislation and research that has the potential to impact their lives.

Chapter 1:

Introduction: Being LGBTQI+ in Ireland

Introducing the study

The *Being LGBTQI+⁴ in Ireland* study is a sequel to and based on the *LGBTIreland* report: the national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex people in Ireland (Higgins et al. 2016)⁵ which was conducted between 2014 and 2016 and was the largest ever study of the mental health and wellbeing of the LGBTQI+ community in Ireland, with over 2,200 individuals completing an extensive online survey. Those findings showed similarity with the general population in the sense that the majority of participants (approx. 70%) from the LGBTQI+ community were experiencing positive wellbeing. However, the research also showed high levels of mental distress on the indicators used in the study, a combination of validated mental health measures and free text open questions. In response to the latter, participants shared insights into the challenges the LGBTQI+ community face in Ireland and how these affect their sense of belonging, safety, and mental health. They also offered their opinions on how to improve services and society to make them better places for LGBTQI+ people. Particularly striking was the seriousness of the issues faced by transgender participants in terms of discrimination, harassment and the deficiencies in their experience of health care systems. Also, the plight of young LGBTQI+ people became abundantly clear. They often experienced bullying and lack of support in school which led to poorer mental health outcomes for them.

The *LGBTIreland* study was conducted several years ago, since then many policy and legal developments have taken place. While there is an expectation that the policy and legal developments would have a positive impact on the lives, health, and mental health of the LGBTQI+ community, the need to take stock became apparent. Through the current study we hope to identify to what extent these developments are affecting the day to day lives, wellbeing and mental health of LGBTQI+ people. Before we introduce the *Being LGBTQI+ in Ireland* study in more detail, the context of these developments and the research conducted since 2016 will be briefly addressed.

Recent legal and policy developments around LGBTQI+ equality

Around the same time as the landmark *LGBTIreland* study was being conducted, significant legislative reform and associated policy implementation was positively impacting the civil rights of LGBTQI+ people. The success of the

4 LGBTQI+ stands for lesbian, gay, bisexual, transgender, queer/questioning and intersex with the + signifying inclusivity to all sexual and gender identities.

5 For the remainder of the document, this study will be referred to as the *LGBTIreland* report or study.

Marriage Equality Referendum, the subsequent passing of the Marriage Equality Act 2015, which allows same-sex couples to get legally married and the Gender Recognition Act 2015, which provides for the legal recognition of a person's self-identified gender by the State, generated an enhanced feeling of comfort and safety among LGBTQI+ people (Ó hUiltacháin et al. 2016). By 2021, 867 gender recognition certificates had been granted to people over the age of 18 (Department of Social Protection, 2022). Other legislative advances in recent years include the amendment to the Employment Equality Act in 2015, which made it illegal for religious-run institutions to discriminate against workers on the basis of their sexual orientation, and the Children and Family Relationships Act 2015, which gave same-sex parents a pathway to be legally recognised as parents. In addition, the Adoption (Amendment) Act 2017 allowed unmarried same-sex and heterosexual couples to adopt a child, while the Family Leave and Miscellaneous Provisions Act 2021 granted male same-sex couples' adoptive leave.

Despite significant and positive developments in Ireland in recent years, some legislative and policy gaps remain. As well as awaiting outstanding legislative changes in relation to hate crime and conversion therapy, legal gender recognition has not yet been extended to intersex and non-binary individuals or those under 16 years of age despite the recommendations of the Review Group of the Gender Recognition Act (Department of Employment Affairs and Social Protection, 2018). In relation to families, some LGBTQI+ parents cannot be recognised as legal parents of their children owing to omissions in the Children and Family Relationships Act 2015. Whether further progress will occur, may depend on the political will of those in government, which is affected by voters and ultimately their opinions and attitudes.

Alongside the aforementioned legislative advances in the intervening period since the 2016 *LGBTIreland* report and shifts in attitudes, there have been efforts to map ways that services, policies and sectors in society can address LGBTQI+ inequality and promote visibility, health and safety among LGBTQI+ communities. To this end, two national strategies have been published, the *LGBTI+ National Youth Strategy 2018-2020* (DCYA, 2018), and the *National LGBTI+ Inclusion Strategy 2019-2021* (DCEDIY, 2019). Several other national strategies and policies including *Connecting for Life Suicide Strategy 2015-2024* (DoH, 2015), *The National Sexual Health Strategy 2015-2020* (DoH, 2015), *The National Drug and Alcohol Strategy 2017-2025* (DoH, 2017), and *Sharing the Vision 2020-2030* (DoH, 2020) recognise LGBTQI+ people as a priority group which require targeted actions. In addition, LGBTQI+ organisations have published their own plans (*LGBT Ireland Strategic Plan 2023-2027*, *Trans Groups Alliance 2023-2027 strategic plan* (TENI and TGA, 2023), *All Different, All Together, Strategic Plan 2022-2024* (Belong To Youth Services, 2022)). These strategies are just a few of a broader set of measures/practices that have been initiated since 2016 which target or encompass LGBTQI+ people and address issues of equality and inclusion.

Research on the lives of LGBTQI+ people in Ireland since 2016

While there are signs that the population of LGBTQI+ people in Ireland is on the increase like elsewhere in the world, no data source exists which quantifies the current number of people who identify as LGBTQI+ as the recent 2022 census only collected data on individual's sex assignment and not their sexual orientation or gender identity. Where an individual declined to identify themselves as either male or female, their gender was randomly assigned⁶. In the Central Statistics Office (CSO) Pulse Survey 2021 involving over 10,000 self-selecting participants, 7% identified as gay or lesbian, 5% as bisexual, and 1% as 'other' in terms of sexual orientation (CSO, 2021). Regarding the transgender population, estimates vary widely depending on, amongst other factors, age and whether non-binary and other gender variant identities are included in surveys (Chevallier et al. 2019). The UN estimates the prevalence of intersex people as ranging between 0.5-1.7% of the population. When applied to Ireland, this would mean that the number of intersex people in Ireland might range between 23,809 and 80,952 (Ní Mhuirthile et al. 2022).

Disappointingly, research carried out since the 2016 *LGBTIreland* report shows that, despite the legislative and social progress made, inequality persists for LGBTQI+ individuals and there continues to be challenges to their health and wellbeing. In a 2019 Equality and Discrimination Survey published by the CSO, the highest rates of discrimination were reported by people who identified as LGBTI+ (33.2%), almost double the rate reported by non-LGBTI+ persons (17.2%) (CSO, 2019). Many LGBTQI+ people in the *Burning Issues* series of research reported that many health services, schools and community services were not fully inclusive or safe spaces for LGBTQI+ people, particularly in rural areas (Ó hUiltacháin et al. 2016). Nearly half of young LGBTQI+ people surveyed reported a lack of acceptance in families and schools, while inadequate healthcare provision was identified as an issue (Noone, 2018). The most recent ILGA (The International Lesbian, Gay, Bisexual, Trans and Intersex Association) rainbow score for Ireland is 54% (ILGA-Europe, 2023), which ranks it 13th out of 27 EU member states, indicating that Ireland has still a way to go to in terms of full equality and inclusivity for LGBTQI+ people. A lack of accessible healthcare to facilitate medical transition for transgender people is of particular concern, while there are many reports of bias-motivated violence against LGBTQI+ people and vandalization of LGBTQI+ spaces and symbols (IGLA-Europe, 2022, 2023). Recent statistics show that sexual minorities are targets of hate crime and that they are more vulnerable to sexual violence compared to heterosexual individuals (An Garda Síochána, 2022, CSO, 2023). In terms of mental health, 'My World Survey 2', a large study of the mental health of nearly 19,000 adolescents and young adults in Ireland, found that lesbian, gay, bisexual, pansexual and asexual young people were more likely to score outside of the normal range for depression and anxiety compared to their heterosexual counterparts (Dooley et al. 2019). LGBTI+ people who have had engagement with mental health services

⁶ Testing and development of questions to capture this data is underway at the Central Statistics Office (CSO).

in the last few years report negative experiences (43%), with less than one in three reporting feeling that they were always treated with respect and dignity by community mental health services. A lack of LGBTI+ competence and sensitivity among mental health professionals contributed significantly to dissatisfactory engagements for LGBTI+ people (Mental Health Reform, 2022).

Current global developments and their impact on the LGBTQI+ community

In line with the legal and policy developments, a broader acceptance of LGBTQI+ identities among the general public in Ireland has been shown in recent research (Noone et al. 2022). A 2018 *'Call it Hate'* survey found a pattern of increasing acceptance of gay and lesbian people over the last two decades which is attributed to greater public awareness and education (Haynes & Schweppe, 2019). However, while attitudes towards LGBTQI+ people have vastly improved over the course of the last few decades, recent public opinion research conducted highlights disparities, with less acceptance of gender diversity (Noone et al. 2022, Haynes and Schweppe, 2019). Haynes and Schweppe (2019) also caution that whilst positive attitudes are generally dominant, socially desirable responses in studies may mask some of the prejudices that people may harbour.

Of concern in this regard is that more recently the sand has been shifting in the sense that prominent spokespeople and fringe groups in both online and offline contexts have been driving homophobic and transphobic campaigns (Cannon et al. 2022, Far Right Observatory & Community Work Ireland, 2022). While it is too soon to say definitively, there are signs of an international backlash towards the more inclusive values that have led to the emancipatory progress made for the LGBTQI+ community in recent years.

Another global impact which has affected the population in general, but minorities perhaps more strongly has been the COVID-19 pandemic. While the pandemic has affected healthcare and mental health systems, the lockdowns also had a deleterious impact on people's social networks. The *Life in Lockdown* report documented some of the impacts of COVID-19 on the LGBTQI+ community in Ireland, with a majority reporting worse mental health since the pandemic started and increased feelings of isolation and loneliness (LGBT Ireland, NXF and GCN, 2020). Belong To's national survey found that 97% of LGBTI+ young people had struggled with anxiety, stress, or depression since the COVID-19 pandemic started (Belong To Youth Services, 2021). Restricted access to health services meant that many LGBTQI+ people in Ireland had unmet health needs during the period of COVID-19 (Witzel et al. 2022). International research has shown that LGBTQI+ people's mental health has been disproportionately adversely affected by the pandemic compared to heterosexual and cisgender individuals (Hunt et al. 2021, McGowan et al. 2021, Mitchell et al. 2022), with reduced access to social support and service disruption being identified as key challenges (Hawke et al. 2021).

Shifts in focus from the *LGBTIreland* study to the *Being LGBTQI+ in Ireland* study

It is evident that a new study on the mental health and wellbeing of the LGBTQI+ community must take the developments described previously into account. Progress in terms of legal and policy development, and public attitudes are evident, but whether progress in mental health care is substantial enough needs to be reassessed. Other than that, the impact of the COVID-19 pandemic and perhaps a developing backlash against the progress in inclusive and affirmative values may also lead to different outcomes for mental health in comparison with the *LGBTIreland* study. Furthermore, other issues have emerged, and these have also influenced the focus and design of the *Being LGBTQI+ in Ireland* study.

Focus on under researched areas of LGBTQI+ youth: A landscape and research gap analysis of LGBTI+ youth in Ireland and across Europe (Költő et al. 2021a) found that although mental health had moderate research coverage, research gaps existed in the following areas:

- Substance use in gender minority youth
- Self-rated health and psychosomatic symptoms in sexual and gender minority (SGM) youth
- Self-esteem, life satisfaction, wellbeing and resilience among SGM youth

More focus on positive wellbeing: Where research on mental health does exist, the aforementioned review (Költő et al. 2021a) found that it focuses disproportionately on poor mental health outcomes. Insufficient attention is paid to protective factors, wellness strategies, and specifically how young LGBT+ people harness resilience to face the challenges they encounter.

More focus on transgender and intersex people's health care experience: Limited research on the lives of transgender people, including their healthcare experiences and mental health has also been identified (Költő et al. 2021a). The intersex population are also under researched owing to the hidden, hard-to-reach nature of this group, with existing research yielding small numbers of participants (Ní Mhuirthile et al. 2022).

More focus on intersecting identities: As much as we refer to 'the LGBTQI+ community', we know that this is not one homogenous group. Recent Irish research has shed a light on this diversity and the challenges faced by different identities within the LGBTQI+ community as well as among individuals with multiple intersecting identities. For example, recent reports have detailed the experiences of LGBTQI+ people in the international protection process in Ireland and those who have migrated here from other countries, highlighting the particular barriers they face (LGBT Ireland and Irish Refugee Council, 2022, Noone et al. 2018). In the latter report, mental health was a concern for the majority of participants and around a fifth displayed severe symptoms of anxiety and depression. Also recent is the first study ever documenting the lived experiences of intersex people/people with variations of sex characteristics in

Ireland. This study covers a range of topics including healthcare experiences and trauma related to medical interventions (Ní Mhuirthile et al. 2022). An in-depth study of homelessness among LGBTQI+ youth in Ireland delved into the unique experiences and needs of what is regarded as a largely invisible population despite the greater risk of homelessness among this group (Quilty and Norris, 2020). The largest study of LGBTI+ Travellers and Roma to date, involving 57 participants, mostly Travellers, reported on the challenges of coming out to their families and communities, experiences of racism within the mainstream Irish LGBTQI+ community and the detrimental impact of both to mental health and safety (Sartori, 2022). A recent Irish study on discrimination towards GBTQ+⁷ people of colour reported incidents of racialisation and xenophobia in a variety of contexts (Heising, 2022). Together these studies provide rich insights into the experiences and challenges for particular cohorts of the LGBTQI+ community in Ireland and underscore the multiple discriminations encountered by people with intersecting identities.

Being LGBTQI+ in Ireland: A follow up study in two modules

The *Being LGBTQI+ in Ireland* study aims to address these issues, by not only collecting data on adverse mental health outcomes, such as self-harm and suicide, but also on positive aspects of mental health (self-esteem, resilience, happiness). In addition to addressing issues around intersecting identities focused questions relating to transgender and intersex people's healthcare experiences were also included.

The *Being LGBTQI+ in Ireland* study consists of two Modules and is a follow-up to the *LGBTIreland* study. Module One aims to track current mental health and wellbeing six years after this was done in the *LGBTIreland* study (Module One). Module Two is a separate survey of attitudes to LGBTQI+ people among the general public in Ireland. Its findings are also compared with the earlier *LGBTIreland* study.

Module One: Mental health and wellbeing in the LGBTQI+ community

Module One consists of an online survey comprised of 144 questions, including a mix of open and closed questions to facilitate the garnering of both quantitative and qualitative data. This was distributed via social media and other online methods with the support of over 200 organisations and individuals.

The objectives were to:

- Explore LGBTQI+ people's mental wellbeing (self-esteem, happiness, resilience, comfort with identity, disclosure, belonging, strategies for maintaining wellness), including identifying the prevalence of mental health problems (depression, anxiety, stress, substance misuse, self-harm, suicidality, eating disorders) among the LGBTQI+ community, with specific emphasis on the adolescent and young adult cohort.

⁷ GBTQ+ is the acronym used in this study.

- Explore LGBTQI+ people's perspectives on safety and discrimination in the context of school and media, including challenges in accessing and using health care.
- Assess any changes in LGBTI people's mental health and wellbeing since the initial *LGBTIreland* report as well as changes in school outcomes.
- Identify priorities and make recommendations for future service provision and policy developments based on the research evidence, best practice and evidence from Ireland and other jurisdictions.

Module Two: Attitudes to LGBTQI+ people in the general public

This module consists of two surveys. One administered through a telephone interview, and one administered online to a nationally representative sample.

The objectives were to:

- Measure attitudes towards LGBTQI+ people in a nationally representative sample of the Irish public.
- Compare findings to the initial *LGBTIreland* Report.

In this report, Module One and Module Two are presented in chronological order. Module One is divided into nine chapters; Chapters 2 and 3 deal with methodology and the profile of the participants. Subsequently five chapters follow, each examining a particular theme derived from the topics addressed in the survey.

- LGBTQI+ wellbeing in context (Chapter 4);
- Mental health and distress in the LGBTQI+ communities (Chapter 5);
- Being LGBTQI+ in school (Chapter 6);
- Safety within Irish society (Chapter 7);
- Healthcare utilisation and experiences of healthcare (Chapter 8).

Module Two (Chapter 9) consists of one chapter which is inclusive of its methodology, findings from both the telephone and online survey, and discussion which compares findings to the *LGBTIreland* study and links findings to wider literature and Module One findings.

Lastly, the key findings from both modules are identified and the recommendations arising from both modules are outlined (Chapter 10).

Further reports and papers relating to older LGBTQI+ people, people who are intersex or have an intersex variation(s), disability in the LGBTQI+ population and the issue of housing will be published subsequently and separately from the publication of this report.

Chapter 2:

Methodology: Module One

This chapter explores the methodology used for Module One and includes a description of data collection tools, recruitment, data analysis and ethical considerations.

Objectives of Module One

- Explore LGBTQI+ people's mental wellbeing (self-esteem, happiness, resilience, comfort with identity, disclosure, belonging, strategies for maintaining wellness), including identifying the prevalence of mental health problems (depression, anxiety, stress, substance misuse, self-harm, suicidality, eating disorders) among the LGBTQI+ community, with specific emphasis on the adolescent and young adult cohort.
- Explore LGBTQI+ people's perspectives on safety and discrimination in the context of school and media, including challenges in accessing and using health care.
- Assess any changes to LGBTI people's mental health and wellbeing since the initial *LGBTIreland* report as well as changes in school outcomes.
- Identify priorities and make recommendations for future service provision and policy developments based on the research evidence, best practice and evidence from Ireland and other jurisdictions.

Research design

This module employed a structured survey design that combined open and closed questions.

Inclusion criteria

The inclusion criteria for Module One were: any person who identified as LGBTQI+, was 14 years of age or over, and living in the Republic of Ireland.

Data collection methods

Data for Module One were collected over a seven-week period using a survey that was designed by the research team and comprised of 144 questions. Some questions were repeated from the *LGBTIreland* survey while some were new questions derived from a range of sources. This included previously developed and validated questions, tested scales and instruments, while other questions were developed by the research team. Previously developed questions were sourced from: the European Union Agency for Fundamental Rights (FRA) 'A long way to go for LGBTI equality' Questionnaire (FRA 2020), the European Web Survey on Drugs (EMCDDA, 2021), National LGBT Survey (Government Equalities Office (UK), 2018), the 2022 Census of the Population of Ireland (CSO, 2022), the

2019 School Climate Survey (Pizmony-Levy & Belong To Youth Services, 2019), Testa et al. (2015) Community Connectedness Scale, and the US transgender survey 2015 (James et al. 2016). Permission for use of measures was obtained from all authors.

Measures that were repeated from the *LGBTIreland* survey include:

- Rosenberg’s Self-Esteem Scale (RSES) (Rosenberg, 1965)
- Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 2001)
- Depression, Anxiety and Stress Scale (DASS-21) (Lovibond and Lovibond 1995)⁸
- Self-harm and suicidality from the Lifestyle and Coping Survey (Madge et al. 2008)

Measures that were added to this survey include:

- The Nebraska Outness Scale (Meidlinger and Hope, 2014)
- The Drug Abuse Screening Test (DAST-10) (Skinner, 1982)
- The Brief Resilience Scale (Smith et al. 2008).
- The SCOFF questionnaire (Morgan, 1999)
- Comfort (Consonance)/Discomfort (Dissonance) Scale (novel measure designed for this study by the team)

Nebraska Outness Scale: The Nebraska Outness Scale (NOS) is a 10-item instrument consisting of two subscales, one measuring disclosure (NOS-D) and one measuring concealment (NOS-C). Respondents are asked to estimate the percentage of people in various social groups (e.g. immediate family, extended family, friends, co-workers, strangers) who are aware of their sexual identity (Disclosure subscale) and the percentage of people with whom they avoid the topic of their sexual identity (Concealment subscale) (Meidlinger and Hope, 2014). The research team replaced the term ‘sexual identity’ in the stem question with the term ‘LGBTQI+ identity’ in order to be inclusive. We also extended the list of social groups to include healthcare providers.

DAST-10: The Drug Abuse Screening Test (DAST-10) is a brief, self-report instrument for drug abuse screening and clinical case finding. It consists of 10 items, with a total sum score ranging from 0 to 10. A score of zero indicates that no evidence of drug related problems was reported. As the DAST score increases there is a corresponding rise in the level of drug problems reported. The level of drug problems may be categorised as follows: Low risk (1-2); Moderate (3-5); Substantial (6-8) and Severe (9-10) (Skinner, 1982).

⁸ Please refer to the *LGBTIreland* report (Higgins et al. 2016) for detailed scoring of the RSES, AUDIT and DASS-21 measures.

The Brief Resilience Scale: The Brief Resilience Scale (BRS) is a reliable and valid six item scale that assesses self-perceived ability to bounce back or recover quickly from stress. Each item is scored on a 5 point Likert scale ranging from 1 (low resilience) to 5 (high resilience) (Smith et al. 2008).

The SCOFF Questionnaire: The SCOFF Questionnaire is a valid and reliable screening tool for detecting the possible existence of an eating disorder. The instrument was designed for use by both professionals and non-professionals. It has shown excellent validity in a clinical population and reliability in a student population. It is a brief 5-item measure where an answer of 'yes' to two or more items indicates the possibility of an eating disorder and warrants further questioning and more comprehensive assessment by a healthcare professional (Morgan et al. 1999, Luck et al. 2002). A further two questions have been found to have a high sensitivity and specificity for bulimia: i) Are you satisfied with your eating patterns? ('no'); ii) Do you ever eat in secret? ('yes'). These questions are not diagnostic but would indicate that further questioning and discussion is required (Hay, 2013).

Comfort (Consonance)/Discomfort (Dissonance) Scale: The extent of comfort or discomfort with LGBTQI+ identities is an important indicator for mental health, wellness, and happiness. To measure comfort (consonance) or discomfort (dissonance) around gender identity and sexual orientation a short eight question measure was generated, in the absence of an accepted validated measure for dissonance/consonance (Vaidis and Bran, 2019). This novel tool was constructed/adapted based on the comfort measure used in the *LGBTIreland* study and supplemented with themes based on the literature on the experiences of LGBTQI+ communities. Four questions focused on dissonance/consonance around gender identity (GI) and four others were focused on sexual orientation (SO). Participants were asked to rate each item on an 11-point Likert scale. Values for the total GI and SO scores have a range of 0-10 with 10 being high comfort/consonance and 0 being high discomfort/dissonance.

Internal consistency and reliability analysis

Internal consistency analysis of each instrument yields an indication of the reliability of each measure and was conducted using Cronbach's commonly used method. Cronbach's alpha values can be seen in Table 2.1. Apart from SCOFF, all measures achieved high values (> .70) indicating that the individual questions addressed a consistent construct, which confirms the reliability of the instruments.

Table 2.1: Internal consistency analysis

	Cronbach's Alpha
Rosenberg Self-Esteem Scale	0.93
Brief Resilience Scale	0.89
DASS 42 - Depression subscale	0.93
DASS 42 - Anxiety subscale	0.89
DASS 42 - Stress subscale	0.87
AUDIT	0.83
DAST-10	0.73
Comfort/Discomfort scale	GI = 0.84; SO = 0.85
SCOFF	0.58

Recruitment, sampling, and sample size

The survey was designed as an anonymous, online survey hosted on Qualtrics (Qualtrics © 2020). To enable participation for those without internet access, a hard copy was also available on request. A multi-pronged recruitment strategy was employed to maximise the number of people that were informed of the survey, and thus afforded the opportunity to participate. In previous studies of the LGBTQI+ population (Mayock et al. 2009, Higgins et al. 2011, Higgins et al. 2016), research teams had been successful in engaging with and informing local and national social, health, youth and LGBTQI+ organisations of the study. Therefore, a similar strategy was adopted for the present module. A range of organisations were contacted and sent information on Module One, including non-governmental organisations, LGBTQI+ organisations, youth groups, mental health organisations, industrial and student unions, universities, community groups and other groups representing older people, migrants and ethnic minorities, those with disabilities, and those supporting people with substance use issues. Organisations were asked to post information about the survey on their websites, social media platforms, and to email their mailing lists. Posters were also distributed at LGBTQI+ spaces and other services/spaces frequented by harder to reach populations, such as homeless people, and migrant and ethnic minorities. As well as publicising the study through the networks, websites and online platforms of Trinity College Dublin and Belong To there were also paid social media adverts of the study on a number of online platforms, including Snapchat, TikTok, Twitter, Facebook/Instagram and LinkedIn; adverts in regional print and digital media; and interviews with Belong To's study spokesperson/people on regional radio station/s.

Data analysis

Survey quantitative data

All quantitative survey data were analysed using SPSS Statistics Version 27 (IBM Corporation, 2020) and Stata 18.0 (StataCorp, 2023). In total 5,656 people commenced the survey. Of these, 5,099 people responded 'yes' to all 3 filter questions (14+ years of age, currently living in the ROI, identifying as LGBTQI+) and all five 'consent to participate' questions. Further screening resulted in the removal of 22 individuals for not meeting eligibility criteria such as age and/or LGBTQI+ identities, leaving a sample of 5,077. Participants who didn't complete the survey up to the 'Eating Disorder' (question 90) section were excluded from the analysis (n=2,271). Considering the time commitment necessary to complete the survey this is not surprising. Thus the final dataset comprised 2,806 participants.

Descriptive statistics in the form of frequencies and percentages, and means and standard deviations are reported. The valid percentage (after missing data excluded) is reported for each question. One-way ANOVAs and Pearson Chi-Square Tests were conducted to identify differences between subgroups on key demographic variables (gender identity, sexual orientation and age group) in terms of outcomes, including wellbeing, mental health, school and harassment outcomes. The significance level for statistical tests was set at $p < 0.001$.

To assess any changes to LGBTI people's mental health and wellbeing, and experiences or problems in school since the initial *LGBTIreland* report, Poisson regression was used to quantify and assess the statistical significance of changes in the prevalence of wellbeing and mental health problems (suicidal behaviour, point prevalence of symptoms of severe/extremely severe depression, anxiety and stress, and point prevalence of alcohol problems, self-esteem and happiness) and school experiences/problems (LGBTQI+ unfriendly, belonging, witnessing LGBTQI+ bullying, experiencing LGBTQI+ bullying, missing or skipping school to avoid negative treatment, thinking of leaving school early due to negative treatment, left school early due to negative treatment) from 2016 to 2024. Crude prevalence ratios, i.e. the prevalence in 2024 divided by the prevalence in 2016, and their 95% CIs were reported. Multivariable Poisson regression was then used to quantify and assess the statistical significance of the changes in prevalence, taking into account the influence of the sexual orientation, gender identity and sociodemographic profile of the participants. These changes in prevalence were reported as adjusted prevalence ratios, hence they describe the relative change so that a change in prevalence from 10% to 20% is represented by a prevalence ratio of two, as it describes a doubling of the prevalence and a prevalence change from 40% to 20% is represented by a prevalence ratio of 0.5 as it describes the halving of, or 50% reduction in, the prevalence. Prevalence ratios were described as highly statistically significant if $p < 0.001$ and statistically significant if $p < 0.05$.

All qualitative data was entered into QSR NVivo Version 11 (QSR International Pty Ltd., 2015) for analysis. Data in each question were thematically analysed using a modified version of Braun and Clarke's (2021) guidance. From this process, descriptive codes describing chunks of the data were generated. The next step involved comparing and contrasting codes and amalgamating codes into higher order themes. The final step of analysis was performed during the write up phase to remove any duplication of themes that became evident across questions.

Ethical considerations

Ethical approval for this module was received from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin. As was the case with the *LGBTIreland* study, parental/guardian consent for participants under the age of 18 was not sought. The rationale and basis for waiving parental consent is outlined in detail in the 2016 report. Essentially, requiring parental consent runs the risk of excluding young people from the research thereby potentially biasing the sample and preventing health inequities from being researched appropriately (Mustanski and Fisher, 2016, Smith and Schwartz, 2019). By waiving parental consent, four additional measures or principles were applied to protect young research participants:

- Securing anonymity: The data collection tool was an anonymous online survey which is deemed 'minimal risk research'.
- Avoiding coercion: Adolescents self-selected to participate in this survey; therefore, no pressure or coercion was applied.
- Low risk: The risks of participating in this survey were minimised to some degree by advertising the research through a range of local and national social, health, youth and LGBTQI+ organisations. By partnering with agencies that have a prior relationship, no matter how tenuous, with the youth involved suggests that young people have a contact and pathway to seek assistance from should they require it (Flicker and Guta, 2008).
- Appropriate survey content: The survey was modified to ensure that its content was appropriate to participants under the age of 18.

In addition to these steps, the Participant Information Leaflet (Appendix 1) was posted on the study website and on the online survey platform. It outlined information about the study and participants' rights. The survey website and participant information leaflet forewarned participants about potentially distressing questions thereby enabling them to make a fully informed decision regarding participation. In addition, when completing the online survey sensitive questions were flagged and participants were given the opportunity to skip the questions if they found them upsetting. These practices were adopted following feedback from some participants in the *LGBTIreland* study who had stated that they would like to be made aware that sensitive questions were coming up,

rather than be unprepared for them which had the potential to cause upset. A list of support services was provided on the study website and with any hard copies distributed.

The 'anonymise response' setting was enabled in the online survey so that participants' IP address and location information was not collected. Participants were advised not to write their name on the survey instrument. All data files were password protected and stored in accordance with Data Protection legislation. Data were cleaned to ensure that in the presentation of findings no person, either the participant or another person could be identified. In presenting the qualitative findings each quote is accompanied by the participant's age, self-identified gender, and sexual orientation, along with the participant's unique study identification number. 'Missing' information are taken to be the choice of the participant, and therefore identifiers only contain the information provided by the participant.

Research advisory group

A research advisory group was set up to advise on the project. It included members of the research team, representatives of the funders, commissioners (Belong To – LGBTQ+ Youth Ireland) and members from a number of national organisations and Governmental departments: National Social Inclusion Office, HSE; National Office for Suicide Prevention, HSE; Department of Children, Equality, Disability, Integration and Youth; Department of Education; Irish Refugee Council; Merchant's Quay Ireland; Focus Ireland; Bodywhys; Rialto Community Drugs Team; Gay Health Network; National LGBT Federation (NXF); LGBT Ireland; Transgender Equality Network Ireland (TENI); and Intersex Ireland.

Chapter 3: Sample Profile

The focus of this chapter is on providing a description of the demographic profile of the participants who completed the study, in terms of gender, sexual orientation, age, ethnicity, education, employment, religion etc. In addition, information on participants' age of awareness, age of disclosing their sexual orientation or gender identity, age of living as their gender and level of outness and concealment is described. Given that one of the objectives is to assess any changes to LGBTI people's mental health and wellbeing since the initial *LGBTIreland* report the chapter concludes with a brief description of the sample in comparison to the 2016 sample.

Gender identity

A two-step approach to collecting gender identity information was used. Participants were asked 1) how they identified their gender and 2) whether this matched the sex they were assigned at birth. Nearly 80% of the sample identified as either a man or a woman (79.4%). Furthermore, nearly 15% of the sample identified as non-binary and approximately 6% provided more specific descriptions of their gender, including genderfluid, genderqueer, agender, trans, questioning, demi-boy and demi-girl (Table 3.1). Figure 3.1 shows that a quarter of the sample had a gender identity that was different from the sex they were assigned at birth.

Table 3.1: *Gender identity*

Category	n	%
Man	1032	36.8
Woman	1196	42.6
Non-binary	415	14.8
Not listed	162	5.8

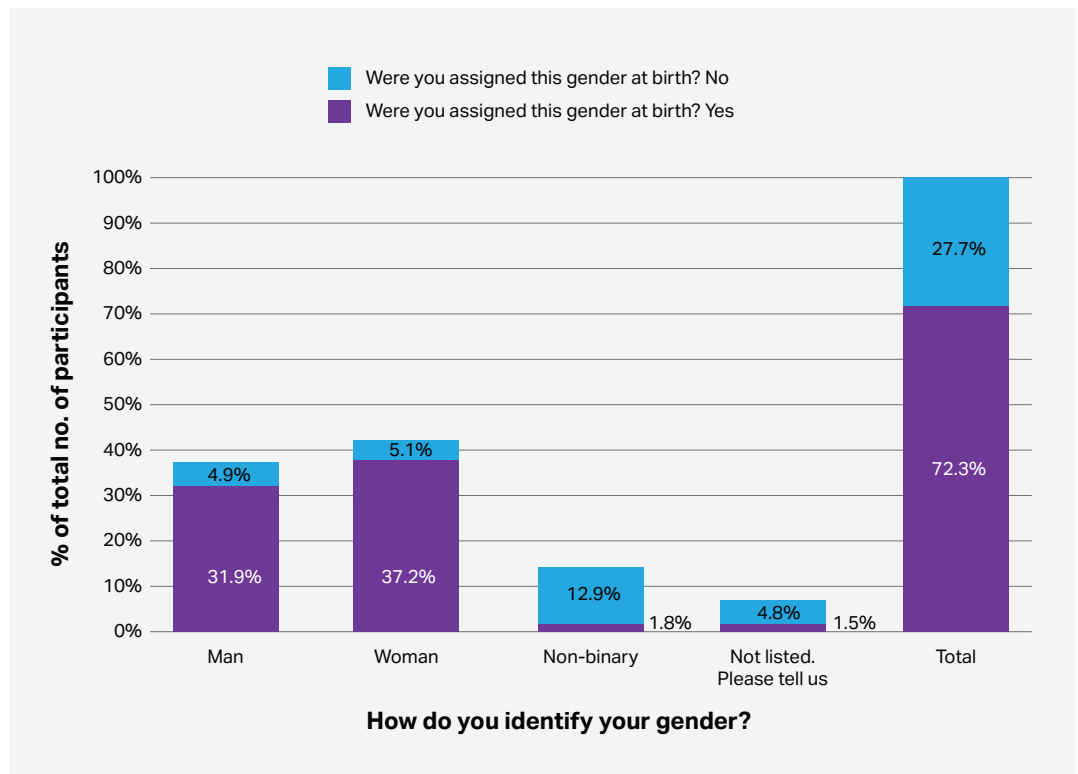


Figure 3.1: Gender identity and match with sex assigned at birth

Participants who indicated that their gender identity did not match the sex they were assigned at birth ($n=774$) were asked if they identified as transgender. In total, 718 participants identified as transgender. Of these, a quarter identified as a trans man and just over a fifth identified as a trans woman. Importantly, almost half of the sample identified as neither. Prompted to specify how they self-described, many self-identified as non-binary, others as genderfluid, genderqueer, agender, transmasculine, and questioning, to name but some. Finally, just over 5% indicated that they'd prefer not to say.

Table 3.2: Trans sample

Category	n	%
Trans man (FTM)	180	25.1
Trans woman (MTF)	150	20.9
Neither	349	48.7
Prefer not to say	37	5.2

NB: Missing responses $n=2$

Based on the responses to the gender questions, for the purpose of analysis of the quantitative data, we categorised participants into three groups: cisgender women (37.8%, $n=1053$), cisgender men (32%, $n=892$), and transgender and gender non-conforming people (TGNC) (30.2%, $n=841$). There were 20 participants who could not be categorised due to missing or inconsistent answers.

The majority of transgender participants lived as their gender, 35% full-time and 43.4% part-time. The average age of first living openly as their gender was 20 years (N=557, SD=8.7) while the most common age was 14 years. 14 years was also the most common age for those under 25. Approximately one fifth did not live openly as their gender (21.6%, n=155), with some people expanding on the reasons for this. The reasons mainly related to i) fear of rejection/non-acceptance from family members; ii) fear of judgement, discrimination, ridicule, or being bullied in society (including friends and peers, religious community); iii) safety issues - fear of violence or being attacked; iv) attending a religious based or single sex school; v) fear of impact on employment/attending work/career; v) living in rural community or town; vi) not being ready to come out; vii) age – being too young or feeling too old; and viii) still questioning their gender identity.

Sexual orientation

The breakdown of the sample by sexual orientation is shown in Table 3.3. Those identifying as gay comprised the largest proportion of the sample (32%), followed by those identifying as bisexual (22%) and those identifying as lesbian (18%). A little over one tenth used the term queer to describe their sexual orientation. A sizeable minority identified as pansexual (6%), 4% as asexual and just 20 participants identified as heterosexual and were included in the sample by virtue of the fact that they identified as either intersex or transgender. 'Other' sexual orientations described included omnisexual, demisexual, androsexual, heteroflexible, no label, as well as a variety of other descriptions.

Table 3.3: Sexual orientation

Category	n	%
Gay	887	31.6
Bisexual	608	21.7
Lesbian	514	18.3
Queer	327	11.7
Pansexual	169	6.0
Asexual	108	3.9
Other	106	3.8
Questioning/not sure	66	2.4
Heterosexual/straight	20	0.7

Based on responses, most lesbian and gay participants were classified as cisgender. The majority of bisexual participants were cisgender women (52%), and nearly one third identified as transgender and gender non-conforming (32%). Transgender and gender non-conforming (TGNC) participants comprised the majority of the remaining sexual orientations (Figure 3.2).

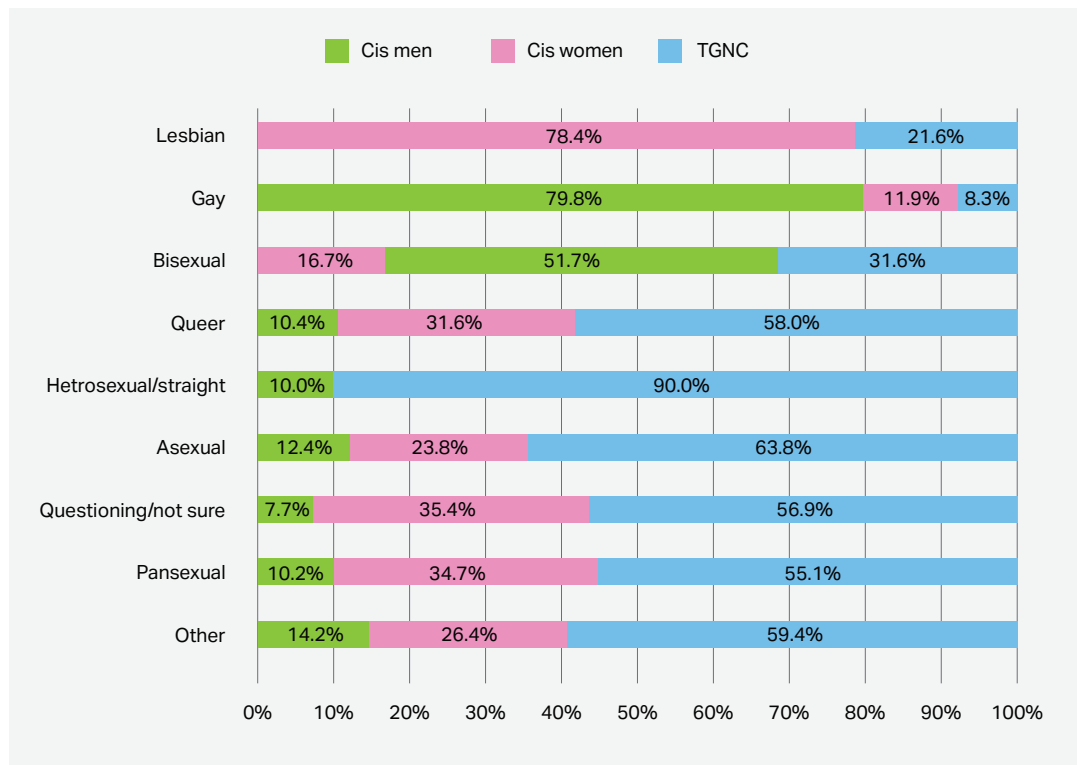


Figure 3.2: *Breakdown of sexual identities*

People with an intersex variation/s

In total 31 (1.1%) participants identified as intersex or as having an intersex variation. There was also 12 (0.4%) people who preferred not to answer and nearly one tenth (9.6%, n=268) who indicated that they didn't know. Of the 31 who identified as intersex, 17 reported that they identified as transgender. The remainder were classified as cisgender men (n=8), cisgender women (n=3), and non-binary (n=2) while data was missing for one person.

Other demographics

The other demographics and characteristics of the sample are displayed in Table 3.4. The mean age of the sample was 31 years (SD=13.4; Range 14-84), with 26–35-year-olds making up the largest proportion of the sample (26.3%). The majority of the sample had completed third level education (55.5%) and were working for payment or profit (53.7%). Nearly a third were students or pupils (30.2%). In total 86% of participants identified their nationality as Irish. The largest minority populations comprised British (2.4%), American (1.5%), Polish (1.5%) and dual nationality holders (1.5%), while the remaining participants (6.8%) represented over 50 other nationalities. In terms of ethnic background, 83% of the sample identified as White Irish, 11.4% had another white background other than Irish/Irish Traveller or Roma, the latter of whom there were only 8 and 3 participants respectively. Most of the sample had never been married (77.8%), had no religion (70%) and were living in Leinster (64%). The sample was more evenly split in terms of the type of area where people

lived, as a quarter lived in a suburb of a city (25.5%), followed closely by those who lived in a city (23.9%) and those who lived in a town (23.1%), with others living in a village (9.5%) and rural/country area (18.2%). Participants were asked if they had ever experienced any housing difficulties, even for one night. Over 70% of the sample hadn't experienced any housing difficulties (72.3%). Over a quarter of participants (27.7%, n=715/2582) reported that they experienced a housing difficulty, of which just over one tenth (13.3%, n=95) had experienced homelessness/rough sleeping. Nearly 70% (n=1810/2609) of the sample reported having at least one of seven disabilities (listed in CSO, 2022) either to some or a great extent. Almost a third (31%, n=805) of the sample reported they or their family were struggling with weekly expenses.

Key sample demographics were compared with the most recent data on the general population of Ireland from Census 2022. In terms of education, the sample is fairly representative. However, the sample overrepresents young people and students and by consequence underrepresents older people and those in retirement. Those looking after home/family are also underrepresented. There's a slightly higher proportion of ethnic minorities in the general population compared to the study sample. In terms of place of residence, those living in Leinster are overrepresented while those living in Munster are underrepresented (Table 3.4).

Table 3.4: *Sample demographics and characteristics*

Characteristic	Category	Being LGBTQI+ in Ireland		Census 2022
		n	%	%
Age Group (n=2777)	14-18 years	631	22.7	8.2
	19-25 years	560	20.2	10.2
	26-35 years	729	26.3	15.2
	36-45 years	424	15.3	19.0
	46-59 years	334	12.0	22.4
	60+	99	3.6	24.9
Highest Education (n=2805)	Some primary education or less	6	0.2	2.6
	Completed primary education	156	5.6	7.9
	Completed lower secondary level	443	15.8	14.1
	Completed upper secondary level	622	22.2	19.4
	Completed third level education	1556	55.5	56.0
	Other	22	0.8	
Employment Status (n=2805)	Working for payment or profit	1506	53.7	56.1
	Sheltered employment	32	1.1	
	Looking for first regular job	59	2.1	0.8
	Unemployed	133	4.8	5.1
	Student or pupil	846	30.2	11.1
	Looking after home/family	32	1.1	6.6
	Retired from employment	59	2.1	15.9
	Unable to work due to permanent sickness or disability	117	4.2	4.6
Other	21	0.7	0.7	

Ethnic Background (n=2805)	Irish	2324	82.9	81.6
	Irish Traveller	8	0.3	0.7
	Roma	3	0.1	0.3
	Any other White background	319	11.4	10.5
	Black or Black Irish	16	0.5	1.6
	Asian or Asian Irish	39	1.3	3.5
	Other including mixed background	96	3.4	1.8
Province (n=2596)	Leinster	1662	64.0	55.7
	Munster	558	21.5	26.7
	Connacht	265	10.2	11.5
	Ulster	111	4.3	6.1
Marital Status (n=2586)	Single	2011	77.8	
	First marriage to someone of the same sex	288	11.1	
	First marriage to someone of the opposite sex	89	3.4	
	Re-married to someone of the same sex	19	0.7	
	Re-married to someone of the opposite sex	10	0.4	
	In a registered same-sex civil partnership	45	1.7	
	Separated/Divorced	107	4.1	
	Widowed	17	0.7	
Religion (n=2604)	No religion	1802	69.2	
	Roman Catholic	485	18.6	
	Church of Ireland	56	2.2	
	Other	261	10.0	
Area living (n=2611)	Rural/country area	474	18.2	
	Village	247	9.5	
	Town	602	23.1	
	Suburb of a city	665	25.5	
	City	623	23.9	

NB: 'Not stated' category in Census 2022 data was excluded in the calculation of percentages.

NB: Census 2022 did not collect data on numbers in sheltered employment therefore this comparator is not available.

NB: 'Other' religions included Islam, Orthodox Christian, Presbyterian as well as a variety of other religions.

Age of awareness and disclosure of LGBTQI+ identity

Participants were asked how old they were when they first became aware of their LGBTQI+ identity and the age at which they first told someone that they identified as LGBTQI+ (Figure 3.3). The average age of knowing for the total sample was 14 years (Mean=14.7, N=2743, SD=6, Range=2-56) and the average age of telling was 19 (Mean=19.0, N=2699, SD=7.3, Range 3-61). The most common age of knowing and telling reported was 12 and 16 years respectively. Compared to *LGBTIreland*, the average age of knowing is one year younger than in 2016 when the age was reported as 15 years while the average age of telling is unchanged.

Transgender and gender non-conforming participants reported an earlier realisation and disclosure of their identity compared to other groups, with the average age of both knowing and telling at approximately 13 and 16 years respectively. Cisgender men reported knowing around the age of 14 while cisgender women reported knowing around the age of 16. For cisgender men and women, the average age of telling was 19-20 years. Most participants reported realising their identity between the ages of 14-15 years, and disclosing between the ages of 17-20. The gap between first realising and first disclosing one's identity was largest for cisgender men and those identifying as gay at 6 years, while for the other groups, the gap was on average between 3 and 4 years. The average age of both knowing and telling of LGBTQI+ identity was lowest amongst the youngest age group, the 14-18-year-olds, at ages 12 and 13 respectively. By comparison, older age groups were, on average, older than 14 when they first became aware and older than 16 when they first told someone. It is notable that the gap between the ages of knowing and telling is much smaller for the younger age groups (14-18 and 19-25) compared to all other age groups. Thus, both awareness and disclosure are happening at a younger age for young people today.

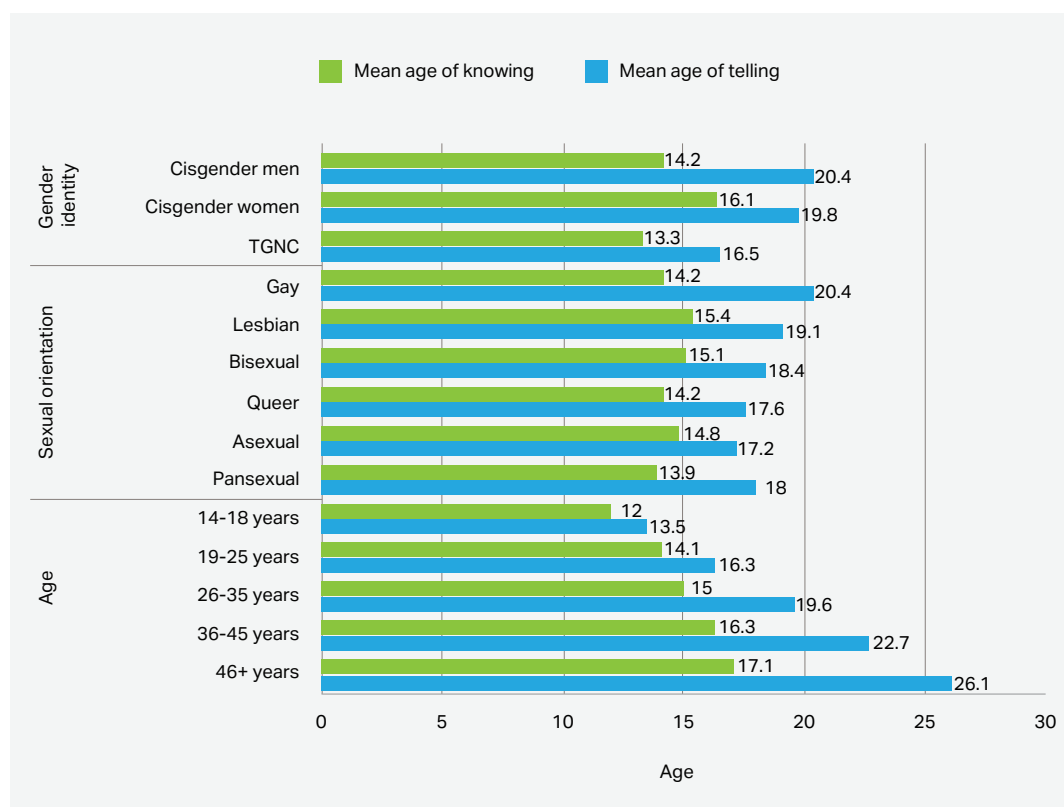


Figure 3.3: Age of first knowing and first telling of LGBTQI+ identity by gender identity, sexual orientation and age

Levels of openness and outness about LGBTQI+ identity

The majority of the sample had told someone of their LGBTQI+ identity (n=2704, 97.4%). Only a small proportion (2.6%, n=72) had not. Most of these identified their sexual orientation as bisexual and the majority were cisgender women and men (85.9%) and aged under 25 (55.7%) (Table 3.5).

Table 3.5: Profile of participants who were not out

Characteristic	Category	n	%
Sexual orientation (n=72)	Bisexual	30	41.7
	Questioning/not sure	11	15.3
	Gay	9	12.5
	Lesbian	7	9.7
	Asexual	6	8.3
	Queer	4	5.6
	Pansexual	2	2.8
	Other	2	2.8
	Heterosexual/straight	1	1.4
	Gender (n=71)	Cisgender women	35
Cisgender men		26	36.6
TGNC		10	14.1
Age (n=70)	14-18 years	25	35.7
	19-25 years	14	20.0
	46+ years	12	17.1
	26-35 years	10	14.3
	36-45 years	9	12.9

Participants who reported that they had told someone of their LGBTQI+ identity were asked about awareness of their LGBTQI+ identity among various groups of people and their openness about their identity in interactions with the same groups of people. Of those who responded to this question, the average levels of outness can be seen in Figure 3.4. Participants reported that approximately four-fifths of their immediate family and people they socialise with are aware of their identity, while there was less awareness among the other groups.

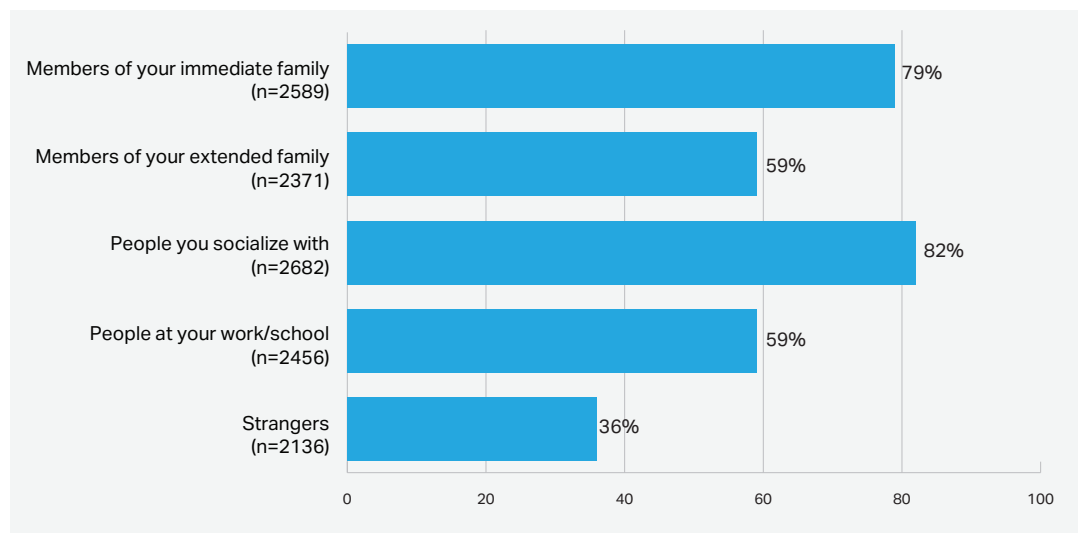


Figure 3.4: What percentage of people in this group do you think are aware of your LGBTQI+ identity?

Participants were asked how often they avoid talking about topics that might indicate their LGBTQI+ identity when interacting with various groups (see Figure 3.5). Participants were most open about their LGBTQI+ identity with the people they socialise with. For the remaining groups, participants avoided discussing topics about half the time which may signal some reticence.

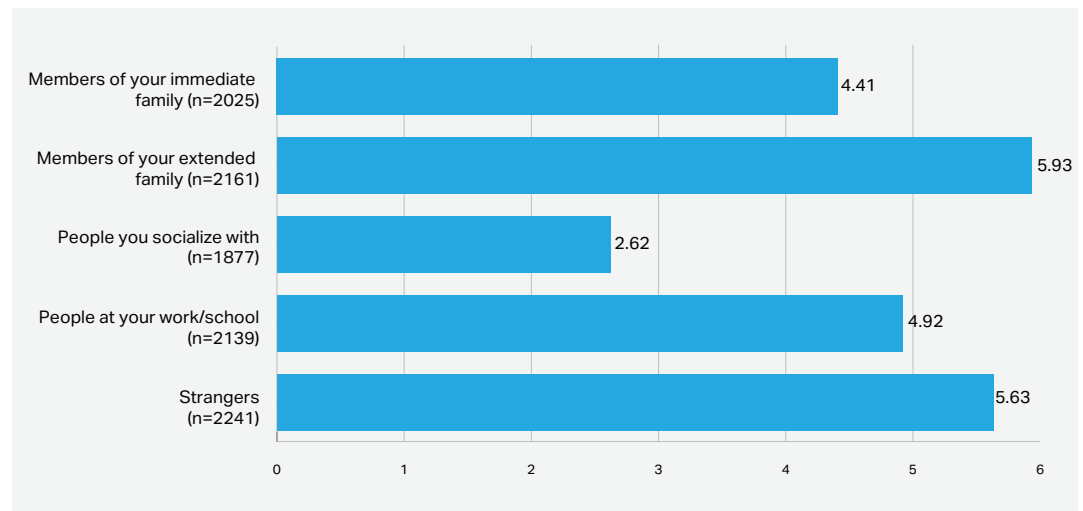


Figure 3.5: How often do you avoid talking about topics that might indicate your LGBTQI+ identity when interacting with these groups?

Note: Scale indicators: 0 = 'never', 5 = 'half of the time'; 10 = 'always'.

LGBTI sample in comparison with 2016 sample

The *LGBTIreland* report presented the findings according to five distinct groups: Lesbian/gay female; Gay male; Bisexual; Intersex; and Transgender, which meant that gender identity and sexual orientation were conflated for some groups. As gender identity and sexual orientation are presented separately in the current study, for the purpose of drawing parallels between this report and 2016's findings, participants' gender identity and sexual orientation was coded into LGBTI categories using a similar process as used in the 2016 report. In total 446 participants fell outside the LGBTI categorisation used for this aspect of the analysis, such as cisgender men and women who identified as pansexual, asexual, etc. or people who identified as non-binary for example who answered 'no' to the 'Do you identify as transgender?' question.

The profile of the study participants in 2016 and 2024 is presented in Table 3.6. The profiles differed with respect to sexual orientation, gender identity, age, ethnicity, education level and employment status (p -value <0.001 for all). Approximately 70% of participants in 2016 were lesbian/gay women (28.3%) or gay men (41.1%) whereas in the present study they accounted for approximately half of the participants (51.7%). This was related to decreasing participation from gay men. Another notable difference is that there was a sizeable increase in the proportion of participants who identified as transgender (from 13% to 30%). The proportion of participants identifying as bisexual was similar in both studies. The number of individuals who identified as being intersex

(n=31) or having an intersex variation in 2024, was down from the number who participated in 2016 (n=45). The proportion of participants in the youngest (14-18 years) and oldest (46+ years) age groups increased from approximately 30% in 2016 to approximately 40% in 2024. There was a reduction in the proportion of White Irish participants from 88% to 83%. The proportion of participants who had completed no more than lower secondary level education was higher in 2024 (21.1%) than in 2016 (14.9%). In 2024, the proportion working for payment or profit was higher than in 2016. Persons unable to work due to permanent sickness or disability were more common. They accounted for just 0.7% in 2016 but 4.2% in 2024.

Table 3.6: LGBTI identities and sociodemographic characteristics of the study participants in 2016 and 2024

Characteristic	Category	2016 (N=2122)	2024 (N=2360)
LGBTI identity	Lesbian/gay women ^a	600 (28.3%)	514 (21.8%)
	Gay men ^b	873 (41.1%)	705 (29.9%)
	Bisexual (women) ^c	247 (11.6%)	313 (13.3%)
	Bisexual (men) ^d	78 (3.7%)	96 (4.1%)
	Transgender ^e	279 (13.1%)	701 (29.7%)
	Intersex ^f	45 (2.1%)	31 (1.3%)
Age	14-18 years	358 (16.9%)	512 (21.9%)
	19-25 years	603 (28.5%)	467 (20.0%)
	26-35 years	531 (25.1%)	600 (25.7%)
	36-45 years	356 (16.8%)	370 (15.9%)
	46+ years	269 (12.7%)	385 (16.5%)
Ethnicity	White Irish	1869 (88.3%)	1967 (83.3%)
	White Non-Irish	185 (8.7%)	275 (11.7%)
	Black, Asian, Mixed or Other	63 (3.0%)	118 (5.0%)
Education level	Completed lower secondary level or less	316 (14.9%)	498 (21.1%)
	Completed upper secondary level	581 (27.4%)	537 (22.8%)
	Completed third level education	1222 (57.7%)	1324 (56.1%)
Employment status	Working for payment or profit	1045 (49.4%)	1291 (54.7%)
	Sheltered employment	48 (2.3%)	26 (1.1%)
	Unemployed/Looking for 1st regular job	231 (10.9%)	159 (6.7%)
	Unable to work due to sickness or disability	14 (0.7%)	99 (4.2%)
	Student or pupil	701 (33.2%)	689 (29.2%)
	Other (incl. looking after home/family, retired)	75 (3.5%)	95 (4.0%)

Note: Percentages calculated after excluding missing data; Respectively, age, ethnicity, education level and employment status were not recorded for five, five, three and eight participants in 2016 and age, education level and employment status were not recorded for 26, one and one participant(s) in 2024

a Includes those who identified as women and lesbian/gay

b Includes those who identified as men and gay

c Includes those who identified as women and bisexual

d Includes those who identified as men and bisexual

e Includes those who identified as transgender with any sexual orientation

f Includes those who identified as intersex with any sexual orientation

Note: If participants identified as both transgender and intersex, they were coded into the intersex group for the purpose of analysis.

Chapter 4: LGBTQI+ Wellbeing in Context

Introduction

Wellbeing can be broadly understood as the combination of feeling good and functioning well. As such wellbeing is made up of having positive emotions, such as life satisfaction or happiness, having a sense of purpose, competency, agency and autonomy as well as experiencing positive relationships (Ruggeri et al. 2020), which is indicative of positive mental health. The World Health Organisation defines wellbeing as a positive state experienced by individuals and societies and describes it as a resource for daily life determined by social, economic and environmental conditions (WHO, 2021).

The *LGBTIreland* report looked at a range of wellbeing related variables, including self-esteem, happiness and life satisfaction. Although there were variations across the LGBTI groups, overall, the findings were positive, with the majority of participants experiencing positive wellbeing in terms of happiness, life satisfaction and self-esteem, with high gender identity comfort and high sexual orientation comfort being associated with higher happiness ratings (De Vries et al. 2020). Other factors that may have been positively related to participants' appraisals of their wellbeing and happiness were public disclosure of their LGBTI identity to at least one person and support from the LGBTI communities.

Since the publication of the 2016 report the importance of taking up a strengths-based approach to inquiry of LGBTQI+ people has been further emphasised (Perrin et al. 2020, Hudson and Romanelli, 2020), with authors identifying a continued need to reorientate research (and practice), towards the identification of positive and protective factors in the lives of sexual minorities (Ceatha et al. 2021, Rostosky et al. 2018). A strengths perspective focuses on positive traits, assets, strengths, and environmental resources that contribute to positive mental health (Seligman et al. 2005, Vaughan & Rodriguez, 2014). Importantly, a positive perspective does not discount the reality of stigma, discrimination or violence experienced by LGBTQI+ people, but recognises the strengths people possess or develop within this context (Rostosky et al. 2018). Conducting research with this lens can provide a better understanding of coping mechanisms and resilience (Rostosky et al. 2018), including how these differ for groups across the diverse sexual minority populations (Frost and Meyer, 2012). This approach may also generate crucial information for developing effective strengths-based health interventions (Poteat et al. 2021, Riggle, 2008).

In the current study, in addition to asking questions about happiness, self-esteem, and resilience, wellbeing has been addressed through the addition of questions about support for LGBTQI+ identity, and a novel instrument measuring comfort and discomfort in terms of consonance and dissonance. In addition, qualitative (open) questions on liking LGBTQI+ identity, coping with LGBTQI+ identity and connection and belonging within the LGBTQI+ communities are included (see Figure 4.1).

This chapter aims to provide insight into the wellbeing of LGBTQI+ participants in the context of their strengths, as well as the challenges they encounter. The chapter presents findings from the quantitative measures first, followed by the results from the qualitative questions.

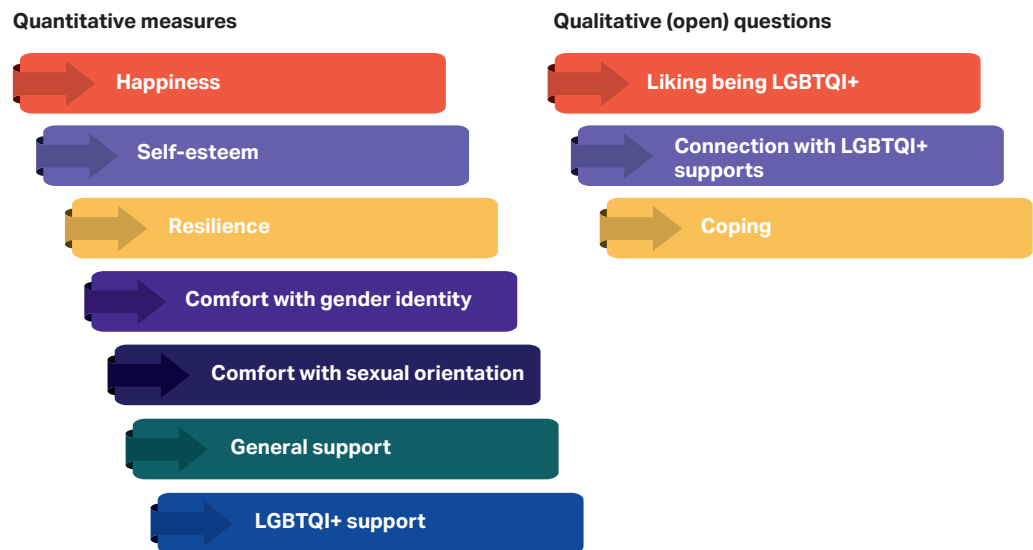


Figure 4.1: *Research questions that address wellbeing*

Happiness

Participants were asked, 'Taking all things together, how happy would you say you are?' on an 11-point scale with 0 being 'extremely unhappy' and 10 being 'extremely happy'. The mean happiness rating given for the total sample was 6.13 (SD=2.16, n=2578, Median=6.0), roughly one point above the midpoint of 5 on the scale. Cisgender men were statistically significantly happier than both cisgender women and TGNC participants, with the latter significantly less happy than cisgender participants. In terms of sexual orientation, people who identified as lesbian and gay had above average happiness scores, statistically significantly higher compared to the other sexual orientations. The youngest age groups (14-18 and 19-25) scored below the mean for the total sample and were statistically significantly less happy compared to the older age groups (see Table 4.1).

Table 4.1: Mean happiness scores by gender identity, sexual orientation and age

Characteristic	Category	N	Mean	SD
Gender identity (n=2561)	Cis men	806	6.88	1.93
	Cis women	957	6.30	2.03
	TGNC	798	5.15	2.17
Sexual orientation (n=2395)	Gay	810	6.86	1.99
	Lesbian	456	6.44	2.15
	Bisexual	561	5.76	1.98
	Queer	309	5.68	2.04
	Asexual	105	5.26	1.99
	Pansexual	154	5.25	2.22
Age (n=2552)	14-18 years	601	5.02	2.04
	19-25 years	530	5.72	2.14
	26-35 years	651	6.37	1.99
	36-45 years	380	6.94	1.82
	46+ years	390	7.17	1.95

Self-esteem

To measure self-esteem participants were asked how much they agreed or disagreed with a series of 10 statements which comprise the Rosenberg Self-Esteem Scale (RSES) (Rosenberg, 1965). Responses were scored from one to four, with higher scores indicating greater self-esteem. The mean score for self-esteem for the total sample was 26.77 (SD=6.80, N=2762, Median=27, Range=10-40), just above the mid-point of 25 on the scale. Norms for the Rosenberg Self Esteem Scale suggest the following ranges: 10-25 (low); 26-35 (normal), 36-40 (high) (Rosenberg et al. 1989). This suggests that the participants' self-esteem was on the low end of the normal range or medium range. Table 4.2 details that all gender identity and age subgroups showed statistically significant differences in terms of self-esteem scores, with TGNC and 14–18-year-old participants scoring the lowest. In terms of sexual orientation, lesbian and gay participants had statistically significant higher self-esteem than all other sexual identities, with the lowest self-esteem found among asexual participants (see Table 4.2).

Table 4.2: Mean self-esteem scores by gender identity, sexual orientation and age

Characteristic	Category	N	Mean	SD
Gender identity (n=2744)	Cis men	879	29.58	6.19
	Cis women	1036	27.15	6.50
	TGNC	829	23.25	6.17
Sexual orientation (n=2572)	Gay	877	29.27	6.37
	Lesbian	503	27.65	6.96
	Bisexual	595	25.46	6.28
	Queer	324	25.49	6.18
	Asexual	105	22.85	6.36
	Pansexual	168	23.61	6.18
Age (n=2734)	14-18 years	616	22.46	5.63
	19-25 years	557	24.81	6.32
	26-35 years	720	27.63	6.36
	36-45 years	418	29.48	5.84
	46+ years	423	31.43	5.83

Comparison between LGBTIreland (2016) and Being LGBTQI+ in Ireland (2024)

To estimate the prevalence of happiness, those with a score of 7-10 were considered to have indicated they were happy. Sixty percent of participants to the survey in 2016 rated their happiness at seven or more out of ten. This was the case for exactly half of the participants to the survey in 2024. This is equivalent to a relative decrease of 16% in the prevalence of being happy.

In relation to high self-esteem, the recommended threshold score on the Rosenberg Self-Esteem Scale (Rosenberg et al. 1989) was applied whereby scores of 36-40 denoted high self-esteem and those with lower scores were considered as not having high self-esteem. The prevalence of high self-esteem was 17.8% in 2016 but it was 12.8% in 2024 (Table 4.3). This is equivalent to a 28% reduction in the prevalence of high self-esteem during the time of the surveys.

The decreases in the prevalence of being happy and of high self-esteem were highly statistically significant. They remained statistically significant but were less pronounced after taking into account differences in the sexual orientation, gender identity and sociodemographic profile of the participants from the two studies. After this adjustment, there was an 11% relative decrease in the prevalence of being happy and a 26% relative decrease in high self-esteem.

Table 4.3: Point prevalence of happiness and high self-esteem in 2016 and 2024

	2016		2024		2024 vs 2016	
	n/N	Prevalence (95% CI)	n/N	Prevalence (95% CI)	cPR (95% CI)	aPR (95% CI)
Happy (Happiness 7+ out of 10)	1,204/ 2,015	59.8% (57.6-61.9%)	1,084/ 2,167	50.0% (47.9-52.2%)	0.84 (0.77-0.91)	0.89 (0.82-0.97)
High self-esteem (RSES 36-40)	344/ 1,932	17.8% (16.1-19.6%)	298/ 2,321	12.8% (11.5-14.3%)	0.72 (0.62-0.84)	0.74 (0.63-0.87)

Note: Respectively, the questions on self-esteem and happiness were unanswered by 5.0-9.0% of participants in 2016 and 1.7-8.2% of participants in 2024; CI=confidence interval. cPR=crude prevalence ratio comparing the prevalence in 2024 relative to 2016 without adjustment for the sexual orientation, gender identity and sociodemographic profile of the study participants; aPR=adjusted prevalence ratio comparing the prevalence in 2024 relative to 2016 with adjustment for the sexual orientation, gender identity and sociodemographic profile of the study participants.

Resilience

The mean Brief Resilience Scale (BRS) (Smith et al. 2008) score was 2.89 (SD=0.89, N=2801, Median=2.83), which is just below the midpoint of 3 on the scale. According to the norms for the BRS this is within the low range of resilience (1-2.99 = Low; 3-4.30 = normal; 4.31 – 5.00 = high) (Smith et al. 2013), with 51.7% (n=1447), 42.6% (n=1193) and 5.7% (n=161) in the low, normal/

medium and high categories respectively. Cisgender men had statistically significant higher resilience compared to cisgender women and TGNC participants, while gay and lesbian participants had statistically significant higher resilience compared to all other sexual identities. There were also statistically significant age differences in resilience, with the youngest group scoring the lowest and the oldest age group scoring the highest (Table 4.4).

Table 4.4: Mean resilience scores by gender identity, sexual orientation and age

Characteristic	Category	N	Mean	SD
Gender identity (n=2782)	Cis men	891	3.21	.85
	Cis women	1051	2.90	.85
	TGNC	840	2.54	.84
Sexual orientation (n=2608)	Gay	886	3.13	.86
	Lesbian	512	3.00	.89
	Bisexual	607	2.76	.85
	Queer	327	2.74	.85
	Asexual	107	2.60	.84
	Pansexual	169	2.57	.82
Age (n=2772)	14-18 years	628	2.54	.78
	19-25 years	560	2.71	.89
	26-35 years	729	2.95	.87
	36-45 years	422	3.08	.82
	46+ years	433	3.32	.85

Comfort/discomfort (dissonance/consonance) with gender identity and sexual orientation

Eight items were used to measure comfort/discomfort with one's sexual orientation (SO) and gender identity (GI). These items relate to the extent of comfort and discomfort experienced by participants in relation to their gender identity and sexual orientation. The questions are based on the principle that comfort relates to consonant experiences around SO and GI while discomfort relates to dissonant experiences. A high score on the discomfort/dissonance items suggests high discomfort levels, while a high score on the comfort/consonance items suggests low discomfort. Overall, the response indicates that (see Table 4.5) on average participants did not experience high levels of inner conflict (Means = Approx. 3) or high levels of shame (Means < 2) in relation to GI or SO. Also, on average they felt comfortable and accepting of their SO and GI (Means > 8). Nonetheless, it should be noted that while on the low end of the scale, the average extent of inner conflict (about gender identity and sexual orientation) was not unimportant (Mean = 2.81/3.03). The higher standard deviation also suggests more variability in these responses. In answer to both of the two inner conflict questions, 25% of participants rated themselves at 5 or higher which suggests that they experienced inner conflict on a regular basis. Moreover, around 5% rated themselves at the highest level (10) indicating that they experienced inner conflict almost all the time.

Table 4.5: Comfort/discomfort (dissonance/consonance) around gender identity (GI) and sexual orientation (SO)

Scale items	N	Mean	SD
GI Consonant: I feel comfortable with my gender identity	2783	8.29	2.14
GI Dissonant: I experience inner conflict about my gender identity*	2680	2.81	3.34
GI Dissonant: I feel ashamed of my gender identity*	2491	1.55	2.61
GI Consonant: I accept my gender identity	2672	8.55	2.36
Total gender identity (GI) comfort*	2796	8.12	2.14
SO Consonant: I feel comfortable with my sexual orientation	2795	8.22	2.05
SO Dissonant: I experience inner conflict about my sexual orientation*	2698	3.03	3.25
SO Dissonant: I feel ashamed of my sexual orientation *	2486	1.76	2.48
SO Consonant: I accept my sexual orientation	2727	8.68	2.07
Total sexual orientation (SO) comfort*	2801	8.01	2.03

**To establish the Total GI and SO values the dissonance items were inverted after which the mean was computed. Values for the Total GI and SO have a range of 0-10 with 10 being high comfort/consonance and 0 being high discomfort/dissonance.*

Additional analysis using the Total GI and SO comfort scores for the sexual orientation, gender identity and age groups revealed variations in the total extent of comfort experienced. As Table 4.6 shows, average levels of gender identity (GI) comfort were high for cisgender men (9.11), gay participants (9.00) and those over 26 years of age (26-35: 8.54; 36-45: 8.88; 46+: 8.85). In contrast, statistically significant lower levels were reported by those who identified as TGNC (6.52), queer (7.18), asexual (7.17), pansexual (7.36) and the youngest age groups (14-18: 7.03, 19-25: 7.70). Differences in GI comfort levels of almost, or over, 2 points on the scale represents an important distinction in the comfort level of participants with their gender identity. It should also be noted that cisgender men and gay participants showed higher average comfort than cisgender women and lesbian participants.

While a somewhat similar pattern appears for sexual orientation (SO) comfort, with participants who identify as cisgender men (8.38), gay (8.44) and the oldest participants (46+: 8.80) showing the highest levels of comfort, the extent of the variation between the groups is much less pronounced. Notably, unlike gender identity comfort, cisgender women had statistically significant lower comfort around sexual orientation compared to TGNC participants.

Table 4.6: Mean total comfort scores by gender identity, sexual orientation and age

Characteristic	Category	GI comfort			SO comfort		
		N	Mean	SD	N	Mean	SD
Gender identity	Cis men	889	9.11	1.51	890	8.38	1.88
	Cis women	1050	8.57	1.81	1051	7.63	2.18
	TGNC	839	6.52	2.17	840	8.09	1.91
Sexual orientation	Gay	884	9.00	1.63	885	8.44	1.81
	Lesbian	510	8.22	2.04	514	8.14	2.03
	Bisexual	606	7.97	2.20	608	7.61	2.16
	Queer	326	7.18	2.16	326	8.00	1.79
	Asexual	108	7.17	2.17	107	7.58	2.14
	Pansexual	169	7.36	2.33	169	8.06	2.00
Age	14-18 years	630	7.03	2.29	630	7.38	2.11
	19-25 years	558	7.70	2.10	560	7.81	2.04
	26-35 years	726	8.54	1.84	729	8.11	1.88
	36-45 years	421	8.88	1.68	421	8.24	2.03
	46+ years	433	8.85	1.99	432	8.80	1.82

Support for LGBTQI+ identity from family and social groups

The majority of participants who were 'out' indicated support for their LGBTQI+ identity among their family, social groups and networks, as well as among strangers whom they encountered. The highest support was reported to come from people the participants socialised with; more than from immediate and extended family. It is important to also note that support from work/school was reasonably high. Around one-third of those who were practising their religion and were 'out' reported that their church/religious community was supportive, while a slightly smaller proportion reported that they were unsupportive (Table 4.7).

Table 4.7: General support for LGBTQI+ identity

How supportive are the following groups of your LGBTQI+ identity?	Unsupportive		Neither		Supportive*	
	n	%	n	%	n	%
Members of your immediate family	392	15.4	243	9.6	1909	75.1
Members of your extended family	384	17.5	552	25.2	1254	57.2
People you socialize with	107	4.1	112	4.2	2422	91.7
People at your work/school	257	11.2	587	25.7	1441	63.1
Strangers	282	14.3	1102	55.8	590	29.9
Church/religious community	145	29.7	175	35.8	169	34.6

* Very (un) supportive and somewhat (un)supportive were merged.
NB: Non applicable answers were excluded from the analysis.

Analysis of the different subgroups showed that cisgender men and women reported higher levels of support from nearly all groups compared to participants who identified as TGNC. The exception was 'people you socialize with', where TGNC participants perceived slightly more support than cisgender participants, though not statistically significant. There were no statistically significant differences between the sexual identities in relation to support from either strangers or people with whom they socialized. From immediate and extended family however, lesbian and gay participants perceived higher support compared to the other sexual identities (Table 4.8).

Table 4.8: Percentage supportive of LGBTQI+ identity by gender identity and sexual orientation

How supportive are the following groups of your LGBTQI+ identity?	Gender identity			Sexual orientation					
	Cis men	Cis women	TGNC	Gay	Lesbian	Bisexual	Queer	Asexual	Pansexual
Members of your immediate family	81.3%	77.9%	65.5%	82.5%	81.4%	67.1%	70.8%	62.8%	61.4%
Members of your extended family	65.2%	59.5%	45.7%	67.2%	62.3%	47.2%	48.7%	40.3%	47.5%
People you socialize with	90.0%	91.5%	94.1%	89.8%	92.1%	91.8%	94.4%	92.0%	95.1%
People at your work/school	68.5%	62.8%	57.7%	69.6%	65.1%	57.4%	61.4%	49.3%	61.7%
Strangers	35.2%	31.3%	21.5%	33.6%	27.6%	28.4%	27.7%	19.2%	34.2%

Note: The 'church/religious community group' was excluded from this analysis as it included a smaller subset of the sample i.e. those who had a religion and were practicing their religion.

Connection or belonging to the LGBTQI+ communities

To get participants' perspectives on their sense of connection to LGBTQI+ communities participants were asked to rate (strongly agree to strongly disagree) six statements regarding belonging, inclusion and representation (Table 4.9).

Around two thirds (65%) of the sample agreed or strongly agreed that they felt welcome within the communities, that the organisations representing LGBTQI+ rights did a good job advocating on their behalf (66%) and also that their 'identity is visible in the LGBTQI+ communities' (62%). In terms of the negatively worded items on sense of belonging and inclusion, 30.9% strongly agreed/agreed that their identity was not given equal recognition within LGBTQI+ communities, just over a quarter (27.4%) strongly agreed/agreed that they felt 'isolated and separate from other people who share their identity', while 21.6% strongly agreed/agreed that they 'didn't feel included in the LGBTQI+ communities'.

There were differences in sense of belonging to the LGBTQI+ communities among the various gender and sexual identity subgroups. Overall, cisgender men, cisgender women, gay and lesbian participants reported somewhat higher levels of support than other identities. TGNC participants mostly reported

feeling welcome, but not quite as well advocated for and a little more isolated. Interestingly, asexual participants reported the lowest levels of advocacy, recognition and visibility. The response to the qualitative questions later in the chapter provides added insights into the inclusivity aspect of the support provided.

Table 4.9: *Percentage agreeing with statements relating to connection or belonging to the LGBTQI+ communities*

	Total sample	Gender Identity			Sexual Orientation					
		Cis men	Cis women	TGNC	Gay	Lesbian	Bisexual	Queer	Asexual	Pansexual
I feel welcome in the LGBTQI+ communities	65.4	63.3	62.5	71.1	65.4	69.6	61.2	68.7	54.9	71.4
I don't feel included in the LGBTQI+ communities	21.6	22.9	23.9	16.9	22.0	17.5	24.9	18.5	25.5	18.2
I feel the LGBTQI+ organisations do a good job advocating for my rights & needs	66	70.4	67.5	59.7	71.9	72.0	62.7	62.2	49.0	60.4
I don't feel that my identity is given equal recognition in the LGBTQI+ communities	30.9	18.1	34.3	40.1	15.2	25.5	44.8	37.5	63.7	31.2
I feel my identity is visible in the LGBTQI+ communities	62	69.3	58.5	58.8	73.7	66.2	54.3	58.3	33.7	49.4
I feel isolated and separate from other people who share my identity	27.4	24.3	25.3	33.5	25.2	20.4	31.2	30.5	35.6	27.5

Note: Agree and strongly agree were combined.

Qualitative findings

What you like most about being LGBTQI+?

In total, 2,555 participants responded to this question. The vast majority provided elaborate comments about what they liked most. A detailed thematic analysis resulted in five themes (see Figure 4.2).



Figure 4.2: Themes on what participants liked most about being LGBTQI+

Belonging to community and friendships

The shared experiences between, or togetherness and solidarity within the LGBTQI+ community was one of the things participants liked most. A wide variety of adjectives were used to describe the community including 'supportive', 'welcoming', 'accepting', 'inclusive', 'close knit', 'open', 'like-minded', 'relatable', 'kind', 'understanding', 'respectful', 'connected', 'safe', 'friendly', 'strong', 'subversive', 'unique', 'vibrant', 'humorous/fun', 'non-judgemental', 'brave', 'resilient', 'loving', 'perspective', 'challenging', and 'diverse community'. Often this community was referred to as 'family'.

"I have a family of queer people that I've surrounded myself with who love me more fully than my own family could. This community accepts me and understand me completely." (28, non-binary, queer, ID 379)

Responses also included references to the nature of the friendships developed, such as having gained 'solid', 'supportive', 'great', 'accepting', 'relatable', 'bonded', 'honest', 'diverse in terms of background and social class', 'close-knit', 'fun', 'interesting', 'loving' and 'alternative friendships'.

"The amazing friends that I have made since coming out. I've found a whole unit of people who think like me and share the same experiences as me. We all validate each other and hype each other up and it makes me feel so great." (24, non-binary, queer, ID 199)

"I have found friends who accept me for who I am through LGBTQI+ groups and other clubs." (24, woman, lesbian, ID 937)

Some participants wrote about how being part of the community gave them labels or language which meant they were no longer 'feeling alone', 'broken' or 'lost' due to now having collective terms for understanding themselves and describing themselves to others.

"I guess it's nice to know that I'm not crazy, you know? Like I grew up being scared of how I felt but when I found out that I wasn't alone and that there was a label for what I felt, I didn't feel so insane anymore." (15, woman, bisexual, ID 1184)

While many participants referred to the support received, the pleasure of giving support to others was also highlighted.

"I am in a position in my work where I can create a visibility for other LGBTQI+ colleagues and for learners. This gives me a sense of worth and purpose and is something I wish had been there for me." (26, non-binary, queer, ID 2801)

LGBTQI+ culture and politics

Many referred to LGBTQI+ social life or to LGBTQI+ events and/or spaces, LGBTQI+ symbols, or the joy and fun that they associate with being LGBTQI+, with some making specific reference to a love of 'gay art', 'gay books' or 'gay music'. There was also an appreciation by many of the joy, pride and solidarity that comes from being amongst others with a 'fighting spirit and activism' and who shared a common history of struggle.

"LGBTQI+ events, where I get to interact with other LGBTQI+ people and witness LGBTQI+ joy." (22, non-binary, ID 370)

"Being part of a minority with a shared history of struggle but who have come a long way." (30, woman, queer, ID 270)

"Also proud of all the activists in our community that have worked and continue to work to improve life for LGBTQI+ people." (37, woman, lesbian, ID 2326)

Some participants used a somewhat rebellious tone, also referred to liking their existence as resistance.

"...that my being can really piss people off." (21, man, gay, ID 542)

"Looking gorgeous and having fun as resistance to marginalisation and oppression." (41, woman, lesbian, ID 626)

Being open, out and proud

Being open or out and proud was identified mainly in the context of this being a release from having previously lived a suppressed or restrained existence in relation to their identity.

"I love finally living my life as hiding for so long." (48, woman, transgender woman, pansexual, ID 297)

"Coming out is like being released from prison." (59, man, queer, ID 516)

Being out and proud was linked to being accepted by other people, including having preferred pronouns or personal relationships recognised, with some referring specifically to being LGBTQI+ in a changed Ireland.

"Acceptance in current times has made being gay and having a same sex partner feel so much easier." (28, woman, gay, ID 1013)

"I get to feel comfortable when people use my correct pronouns and name." (14, man, transgender man, gay, ID 1291)

"How normalised different identities are in Ireland now." (22, woman, bisexual, ID 902)

"Feeling 'normal' in a modern Ireland." (38, man, gay, ID 2481)

Joy of relationships and attraction

Within this sub-theme participants referred to the joy of relationships with 'partner', 'wife', 'husband', 'girlfriend', 'fiancé', with references made to relationships as being 'communicative', 'accepting', 'solid', 'unique', 'happy' or 'understanding', along with references to equality within relationships.

"I think w/w relationships experience a whole deeper level of love and intimacy and I'm glad I've been able to experience it." (No age, woman, bisexual, ID 2657)

For some having attraction/relationship 'options' that are not limited by gender or 'being free to love' regardless of gender was what they liked about being LGBTQI+.

"It's nice to be able to experience attraction and connection to more than one gender." (39, woman, bisexual, ID 1353)

"Also, queer sex is SO good and freeing." (23, non-binary, queer, ID 2592)

"I love queer expressions of love." (32, woman, queer, ID 8)

"How beautiful being a lesbian is and just connecting with other lesbians is so lovely and sweet." (16, non-binary, lesbian, ID 592)

For a small few 'not having to be involved with men' or 'not being attracted to men' was what they liked most about being LGBTQI+.

Personal growth and development

Participants also referred to their personal growth and the ongoing opportunity and potential that being a LGBTQI+ person gave them to explore or shape their identity.

"...the agency to explore different identities." (28, man, bisexual, ID 143)

"Being able to shape my identity into what makes me happiest." (18, non-binary, asexual, ID 1222)

"Individual, independent and clear about my identity." (59, man, gay, ID 295)

In addition, participants liked how being LGBTQI+ 'expanded their life experiences' or 'added depth to their life' which enabled them to gain a different perspective, not only of the self in the world, but also of the world in which they

live. Participants wrote of becoming more open minded, having developed a greater interest in politics, or acquired altered political perspectives and gaining a greater understanding of how marginalisation occurs, which in turn enabled them to develop greater compassion for minority group struggles.

"A different perspective on life, made me politically progressive." (63, man, gay, ID 964)

"...and gives me a unique perspective of life which allows me to be more accepting and compassionate towards all marginalised people." (19, non-binary, bisexual, ID, 2390)

Many participants mentioned feeling free from the constraints of heteronormativity or social norms, as well as having a sense of freedom to be themselves, to express themselves, be true to themselves and live according to their beliefs and values for example, through 'crossdressing', 'presenting femininely', or 'being able to wear gender affirming clothes'.

"My uniqueness and that I am living my truth despite the hate and negativity trans people face." (23, man, transgender man, gay, ID 10)

"I like that there are no guidelines, no traditions already set out. It means we get to create the reality of being LGBTQ and there's no blueprint, it's whatever you want it to be!" (23, woman, lesbian, ID 739)

Not much

A small number gave responses suggesting that there was 'nothing', or 'not much', they like about being LGBTQI+. For example:

"Not much. I'm too scared to really explore it." (32, woman, questioning, ID 1712)

"I don't really like much about it. A lot of the time it feels like something unfortunate and wrong about...that I need to keep hidden no matter what." (15, woman, bisexual, ID 1338)

What helps you cope most effectively with issues you encounter around your LGBTQI+ identity?

In total, 2,514 participants responded to this question. Participants wrote about using multiple strategies, which resulted in eight themes (See Figure 4.3). There is overlap between the answers provided to this and the previous question, in regard to social support and involvement in LGBTQI+ communities.



Figure 4.3: Themes on what helped participants cope with issues encountered around their LGBTQI+ identity

Social support

Within this theme support from friends was emphasized most often (n=805). In about two thirds of cases, it was stated or implied that these friends were LGBTQI+ peers, but the importance of non-LGBTQI+ friends and allies were also identified.

"Having good friends that are also LGBT." (18, woman, bisexual, ID 277)

"Straight friends being amazing allies." (42, woman, queer, ID 82)

Support from 'community' was the second most frequently indicated coping resource. The term 'community' was generally used to refer to the LGBTQI+ community, but also more narrowly to a personal support network. Family who was accepting and affirmative was also referred to as an important source of coping. These responses referred to both birth-family members, but also to a 'chosen family'.

"Support network of friends and chosen family." (34, non-binary, gay, ID 104)

The role of a long-term partner was also emphasized regularly, with the terms 'husband' or 'wife' used frequently. Only a small number of references to multiple partners were made.

"Being in a long-term loving stable relationship is by far the single most effective way to combat pretty much every issue I've ever encountered. It's a very tangible and quickly recalled fact that helps me rise above people's negativity, prejudice, etc. I just don't engage in that anymore." (49, man, gay, ID 2490).

LGBTQI+ activism

Several participants highlighted that being active in giving support to others and the LGBTQI+ cause in general, was a form of coping for them.

"I don't have any issue with my identity - we as a community have to cope with others who have issues with our identities and the best way of doing this is by gathering together to resist opposition to our communities." (31, man, bisexual, ID 69)

"Stubborn determination, fighting for more legal recognition and medical support, acting as a "mother hen" to "babies gays", educating fellow community members, fighting erasure." (30, non-binary, bi-pan, ID 444)

Taking strength from societal developments

A small percentage (2.6%, n=61) of participants mentioned the influence of societal developments, mainly positive developments which bolstered their coping abilities. Progress made in Ireland was highlighted, and positive comparisons with other countries were made.

"Observing change in a generally positive and inclusive direction." (41, woman, queer, ID 83)

"The 'yes' vote." (38, woman, lesbian, ID 67)

Self-care

Self-care was the second largest theme and contained some short responses such as: *'resilience', 'self-love', self-acceptance', 'self-esteem', 'my strength'*. Many responses were in the form of affirmations, reminding oneself of *'good things'*, such as, having worked through identity issues, finding that one is *'not alone'* or *'I have the right to be here just like everybody else'*, or confirming that one can't change one's sexual orientation or gender identity. Or simply,

"Count my blessings." (31, man, gay, ID 2405)

The process of building confidence, self-esteem, resilience and self-reliance were also regularly mentioned as was emotion focused coping (crying) but, the latter, not so frequently. Meditation and mindfulness practices that were aimed at building internal self-awareness and strength were also mentioned.

"Developing resilience to be my true self always. Not allowing societal stigma to impact my life." (30, man, gay, ID 328)

"Years of personal development and self-love. Looking at how lucky I am." (42, woman, lesbian, ID 05)

Avoidance

Avoidance was also identified as a coping strategy, with a variety of avoidance methods being used. Participants indicated that they used strategies such as avoiding thinking about or ignoring issues, dissociating, seeking distraction, trivialisation, avoiding situations where one could be exposed, avoiding non-LGBTQI+ spaces, or not engaging with others.

"Staying in bed." (20, woman, transgender woman, questioning, ID 29)

"Ignoring it [feelings about gender]-Avoiding the thoughts." (48, woman, transgender woman, pansexual, ID 297)

"But I also tend not to hang out in 'normal' social spaces anymore." (36, woman, bisexual, ID 294)

Substance use was also described as a mechanism of avoidance. In many cases avoidance was not mentioned as the sole coping approach.

"Drugs, rarely leaving the house and rarely socialising with cisgender people." (23, woman, transgender woman, bisexual, ID 848)

"I just try and not think about it or talk to someone like a friend or guardian about it." (15, non-binary, lesbian, ID 2478)

Internet and media

The internet and other media (books, television, films etc.) were also regularly mentioned as a source of information, research, and affirmation of LGBTQI+ identities. Online communities were also identified as an essential support option, with a small number of participants highlighting that in the absence of friends in the LGBTQI+ community they try *'to find as many people [as possible] online who have at least spoken about similar issues, so I know I'm not alone in them.'* (26, man, transgender man, queer, ID 2650)

"Reading about how others cope with it. Watching gay TV shows and movies. Watching queer YouTubers or people who are open and proud of who they are. Researching the history of pride and our rights." (18, woman, bisexual, ID 250)

"Both talking with my two best friends and online LGBTQI+ communities help me with my internal struggles. My friends are extremely supportive.... It's also helpful to find people with similar experiences to myself in online LGBTQI+ communities. It makes me feel valid about my identity when I see others like me who didn't realize until later in life-had similar experiences with their gender identity." (24, genderqueer, omnisexual, ID 399)

Mental health support

Just under 6% of participants (n=147) mentioned that their coping was helped most effectively by psychotherapy and counselling. Often it was emphasised that this had been a long-term form of support. Where further detail was provided, its importance or the supportive relationship with the therapist was highlighted.

"I find counselling and support groups are the best supports and help me cope." (27, woman, transgender woman, ID 44)

"I have a very good psychologist as I have very complex mental health difficulties and trauma related to how I was treated in school with undiagnosed autism and a sexual assault which all makes it even harder to figure out my sexuality and what I want. My psychologist can help me explore it a bit and my family and close friends are also very supportive as I talk very openly about how confused I am as I don't have any stigma against any kind of sexual orientation (I just want to know what mine is)." (27, woman, questioning, ID 2509)

Hobbies

Creativity, involvement in hobbies, writing, work, exercise, sex, spirituality or religion, and humour were all mentioned infrequently:

"Queer film has also been great in helping me understand the complexities of sexuality and feel part of the community because I can relate to a lot of it and the feeling of disillusionment from the cishetero community. I also write fiction and fanfiction to try to express the asexual identity I don't see in other media." (29, non-binary, asexual, ID 2263)

Music was among a number of infrequently mentioned strategies identified. Interestingly, some people mentioned 'music' as a support in itself, but others highlighted it as a form of escapism, such as in this quote:

"Listening to music, helps me to escape. It drowns out other peoples' voices and stuff." (18, woman, lesbian, ID 2456)

Sense of connection or belonging to the LGBTQI+ communities, including suggestions for how connection might be improved

A total of 873 participants provided comments in response to the question on connection and belonging. Their answers provide added insights into the quantitative ratings and the challenges people experience in connecting with LGBTQI+ communities (see Figure 4.4). Although some people did identify what works (n=47), the majority used this question to express more critical perspectives. This section starts with these positive comments and then discusses the challenges to connection and belonging.



Figure 4.4: Comments on connection or belonging to the LGBTQI+ communities

Positives

In addition to **positive comments about the importance of LGBTQI+ supports**, such as *"It's great to have local LGBTQI groups"* or *"I feel like it's the one place I can be myself"*, participants mentioned involvement in initiatives like drama groups, choirs, sports clubs, activism, or the positive effects experienced from being in LGBTQI+ groups in general. Participants also mentioned **specific initiatives** such as the Small Trans Library, LINC, various Pride committees, the Midlands LGBT+ project, or LGBTQI+ societies in university.

"Attending groups for LGBTQ+ people have drastically improved my mental health and the mental health of my LGBTQ+ peers and creating more would likely have a significant positive impact." (16, demi-girl, bisexual, ID 1390)

"A support group was recently set up in my town and I have joined this and feel it's really necessary and important and I am so grateful for it." (45, non-binary, queer, ID 680)

"Groups like the Small Trans Library are making a huge and positive difference to me and my social circle." (21, genderqueer, bisexual, ID 506)

"Feel like a bit of an outcast in school. I don't belong. But I have some really nice friends online." (18, woman, transgender woman, omnisexual, ID 2205)

Challenges

Signals of **feeling excluded** were sounded most frequently by participants who identified as bisexual, or variants of a bi identity including bi-pan, queer-pan-bi, and bi+. They felt unwelcome, overlooked, invalidated, being told they are indecisive, over sexualised, queer baiting, and disbelieved. Exclusion was also mentioned by people with other identities/orientations, such as

non-binary, non-binary lesbians, non-binary fluid, genderfluid, demisexual, panromantic, asexuality, aromantic, transgender, intersex, those who are 'queer in a straight-passing relationship' or non-binary people who felt that their trans identity wasn't recognised. The term '**erasure** of identity' was used by several participants. The following is a selection of the critical comments made:

"There is also often gatekeeping in groups which exclude people of certain identities and aren't open to allies or there's bi erasure or someone is accepted as being trans enough while others are excluded." (35, man, transgender man, bisexual, ID 975)

"I find the LGBTQI+ communities to be very cliquey. If you do not fit in, you are very much not wanted in this community." (33, man, gay, ID 966)

*"Ageism is rife in our community (along with all of the other 'isms' like racism, sexism-misogyny, biphobia and transphobia: the community needs to look at *itself*)." (58, man, gay, ID 594)*

"As an aroace individual, it is very common for me to feel estranged from these communities as they focus a lot on sexual and romantic attraction. I can't help but feel a deep sadness over it." (18, non-binary, asexual, ID 2744)

"I don't know how to safely connect with LGBTQI+ communities. I feel intimidated to speak with other gay people and uneasy to have other gay friends." (30, man, gay, ID 328)

"Body image has slowly become more and more of an issue for me. I'm a skinny guy. I feel like I'm looked at as a kid. There are so many muscular gay guys that go to the gym regularly and I'm finding myself envious of them. I find it so difficult to participate in sport and physical activity because the space is not gay friendly. I look at my body and I tell myself it's worthless." (23, man, gay, ID 73)

"Sometimes it is difficult for me to feel as though I fit in with other queer people because as an autistic person, I have trouble fitting into groups in general and functioning in public spaces." (26, non-binary, bisexual, ID 152)

The impression is given that the increasing diversity within the LGBTQI+ movement and supports is at a **risk of becoming fragmentary** and lacking in inclusivity. The groups mentioned previously, may be feeling this the most. The majority of responses about being pushed out were from people who identified as lesbian, including trans lesbian (n=31). Participants wrote about feeling 'silenced', 'sidelined' or 'hated'. This was linked specifically to a perception that the LGBTQI+ community prioritises gay men, who in turn pushed others to the background. A gay cis man acknowledges this:

"As a gay man I'm probably OVER represented, too much focus on people like me is hurting others." (42, man, gay, ID 2276)

There was mention of side-lining of lesbians due to them not being attracted to 'male bodied people', or due to their position on 'gender ideology'⁹. For others again, the current 'focus on trans issues', and/or lesbian spaces being 'overrun by men with trans identities' was the reason they felt they were being 'pushed out'. There was also reference to lesbians being 'side-lined' because of the false view that all lesbians oppose trans people. Several participants sounded regret over these divisions.

"It used to be inclusive. There is not much unity in the community anymore. There used to be." (53, woman, gay, ID 2442)

"Stop labelling events as for "women and non-binary". It makes AFAB enbies [Assigned female at birth non-binary people] feel seen as "woman-lite" and AMAB enbies [Assigned male at birth non-binary people] as unwelcome." (28, non-binary, gynosexual, ID 2267)

LGBTQI+ organisations were sometimes criticised for being **inward focused**, in the sense of representing their own agendas and imposing these on the wider community, being too focused on getting sponsorship or aligning with government over campaigning and lobbying for LGBTQI+ rights. Some expressed the fear that the LGBTQI+ community is being reduced to a brand. Participants also referred to there being a set of **polarised political ideas** in the LGBTQI+ community, framing what is acceptable to say, a non-acceptance of, or tension due to, a diversity of political perspectives, and sometimes a fear of speaking out.

"I don't agree with everything in the LGBTQI+ community. So sometimes I feel like I can't express my opinion without getting called (blank)phobic or a bigot." (32, man, gay, ID 1243)

"I grew up in an era of appalling societal censorship around everything to do with sex, women's reproductive rights and LGBT lives. I'm shocked by the censorship that radical activists are driving. We have to talk to each other about sensitive areas where rights overlap. Instead, people are killing each other while the right laughs at our intolerant stupidity. Totally disheartened by this circular firing squad and have never felt more alienated from my own community." (65, woman, lesbian, ID 2054)

Finally, participants mentioned that an important obstacle to connecting with the LGBTQI+ supports is a matter of **uneven geographic presence of supports**, with much of these centred in and around Dublin and fewer available in rural areas. There were also people who wanted it known that they **did not want to seek connection** with support groups. One of the arguments for this was that they did not feel their main interest was in connecting with others on the basis of sexual orientation or gender identity.

These critical findings need to be seen within the context that most participants found support from LGBTQI+ organisations very effective. Nonetheless, the fact that it is so essential for their happiness and mental health means that criticism

⁹ Gender ideology is a term used to encapsulate a critical view of gender as a social construct.

on that support needs to be taken very seriously. Considering how hard some LGBTQI+ people find it to overcome their own inhibitions and other obstacles to engage with LGBTQI+ supports, it is essential that this experience should not lead to disappointment.

Summary of findings and discussion

This chapter explored LGBTQI+ wellbeing in terms of strengths and challenges, with many positive findings emerging. Participants rated their comfort with both their gender identity and sexual orientation highly, and this was supported by their comments on the many positive aspects to identifying as an LGBTQI+ person. While participants provided pertinent comments on the fragmentation and limitations to the claimed inclusiveness of LGBTQI+ organisations, the majority reported having a positive sense of belonging and connection to the LGBTQI+ communities. They reported using a range of coping skills to manage the issues they encountered around their LGBTQI+ identity and were positive about the support they received from various social groups, including family, friends, school, health services and work. Nonetheless, participants' ratings on self-esteem and resilience fell towards the lower end of the scales while their happiness rating is comparatively lower than general population ratings. Additionally, some gender and sexual identities fared better than others on wellbeing outcomes, and this generally followed a consistent pattern across the measures.

Happiness

The mean happiness rating for the total sample was 6.13, just above the midpoint of 5 on the scale. Cisgender men and women and participants identifying as lesbian or gay had above average happiness scores, while transgender and gender non-conforming participants and participants who identified with sexual orientations other than lesbian and gay scored closer to the midpoint. Younger participants (14–18-year-olds) had the lowest happiness score. A direct comparison of happiness ratings between *LGBTIreland* and the current study shows a relative decrease of 11% in the prevalence of being happy (score of 7 or more), even after differences in the sexual orientation, gender identity and sociodemographic profile of the participants in the two studies were taken into account. While the score for happiness is lower than that found in the general population, internationally and nationally (Veenhoven, 2023, Helliwell et al. 2023, CSO, 2023b), the decline between 2016 and 2024, is reflective of a decline in happiness in the general population of Ireland. The percentage of people in Ireland reporting that they are 'happy all or most of the time', fell from a high of 80.4% in 2018 to a low of 57.4% in November 2020 (CSO, 2023b). While the 2023 CSO survey was examining the social impact of the Level 5 stringent restrictions that were imposed on movement, socialising and work, during the first wave of the COVID-19 pandemic, a decline is also reported in the World Happiness Reports. In the 2020 World Happiness Report covering the general population in 153 countries, Ireland was ranked 16th with a rating of 7.09 (Finland ranked 1st, with a of rating 7.81) (Helliwell et al. 2020),

however, Ireland's rating for happiness, based on a three-year-average between 2020–2022, fell to 6.9 in the 2023 report (Helliwell et al. 2023).

Self-esteem

The mean self-esteem score was 26.77, just above the midpoint of 25 on the Rosenberg Self-Esteem Scale (Rosenberg, 1965), with TGNC participants and people who identified their sexual orientation as bisexual, queer, asexual, or pansexual scoring either close to the midpoint (bisexual, queer) or below the midpoint (asexual, pansexual) which is in the low range of the scale (Rosenberg et al. 1989). The younger cohort also showed self-esteem levels below the midpoint (14-18 years, 22.46; 19-25 years, 24.81). Findings in a benchmark study of 53 nations of which 23 were European, show a mean score of 30.85 (Schmitt and Allik, 2005), suggesting self-esteem in our study is lower than the average for the general population in these countries. Unfortunately, Ireland was not included in this study and no other recent Irish data were located, other than the *My World Survey 2*, a national study of youth mental health in Ireland (Dooley et al. 2019). Compared with the *My World Survey 2* which used the same self-esteem measure, adolescents (14-18, Mean=22.46) in our study have lower self-esteem compared to adolescents (12-19 years) in *My World Survey 2* (approx. Mean=27). Similarly, young adults (19-25 years) in this study have slightly lower self-esteem (M=24.81) compared young adults (19-25 years) in *My World Survey 2* (M=25.71) (Dooley et al. 2019).

Comparisons with the findings of the *LGBTIreland* study also revealed a 26% decrease in the prevalence of high self-esteem which remained statistically significant after taking into account differences in the sexual orientation, gender identity and sociodemographic profile of the participants from the two studies. This same pattern of a reduction in self-esteem over time was found in the general population of adolescents and young people between *My World Survey 1* (2012) and *My World Survey 2* (2019).

Resilience

In terms of resilience, the mean score for the sample was 2.89 which was just below the mid-point of 3 on the BRS (Smith et al. 2008). Once again TGNC participants and sexual orientations other than lesbian/gay had the lower scores (all below the mid-point). In terms of age, only those aged 36 years and older scored above the mid-point, with the 14-18-year-olds (M=2.54) and the 19-25-year-olds (M=2.71) scoring below the mid-point of 3. Because the resilience measure was not used in the *LGBTIreland* study, no comparison could be made with 2016. Moreover, no benchmark studies were located to make reliable comparisons with the general population. Nevertheless, to provide some indication of what these findings mean, it should be noted that a recent study among Irish employees showed an average BRS of 3.24 (Heavin, 2018). In addition, a study of students in the Dublin area showed a mean BRS of 3.17 (O'Brien et al. 2020) and another study involving 4th year medicine students yielded an average of 3.77 (McManus et al. 2020). While these were all small studies, they do suggest that with the exception of cisgender men, gay and the

older participants (46+), participants in our study seem to compare negatively with these groups.

A further comparison between the young LGBTQI+ participants in this study and the *My World Survey 2* shows that, just like with self-esteem, adolescents (12-19 years) in the general population scored on average above the mid-point of 24 on the Personal Competence Resilience subscale ($M=27.97$) (Dooley et al. 2019), while young LGBTQI+ participants in this study scored below the mid-point of the BRS. Although the scales differ, this suggests that LGBTQI+ young people's resilience compares negatively with their peers.

Comfort (consonance)/Discomfort (dissonance)

Overall, the response indicates that on average participants felt comfortable and accepting of their sexual orientation and gender identity. Most importantly, the highest average gender identity comfort levels are found in the cisgender men and gay groups, while the lowest levels are found in the TGNC group and the 14-18-year-olds. Differences in sexual orientation comfort were less pronounced, although the fact that cisgender men had higher average comfort rates than cisgender women suggests that there is a possible gender effect involved. Because findings for comfort/discomfort with gender identity and sexual orientation were based on a novel measure, no comparisons could be made with any benchmarks within the literature. This suggests a need for further investigation, including the mechanisms of cognitive dissonance reduction (Festinger, 1957) and how LGBTQI+ people generate inner harmony and comfort with their sense of self (De Vries et al. 2020, Bejakovic and Flett, 2018).

Family and general social support

The findings also show that the majority of participants receive support from various social groups, including family, friends, school, health services and work and have a positive sense of belonging and connection to the LGBTQI+ communities. Indeed 'people you socialise with' was identified as the highest source of support (92%) among participants who were out. Support from many of these sources, was utilised by participants as a coping strategy for dealing with issues encountered around LGBTQI+ identity. Overall, the levels of support reported from friends and immediate family are reassuring, because like self-acceptance social support plays a buffering role between levels of minority stress and mental health and wellbeing, in all groups regardless of age (Trujillo et al. 2017, McDonald, 2018, Verrelli et al. 2019, Garcia et al. 2020, Krueger and Upchurch, 2022). In addition, the literature also shows that family support is particularly important and correlates with several mental health indicators (Snapp et al. 2015). Its absence is not uncommon as family members, in particular parents, don't always find it easy to accept their child's sexual orientation or gender identity, which is often described as particularly hurtful (Roe et al. 2017).

LGBTQI+ personal development and growth was a significant theme within the open-ended question on what participants liked most about being LGBTQI+, with participants noting the new perspectives they gained about themselves in the world, and of the world itself, due to the self-reflection that they underwent in accepting themselves. Költő et al. (2021) also note that this kind of insight may motivate sexual and gender minority people to become more involved in combatting injustice and marginalisation. Indeed, a bidirectional relationship is thought to exist between community connectedness and socio-political involvement (Harris et al. 2015, Roberts and Christens, 2021), with socio-political involvement facilitating community connectedness and psychological wellbeing (Roberts and Christens, 2021) and equally 'feelings of connectedness' being a significant predictor of socio-political involvement (Harris et al. 2015). It is unsurprising therefore that activism was identified in this study as one of the coping mechanisms for addressing issues around LGBTQI+ identity and this offers insight into the wellbeing related benefits that encouragement of socio-political involvement (and connectedness) can offer to LGBTQI+ people.

Furthermore, similar to findings in other studies, friendships and social networks within the LGBTQI+ communities were often described as having a particularly important role in people's lives in that they may be the main source of support, more so than biological family, kin or religious communities (Dykewomon, 2018, Hsieh and Liu, 2021). These friendships, as well as non LGBTQI+ allies, can help mitigate the impact of stigma and threats to identity and self-esteem, and be necessary for survival in a heteronormative society (Dykewomon, 2018). Indeed, the literature on LGBTQI+ young people and mental health (Wilson and Cariola, 2019, Garcia et al. 2020) identifies connectedness with peers as a protective factor for mental health and wellbeing. For this to develop, physical identity-safe spaces such as Gay-Straight Alliances/Genders and Sexualities Alliances (GSA), community groups, or else online spaces have been promoted as facilitating young people to engage in self-development while forging connections that can offer solidarity and friendships, and ways to cope with emotional distress and respond to discrimination (Frost & Meyer, 2012, Kaniuka et al. 2019, Wilson and Cariola, 2019, Garcia et al. 2020).

Interestingly, taking strength from positive societal developments was also identified as a coping mechanism, in particular recent progressive policies were seen as coping ability boosters. This highlights the importance of societal developments for LGBTQI+ people, not only as potential sources of stress (stigma, discrimination), but also, where they are LGBTQI+ rights based, as coping mechanisms for addressing stressors that may be encountered by LGBTQI+ people (Gonzalez et al. 2022). Other coping mechanisms people identified included mental health support/therapy, hobbies and media. These coping approaches used by LGBTQI+ people can be understood as active or adaptive oriented, in other words people are engaging with their concerns when they arise and drawing from coping resources, actions that have been linked to

psychological wellbeing (Szymanski and Carr, 2008, Szymanski et al. 2017). In this study avoidant strategies were also used, mainly keeping oneself, mentally or physically, removed from the stressors of concern, however, a positive twist on these findings, was that many participants who used an avoidant coping approach reported this alongside the use of active coping strategies.

To conclude this section, it is important to emphasise that around two thirds of the sample reported a sense of belonging and inclusion within LGBTQI+ communities. They felt welcome, visible and were of the view that the organisations representing LGBTQI+ rights did a good job advocating on their behalf. As discussed, friendships forged with the LGBTQI+ communities and the reciprocity of support was a significant coping resource. The sense of belonging to, and togetherness with, the LGBTQI+ communities was also a strong theme in what participants liked most about being LGBTQI+.

An emerging concern - marginalisation within the LGBTQI+ communities

Notwithstanding the overall positive results related to connectedness and belonging to the LGBTQI+ communities, not all participants felt the same level of connection and belonging. Some felt *'pushed out of'* or *'not being welcomed into'* the LGBTQI+ communities. These responses came from both longer 'established' groups such as participants who identified as bisexual and lesbian, as well as more recently documented/emerging identities, such as asexual or aroace people. In line with other research findings lesbian participants reported experiences of exclusion because of what they view as 'the prioritisation of gay men', due to their position on 'gender ideology', or their view that the lesbian community is being undermined due to the presence of transgender women (Pearce et al. 2020, Johnson, 2007). Bisexual people commented on identity erasure within the LGBTQI+ communities, an issue that has been identified by other researchers (Corey, 2017, Pennasilico and Amodeo, 2019, McInnis et al. 2022).

Similar to other studies, transgender and gender non-conforming people also experienced lower levels of connection and belonging to the LGBTQI+ communities, than their cisgender counterparts (Parmenter et al. 2020). This is concerning because a sense of belonging has been found to be an important construct in the mental health of transgender people (Barr et al. 2016). More generally, those belonging to emerging identities and, to date, smaller sexual orientation groups, reported not feeling welcomed into existing LGBTQI+ communities. They were also struggling to fit in and locate their communities. People who identified as asexual seemed to particularly struggle with community connection and belonging. While there is a dearth of research on this sexual minority group, Rothblum et al. (2020) highlight the importance of asexual people finding supportive communities because they can feel invisible or left out by friends and the queer/LGBTQ+ communities when they talk about 'sex/sexual pleasure' or they can encounter negative attitudes to asexuality in society. Notwithstanding the importance of inclusion of asexual people within the LGBTQI+ community, asexual people may also identify as heterosexual,

or another identity rather than LGBTQI+. Hence, the need for research into asexual people's experiences, to inform what supportive communities might mean to them. In addition, community connection cannot be assumed to be always positive. For example, as alluded to in the findings around 'pub culture', this may, depending on context, be associated with substance use and misuse (Rogers et al. 2021, Garcia et al. 2020). Hence, attention to the implications of connectedness is an essential consideration for providers and LGBTQI+ people alike.

Barriers to community connection/belonging were also experienced for reasons other than sexual or gender identity. Participants identified experiences of racism, ageism, ableism, and sexism. This highlights that people 'are not contained discretely in unitary categories of identity but hold many co-occurring identities that intersect to influence their experiences' (Murphy and Higgins, 2022, p322), and acts as a reminder that the social relations of gender, race, class and disability (among others) may impact on LGBTQI+ people's experiences of inclusion and exclusion (Rothblum et al. 2020). Indeed, the finding that political fragmentation, or an absence of solidarity across the LGBTQI+ communities was a reason why some people reported feeling disconnected from the LGBTQI+ communities serves as a reminder that the route towards a greater sense of community connectedness/belonging must not be limited to a focus on LGBTQI+ identity-based exclusions but must pay attention to the broader causes of inequalities that may contribute to LGBTQI+ people's marginalisation. On the positive side, the theme of a 'fighting spirit and activism' was also identified as what participants liked most about being LGBTQI+. Indeed, for these participants, the solidarity that comes from a collective history of struggle, progressive achievements, the continued campaigns for equality, and resistance against oppression was what appealed to them. Personal experiences on this front have led to greater awareness of the importance of social justice among all sexual minority groups, a point also noted by Riggle and Rostosky (2012).

Finally, there was a clear sense of autonomy contained in comments about being open, out and proud, and responses about feeling free from the constraints of heteronormativity that were expressed in response to the open question on what participants liked most about being LGBTQI+. In Riggle et al.'s (2008) study of the positive aspects of being lesbian or gay, these factors were described as expressions of creative and authentic living, an awareness of which could help participants to unpack normative beliefs about gender and sexual minority related stigma and freeing them to create their own relationship norms, uninhibited by expectations underpinned by heteronormativity. This element may well be at the core of wellbeing for LGBTQI+ people.

Chapter 5: Mental Health and Distress in the LGBTQI+ Communities

Introduction

As detailed in the previous chapter, there are many strengths and supports in the lives of LGBTQI+ people which can positively impact on their wellbeing and mental health. At the same time, in a heteronormative and cisgender society, there are also undeniable challenges which can negatively impact mental health, particularly in the absence of resources and supports. There is now strong evidence from both Ireland and international studies that LGBTQI+ populations face higher levels of mental health difficulties compared to cisgender and heterosexual individuals (Gmelin et al. 2022, Dooley et al. 2019, Semlyen et al. 2016, Plöderl and Tremblay, 2015). As well as having disproportionality higher mental health difficulties, there is some evidence that sexual and gender minorities are at higher risk of disordered eating (Parker and Harriger, 2020, Nagata et al. 2020) and substance use compared to cisgender and heterosexual populations (Dyar et al. 2019, Parent et al. 2019). In the *LGBTIreland* report, a significant proportion of LGBTI participants experienced symptoms which are indicative of depression, anxiety, and substance misuse, and engaged in self-harm and suicidal behaviours, with younger cohorts, and transgender and intersex participants consistently faring worse on indicators compared to older cohorts and LGB groups.

Stark differences in mental health challenges have also been found elsewhere between LGBT+ youth and non-LGBT+ youth (Becerra-Culqui et al. 2018). A recent biennial representative survey of high school students in the US found higher levels of sadness and hopelessness, poor mental health, and suicide attempts among LGBQ+ students compared to their peers (Centers for Disease Control and Prevention, 2023). A survey of 2,934 secondary school pupils across the UK found that LGBT+ young people are twice as likely to contemplate suicide compared to non-LGBT+ peers (Just Like Us, 2021).

Some studies have found that the COVID-19 pandemic also had a disproportionate impact on LGBTQI+ people's mental health (Gibson et al. 2021, Just Like Us, 2021). The Life in Lockdown report documented some of the impacts of COVID-19 on the LGBTQI+ community in Ireland, with a majority reporting worse mental health since the pandemic started and increased feelings of isolation and loneliness (LGBT Ireland, NXF and GCN, 2020). Belong To's national survey found that 97% of LGBTI+ young people in Ireland had struggled with anxiety, stress, or depression since the COVID-19 pandemic started (Belong To Youth Services, 2021).

Minority stress theory (Meyer, 2003) is the overarching framework through which much of the research on mental health inequalities among sexual and gender minorities is articulated and understood. Underlying this theory is the

premise that in addition to the array of everyday life stressors, individuals from minority or stigmatized groups have to deal with stigma, prejudice, discrimination, microaggressions, harassment and even violence. These external/distal stressors can result in minority groups living in a perpetual state of stress which forms a mental health risk. In addition, inner/proximal stressors related to coming to terms with one's sexual orientation or gender identity, including the potential internalisation of homonegativity and heterosexism, adds further stress. Further examples of inner/proximal stressors include the continual expectations of rejection, and monitoring and censoring of one's thoughts and actions (Hoy-Ellis, 2023).

This chapter examines the prevalence of mental health challenges in the LGBTQI+ population, including the prevalence of symptoms of depression, anxiety and stress; the lifetime prevalence of self-harm, suicidal thoughts and suicide attempt; the possible presence of eating disorders; and indications of substance misuse. This chapter also examines the prevalence of mental health challenges in relation to key demographic characteristics (gender identity, sexual orientation and age) in order to identify any patterns. In addition, participants who indicated that their self-harm, suicidal thoughts or suicide attempt were related to their LGBTQI+ identity were asked to detail in what way it was related, and this analysis is also presented. The impact of COVID-19 and the impact of other factors on mental health are also explored through both open-ended and closed questions. As many of the aforementioned mental health indicators were examined in the *LGBTIreland* study, this chapter also provides a comparative analysis of repeat measures to assess changes in the intervening period.

Depression, anxiety and stress

The Depression Anxiety and Stress Scales (DASS-42; Lovibond & Lovibond, 1995) were developed to be self-report measures of anxiety, depression and stress by assessing negative emotional symptoms. Scores on each of the sub-scales range from 0 to 42, with higher scores reflecting higher levels of distress. Scores are categorised into five groups: normal, mild, moderate, severe and extremely severe. While not a diagnostic tool, this categorisation provides an indicator of the severity of the negative emotions of depression, anxiety and stress. Interpretation of severity is based on cut-off points, with higher scores indicating greater levels of distress; for example 'mild' means that the person is above the population mean, but still well below the typical severity of people seeking help.

The mean scores for symptoms of depression, anxiety and stress were 14.27 (Median=12, SD=11.8), 12.12 (Median=10, SD=11.1), and 16.7 (Median=16, SD=10.3) respectively. Figure 5.1 shows the distributions according to category for the whole sample. Between approximately two-fifths and one half of participants had scores which fell outside the normal/mild range for depression, anxiety, and stress (47.2%, 49.8% & 39.3% respectively). One fifth of the sample had scores indicative of a moderate level of depression symptoms while over a

quarter had scores indicative of severe/extremely severe depression symptoms (27.2%). Over one third of the sample had scores indicative of severe/extremely severe anxiety (34.2%) while just over one fifth (22.8%) had scores indicative of severe/extremely severe stress. For 14-25-year-olds, approximately three quarters of the sample self-reported symptoms of depression, anxiety and stress which fell outside the normal range (69.2%, 76.8%, 79.2%) while symptoms of severe/extremely severe depression, anxiety and stress were 42.7%, 56.8% and 35.2% respectively. For TGNC participants, symptoms of severe/extremely severe depression, anxiety and stress were 44.3%, 54.7% and 34.9% respectively.

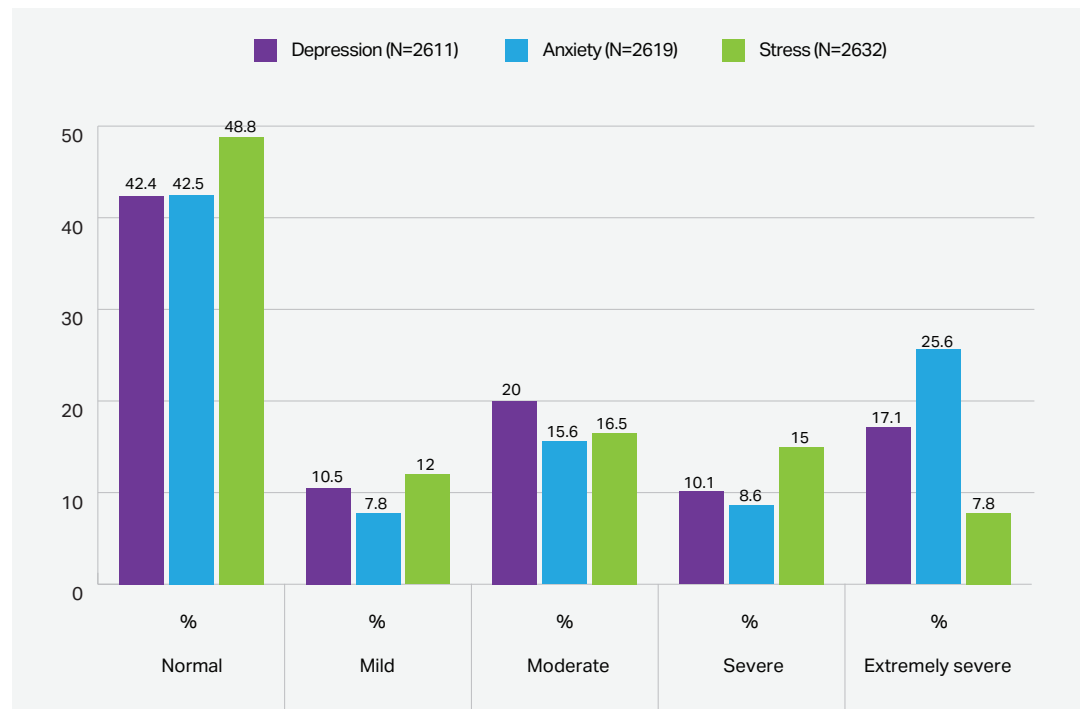


Figure 5.1: DASS-42 categories

Transgender and gender non-conforming (TGNC) participants and participants under the age of 25 had statistically significant higher levels of symptoms associated with depression, anxiety and stress. Lesbian and gay participants had statistically significant lower levels of symptoms associated with depression, anxiety and stress relative to other sexual orientations (Figure 5.2).

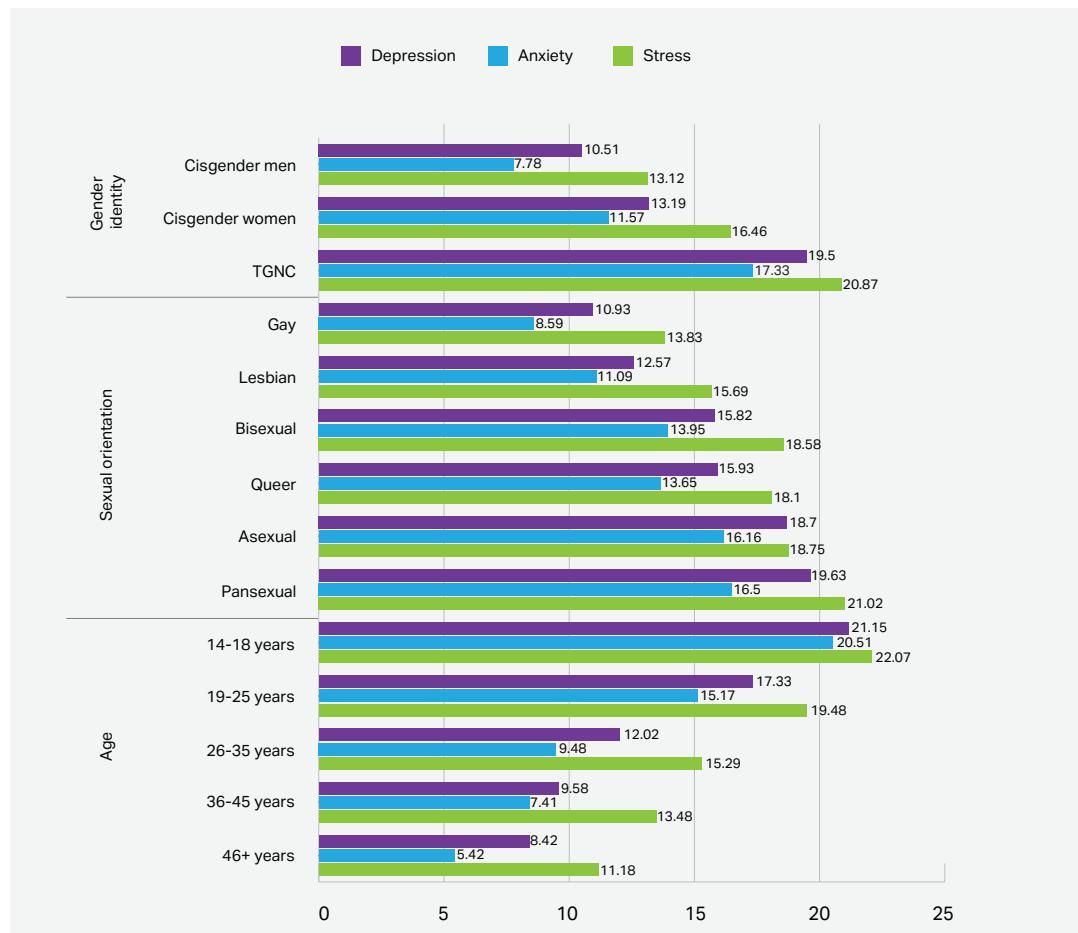


Figure 5.2: Mean DASS-42 scores by gender identity, sexual orientation and age

Self-harm and suicide

Due to the sensitive and potentially distressing nature of questions on self-harm and suicide, participants were given the option to skip these questions if they wished. Encouragingly, a relatively small percentage of participants did not answer the questions on whether they had ever self-harmed, had suicidal thoughts or made a suicide attempt (6.7%, 7.2%, 11% respectively).

Self-harm

Over half of the sample (52%, $n=1361/2617$) had deliberately harmed themselves in a way that was not intended as a means to take their own life, with just under half of those reporting doing so within the last year. The average and most common age of first self-harm was 14 years old, with a range of 3-47 years ($M=14.7$, $SD=4.6$, $N=1308$, $Median=14$). This was also the most common age for those under 25 years of age. The characteristics of those who self-harmed are shown in Table 5.1. Nearly two-thirds (64.5%) reported self-harming six or more times. For many, their self-harm appeared to be relatively impulsive, with 44% reporting that less than one hour lapsed between thinking about self-harming and doing it. Nearly half (47%) reported that no one knew that they had tried to harm themselves while just one tenth reported that they received medical care from a GP, nurse or at the emergency department for treatment. Nearly 60% reported that their self-harm was 'somewhat'/'very'/'very much' related to being LGBTQI+.

Table 5.1: Self-harm characteristics

Question	Response categories	n	%
When was the last time you deliberately harmed yourself?	Within the last month	260	19.1
	Between a month and six months ago	242	17.8
	Between six months and a year ago	174	12.8
	More than a year ago	683	50.3
How long before you tried to harm yourself on that occasion had you started to think about doing it?	Less than an hour	595	44.0
	More than an hour but less than a day	258	19.1
	More than a day but less than a week	173	12.8
	More than a week but less than a month	121	9.0
	A month or more	204	15.1
How many times have you harmed yourself?	Once	91	6.7
	Two or three times	215	15.9
	Four or five times	174	12.9
	Six times or more	871	64.5
How much of your self-harm is/was related to being LGBTQI+?	Very much related	120	8.9
	Very related	179	13.2
	Somewhat related	491	36.3
	Not very related	316	23.3
	Not at all related	248	18.3

Qualitative findings: In what way is self-harm related to LGBTQI+ identity?

Participants were asked to detail in what way their self-harm is/was related to their LGBTQI+ identity. In total, 77.8% (n=693) of participants who reported that their self-harm was in some way related to their LGBTQI+ identity provided comments. Findings are presented using Meyer's (2003) concepts: internal/proximal stressors arising from LGBTQI+ identity (n=243) and external/distal stressors (n=201) (Figure 5.3).



Figure 5.3: Relationship between self-harm and LGBTQI+ identity

Internal/proximal stressors

A common explanation of how self-harm was related to LGBTQI+ identity was the negative emotions that being LGBTQI+ elicited in participants. Some participants reported a feeling of self-hatred (n=110) because of who they were, or because they could not be who they wanted to be.

"I only self-harmed during my teenage years where I hated myself, primarily because I was gay and didn't want to be. That hatred would manifest itself as pain and inner turmoil and then I would self-harm." (27, woman, gay, ID 1074)

"I hated my body and myself for not being who I was supposed to be." (16, non-binary, pansexual, ID 1225)

Participants detailed how their inability to accept themselves contributed to their self-harm. This lack of self-acceptance resulted in a discomfort with their identity with some participants using pejorative words like 'alien' and 'freak' to describe themselves. Some participants stated that they wished they were not a member of the community, with others suggesting that being heterosexual or cisgender, which were used interchangeably with the word 'normal', would afford them an easier and better quality of life.

"I just wanted to be "normal" i.e. straight!" (37, woman, gay, ID 1062)

Others (n=49) detailed how they were made to feel ashamed of being LGBTQI+ because of the negative reactions of others to their identity, with negative attitudes of loved or trusted ones being most impactful.

"At the time, I was not out. I had known for years that I was gay but felt it was something to hide and be ashamed of. I had fallen for my best friend, and I made suggestive remarks to him about my sexuality, he was

disgusted and stopped being my friend. This sent me into a very severe depressive spiral resulting in me cutting myself to replace the mental pain with a physical one." (25, man, gay, ID 170)

"When I was a teenager, I used self-harm as a way of punishment for being gay. I remember thinking that I was branding myself, as a mark of shame. It took me a long time to undo the damage this caused." (28, woman, gay, ID 1013)

These quotes highlight a common purpose of self-harm that has been identified in all populations, i.e. eliciting physical pain as a manifestation of psychological pain, and using self-harm as punishment, however, they exemplify how the emotions that led to self-harm were as a result of internalised shame around their LGBTQI+ identity.

A number of participants reported experiencing confusion around their identity (n=37), not understanding why they felt the way they did and not being able to comprehend their identity. Of those who reported confusion, the majority discussed confusion surrounding their identity that occurred early in life, in particular their experiences in school.

"I struggled a huge amount in secondary school, I was in love with my best friend, and I found it really really tough to handle and didn't really understand it. We would be very different texting than we would be in school, and it was just incredibly confusing because boys came on the scene as well and I felt I had to like them and thought I did. It was a very difficult time." (30, woman, lesbian, ID 7)

Less prevalent, though present, were participants' (n=24) references to the stress associated with being LGBTQI+, hiding their identity and the stress of being outed.

"At times I resorted to self-harm when stressed about people finding out about my identity." (30, woman, pansexual, ID 1926)

A proportion of participants (n=51) explicitly reported that feelings of discomfort or distress associated with their gender identity, was associated with their self-harm. Typically, participants simply stated 'dysphoria' or 'gender dysphoria' in their response, but where they expanded further, participants detailed their experiences of feeling trapped in a body that felt alien to them, which for some were exacerbated by issues related to treatment, including waiting times and costs.

"Living with intense gender dysphoria that drives me to hate the body I'm in as well as knowing it could take years of medical treatment before I begin to see even the slightest of changes significant enough to help my image of myself. Ultimately it is this engulfing feeling of hating myself and knowing I will be stuck with this feeling for years at the minimum." (22, woman, transgender woman, lesbian, ID 1428)

Within this theme, participants (n=201) reported how external factors, including negative responses from loved ones and wider society, bullying and discrimination contributed to their self-harm. A significant number (n=117) described how unfavourable responses from others, including both family/friends and wider society influenced their self-harm. Not being accepted by loved ones, being rejected, as well as fear of rejection contributed to their self-harm. The impact of individuals of influence, such as family, teachers and peers, is exemplified by the following extract. In addition, the use of the words 'disgusting', 'disturbing' and 'unnatural' used by the participant's parents to describe LGBTQI+ people underscore the depth of their feelings which go beyond non-affirmation.

"Some family members, peers, teachers, adults, and others in society did not approve of it [LGBT+]. I was aware of rumours and accusations made-up by others about LGBT+ people, and somewhat believed them and that I must be a bad person because of what people were saying. Particularly my parents view of it being disgusting, disturbing, unnatural, etc, troubled me. Though I could not see the logic, I thought they must be right purely by virtue of them being parental figures and older than me, etc." (22, man, transgender man, bisexual, ID 1321)

Participants also identified societal factors such as non-positive media portrayals, reversal/ amendments to laws and religious attitudes to LGBTQI+ individuals as factors contributing to their self-harm. Where laws were discussed, this was not just related to Ireland but also to international challenges to LGBTQI+ civil rights progress.

"So my attempts to...harm myself all stemmed from societies views on LBGT+ identity, being LBGT+ was not the problem it was societies views that caused me to think it was. So, I felt I was something wrong, I did not fit in, and I tried to get out." (65, man, queer, ID 2029)

"Observing the worlds attitude... Laws being reversed etc." (25, man, gay, ID 2441)

Experiences of homophobia, transphobia, bullying and discrimination were also discussed (n=84), such as bullying in school and the workplace. For example, this participant detailed their experience of being bullied in school and the difficulties associated with this, including the inaction taken by those in authority.

"I've experienced a large amount of transphobic bullying from people in my class. They told me that I was a freak and that I was just saying that I was gender fluid for attention. They told me to die, starve myself because I was fat, that I was ugly and spread rumours around my whole school year that I had lice. When covid restrictions lifted and we were allowed to change in the changing rooms for PE again, my class wouldn't change in the same room as me because I was "gay" and I was going to stare at them the entire

time like a pervert. After that, I had enough so I told the vice principal, but she didn't do anything. She just gave me permission to change in the bathroom on my own. The people in my class still say everything about me but whenever I try to tell someone, they just move me away from the problem." (14, genderfluid, pansexual, ID 275)

"I was confused about who I was. I was excluded by other kids, and I didn't understand why. It generally contributed to poor mental health". (26, non-binary, queer and bisexual, ID 15)

Other reasons for self-harm included self-harming to assume control, to distract from distress, and as a way of feeling 'something'. For each of these responses, participants again highlighted how their LGBTQI+ identity was underlying these motivations.

"I used my self-harm to distract from my feelings of inferiority, feeling like it gave me a "valid" reason to feel upset-angry at myself and those around me rather than how I was really feeling." (17, non-binary, lesbian, ID 368)

Suicidal thoughts

Nearly 65% of the sample reported having seriously thought of ending their own life (64.1%, n=1671/2605). The average age of first thinking about ending one's life was nearly 17 years old (16.9, SD=7.3, N=1633, Median=15), with a range of 5-59 years. The most common age reported was 14 years. This was also the most common age for those under 25 years of age. The characteristics of those who had suicidal thoughts are shown in Table 5.2. Nearly half of those who had thought about it reported that they had done so over one year ago (48.7%), whilst the remainder had more recent suicidal thoughts. Around half reported that their suicidal thoughts were 'somewhat'/'very'/'very much' related to being LGBTQI+.

Table 5.2: Suicidal thoughts characteristics

Question	Response categories	n	%
When was the last time you seriously thought about ending your own life?	Within the last month	380	22.7
	Between a month and six months ago	255	15.3
	Between six months and a year ago	223	13.3
	More than a year ago	813	48.7
How much are/were your suicidal thoughts related to being LGBTQI+?	Very much related	183	11.0
	Very related	206	12.3
	Somewhat related	459	27.5
	Not very related	426	25.5
	Not at all related	396	23.7

Qualitative findings: In what way are suicidal thoughts related to LGBTQI+ identity?

Participants were asked to detail in what way their suicidal thoughts are/were related to their LGBTQI+ identity. In total, 84.2% (n=714) of participants provided open-ended comments. As with the question on self-harm and LGBTQI+ identity, the two most commonly reported LGBTQI+ related factors were: internal/proximal stressors arising from LGBTQI+ identity (n=209) and external/distal stressors (n=238) (Figure 5.4).

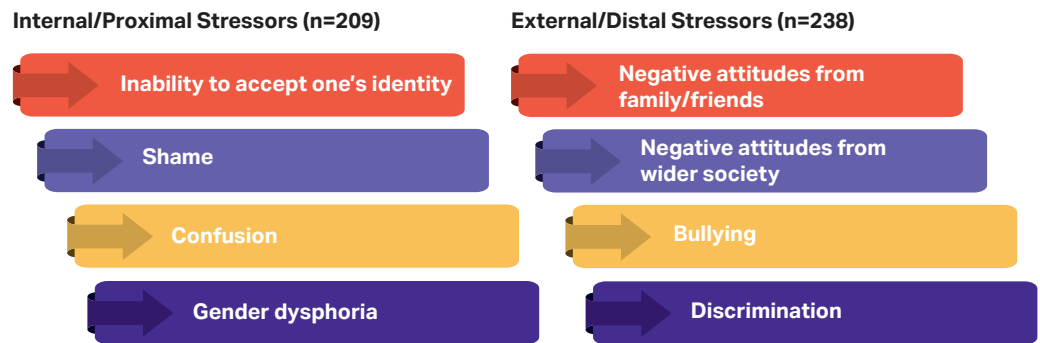


Figure 5.4: Relationship between suicidal thoughts and LGBTQI+ identity

Internal/proximal stressors

Within the internal stressors theme the same issues of self-hatred and an inability to accept one's identity, shame, confusion and issues with 'gender dysphoria' were identified as contributing to participants thinking about ending their lives.

External/distal stressors

Negative attitudes from family/friends and wider society, and bullying and discrimination were again highlighted as the key external LGBTQI+ related factors that were associated with suicidal thoughts. To avoid repetition of very similar quotes to those relating to the internal and external stressors in the section on self-harm, only an example of responses is identified here.

"I'll never be able to be a real boy. I'll always be 'the trans guy'. So what's the point in trying? I'll always have dysphoria because I'll always be trans. That just doesn't seem worth it does it?" (16, man, transgender man, bisexual, ID 2085)

"Frustrating thoughts about not thinking I could be my authentic self, lead to a shame spiral. I once built up the courage ask questions about the LGBTQI community to my father, testing the water before coming out. He said he would be disappointed if any of his children were "that" way. So, I held that in and it kept eating at me." (26, man, gay, ID 554)

"The negative thoughts-moods I had, I think came from a lot of pushed down emotion from being in the closet-having to pretend to be someone else-coming to terms with who I am, having that in the back of my mind for years I think somewhat contributed." (18, woman, lesbian, ID 1543)

Concerns for the future

In addition to the internal and external stressors, participants (n=85) reported that having concerns about their future as a result of their LGBTQI+ identity contributed to their suicidal thoughts. For some, a lack of acceptance from family was a significant issue while for others a lack of self-acceptance was problematic.

"I had suicidal thoughts because my family couldn't accept me. I felt I had no future being bisexual as I was going to face challenges for the rest of my life because of my sexuality." (23, woman, bisexual, ID 173)

"I couldn't accept that I was gay and couldn't see a future." (30, man, gay, ID 879)

With respect to their future, many participants detailed their perceived difficulty in pursuing relationships, both platonic and romantic. For example, one participant referenced falling into a grey area of not being perceived as one of the guys or one of the girls, and the feelings of isolation that this evoked.

"It's harder to form lasting valuable friendships when you're gay sometimes because a lot of the girls you befriend don't look at you as one of the girls and a lot of the guys you befriend don't look at you as one of the guys so you fall into no man's land, I felt very alone for a long time." (25, man, gay, ID 1562)

In terms of concerns for the future, transgender participants discussed how difficulties in accessing gender affirming care impacted their future outlook and contributed to their suicidal thoughts.

"...sometimes I'll wake up and not be able to get out of bed or get dressed because of how dysphoric I feel and then I remember how hard it is to get the healthcare I need and how long it will be until I can feel comfortable in my own body. It's all just basically a big spiral from there... Not having hope in the future doesn't inspire the will to live." (17, man, transgender man, queer, ID 1409)

Suicide attempt

Just over one quarter (26.4%, n=659/2497) of the sample reported that they had attempted to die by suicide. The average age of first suicide attempt was 17 years with a range of 5-50 years (M=17.3, SD=6.5, N=644, Median=16). The most common age reported was 15 years. This was also the most common age for those under 25. The characteristics of those who made a suicide attempt are shown in Table 5.3. For three quarters of participants, their last attempt had occurred more than one year ago. The majority (65.3%) reported that someone knew that they had made a suicide attempt while just over one third (36.7%) reported that they received medical care from a GP, nurse or at the emergency department for treatment for their most recent attempt. Approximately half felt that their suicide attempt was 'somewhat'/'very'/'very much' related to being LGBTQI+.

Table 5.3: Suicide attempt characteristics

Question	Response categories	n	%
When was the last time you seriously tried to take your own life?	Within the last month	23	3.5
	Between a month and six months ago	59	9.0
	Between six months and a year ago	89	13.5
	More than a year ago	487	74.0
How much of your suicide attempt is/was related to being LGBTQI+?	Very much related	85	12.9
	Very related	87	13.2
	Somewhat related	152	23.1
	Not very related	160	24.4
	Not at all related	173	26.3
Did anyone know that you had tried to take your own life?	Yes	430	65.3
	No	179	27.2
	I don't know	49	7.4
Did you receive medical care from a GP, nurse or at the emergency department for your most recent suicide attempt?	Yes	242	36.7
	No	417	63.3

Qualitative findings: In what way is suicide attempt related to LGBTQI+ identity?

Participants were asked to detail in what way their suicide attempt is/was related to their LGBTQI+ identity. In total, 39.9% (n=263) of participants who reported that their suicide attempt was in some way related to their LGBTQI+ identity provided open-ended comments. This is significantly fewer than the proportion who responded to the same question on self-harm (77.8%) and suicidal thoughts (84.2%). This is partly explained by a number of participants reporting that their response was 'the same as the last question', which focused on suicidal thoughts. Despite the lower number of responses, there was again significant overlap between the reasons identified for suicide attempt, and those reported for both self-harm and suicidal thoughts. Once again, the prominent themes were the influence of proximal factors, distal factors, and concerns for the future.

Internal/proximal stressors

The influence of proximal factors again concentrated on key issues such as self-hatred, shame, an inability to accept oneself and struggling with gender dysphoria. Participants reported an inability to reconcile themselves with their LGBTQI+ identity and reported how a suicide attempt was a way to stop the self-hatred and lack of self-acceptance. Gender dysphoria was also reported by several participants who identified the difficulties it caused them.

"I felt it would have been easier to take my own life than actually be the person I was. I was so scared of being me I thought it would have been easier to be dead. That way all the suffering would end." (36, man, gay, ID 2408)

*"Depressed and repressed, felt existentially *wrong* in a way I couldn't understand, retrospectively this is puberty onset ramping up dysphoria." (36, woman, transgender woman, lesbian, ID 2192)*

External/distal stressors

The influence of distal stressors related to how participants were perceived, and responded to, by family, friends, and wider society, in addition to experiences of bullying and discrimination. The impact of a non-affirming and overtly critical response from a parent and its relationship to a suicide attempt is poignantly described by the following participant.

"My father spent my teen years systematically trying to convince me that my life was not worth living because I am transgender. He tried to convince me that the world would hate me, that I would be a "pariah" and that the weight of "my choices" would kill my grandparents out of stress. He made me believe I was incapable of knowing right from wrong or succeeding at anything, because my choice to be a girl was clearly an intrinsic moral failing that would forever distract me from success. He wanted me to kill myself so that he would be the victim; father of a dead child and worthy of sympathy from all. He wanted me to kill myself, and like a good child, I tried to make him happy." (29, woman, transgender woman, questioning, ID 185)

Concerns for the future

As with the responses on suicidal thoughts, concerns for the future focused predominantly on how participants found it difficult to envision themselves having a happy and fulfilled life.

"Felt worthless and hated myself. Couldn't see a future for myself the way I was feeling and being LGBTQI." (25, man, gay, ID 1562)

Self-harm, suicidal thoughts and suicide attempt by gender identity, sexual orientation and age

The highest rates of self-harm, suicidal thoughts and suicide attempt were reported by transgender and gender non-conforming participants, followed by cisgender women, with cisgender men having the lowest rate of the three groups. Gay participants had a 1.5-2 times lower rate of self-harm compared to other sexual orientations, and the lowest rates of suicidal thoughts and suicide attempt. Pansexual participants reported the highest rates of self-harm, suicidal thoughts and suicide attempt of all sexual orientations. The youngest age groups (14-18 and 19-25) reported the highest rates of self-harm, suicidal thoughts and suicide attempt (Figure 5.5).

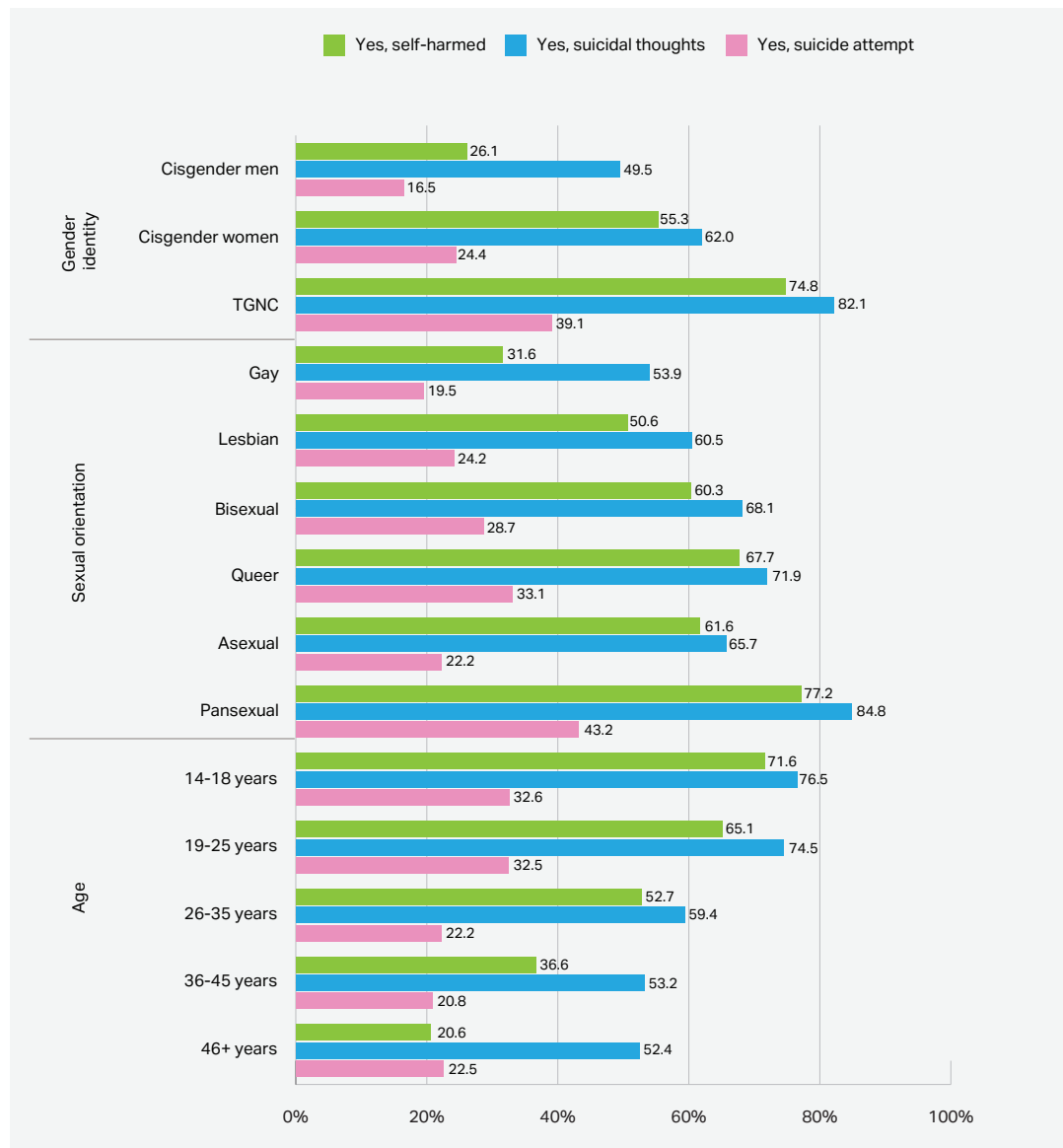


Figure 5.5: Self-harm, suicidal thoughts and suicide attempt by gender identity, sexual orientation and age

Eating disorders

The SCOFF Questionnaire is a 5-item measure used to raise awareness of the possible existence of an eating disorder (Morgan et al. 1999). A 'yes' to two or more items (Q1-Q5) (Table 5.4) indicates the possibility of an eating disorder and warrants further questioning and more comprehensive assessment by a healthcare professional. A further two questions (Q6 & Q7) have been shown to indicate a high sensitivity and specificity for bulimia nervosa and would indicate further questioning and discussion is required. 40.7% (n=1041/2559) of participants reached the risk threshold indicative of a potential eating disorder. In relation to the two additional questions, 36.5% (n=969) of the sample indicated that they were dissatisfied with their eating patterns and ate in secret, answers which would indicate a need for further assessment.

Table 5.4: *SCOFF items (Q1-Q5) and additional questions (Q6-Q7)*

Questions	No		Yes		Total
	n	%	n	%	n
Q1. Do you make yourself sick because you feel uncomfortably full?	2301	86.4	363	13.6	2664
Q2. Do you worry you have lost control over how much you eat?	1304	49.1	1353	50.9	2657
Q3. Have you recently lost more than one stone in a 3 month period?	2183	82.7	457	17.3	2640
Q4. Do you believe yourself to be fat when others say you are too thin?	1999	75.4	653	24.6	2652
Q5. Would you say that food dominates your life?	1925	72.2	742	27.8	2667
Q6. Are you satisfied with your eating patterns?	1809	68.0	851	32.0	2660
Q7. Do you ever eat in secret?	1574	58.8	1102	41.2	2676

Table 5.5 presents the proportion of participants from the different subgroups scoring positive (score of 2 or more on the 5-item SCOFF Questionnaire) for a potential eating disorder. Transgender and gender non-conforming participants had the highest rate of potential eating disorder, approximately 20% higher than cisgender men and 8% higher than cisgender women. Gay participants had the lowest rate of potential eating disorder of all sexual orientation subgroups, with pansexual participants registering the highest rate. The rate of potential eating disorder decreased with increasing age.

Table 5.5: *Potential eating disorder by gender identity, sexual orientation and age*

Characteristic	Category	% SCOFF \geq 2
Gender identity (n=1034)	Cis men	30.0
	Cis women	42.0
	TGNC	50.2
Sexual orientation (n=956)	Gay	33.8
	Lesbian	38.2
	Bisexual	43.3
	Queer	42.3
	Asexual	48.4
	Pansexual	58.2
Age (n=1031)	14-18 years	59.2
	19-25 years	47.3
	26-35 years	37.3
	36-45 years	31.6
	46+ years	20.9

Substance use

Alcohol consumption

Approximately a fifth of the sample never drank alcohol (21.9%, n=614). In total, 26.5% (n=741) reported drinking 2-4 times a month, a quarter reported drinking monthly or less (25.1%, n=702), a fifth reported drinking a few times a week (19.4%, n=544) and 7.1% reported drinking more than 4 times a week (n=199).

Participants were asked 10 questions to ascertain their alcohol use based on the Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 2001). Responses were scored from zero to four. Scores were totalled and fell into four categories: low risk level of alcohol consumption (7 or lower), moderate risk level of alcohol consumption (8-15), high risk level of alcohol consumption (16-19), and a very high risk level of alcohol consumption (20+). The average AUDIT score was 7.68, with a range of 1-36 (SD=5.78, N=2158, Median=6). In terms of AUDIT categories (Table 5.6), 58.2% of those who drank alcohol scored as low risk. Nearly one third scored within the moderate category (32.4%), with AUDIT guidelines recommending that, at this level, the best course of treatment by healthcare professionals is to provide advice and information to reduce hazardous drinking behaviour. Just under 5% of the sample's scores indicated a high risk level of alcohol consumption, with recommended treatment at this level being brief counselling and continued assessment. A further 5% of the scores were within the very high risk level category indicating a need for further diagnostic assessment for alcohol dependence by a healthcare provider.

Table 5.6: AUDIT scores

AUDIT categories	n	%
Low risk (1-7)	1257	58.2
Moderate risk (8-15)	699	32.4
High risk (16-19)	97	4.5
Very high risk (20+)	105	4.9

Cisgender men were more likely to record higher AUDIT scores than cisgender women and transgender and gender non-conforming participants. Gay participants had the highest AUDIT scores of all sexual identities. In relation to age, the youngest and oldest age groups had the lowest AUDIT scores of all age groups, with statistically significant higher scores among the 19–25-year-olds (Figure 5.6). Around one third of 14-18-year-olds (29.7%) and around half of 19-25-year-olds (48.4%) scored 8 or more which may indicate hazardous and harmful alcohol use, as well as possible alcohol dependence.

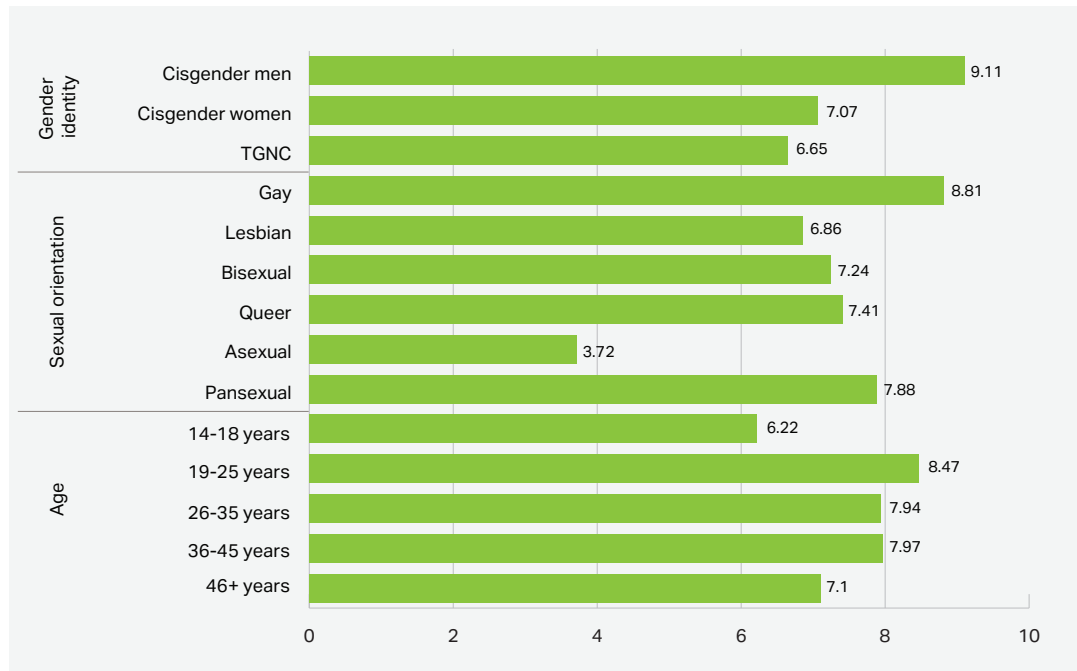


Figure 5.6: Mean AUDIT scores by gender identity, sexual orientation and age

Drug use

Participants were asked if they had ever taken drugs, other than those required for medical reasons, with 54% indicating that they had (n=1518). Of those who had taken drugs, just over two-fifths had taken drugs more than one year ago (43.5%, n=661), a quarter had taken them within the last year (24.9%, n=378), and 31.6% had taken them within the last month (n=479). Substantially more young people aged 19-25 had taken drugs compared to those aged 14-18 (61.2% vs. 19.7%).

DAST-10 was administered to those who had taken drugs within the previous year. Of these, 1.7% scored as being at no risk. The majority scored as being at low risk (59.4%), with the suggested action being to monitor and re-assess at a later date. Nearly one third (30.1%) scored at a moderate level, with further investigation recommended at this level. Approximately one tenth (8.9%) scored at a substantial/severe level, with intensive assessment the recommended course of action at these levels (Table 5.7). The mean score on the DAST-10 was 2.57 (SD=1.9, N=805, Median=2).

Table 5.7: DAST-10 scores

DAST-10 categories	n	%
No risk (0)	14	1.7
Low level (1-2)	478	59.4
Moderate level (3-5)	242	30.1
Substantial level (6-8)	56	7.0
Severe level (9-10)	15	1.9

There were no statistically significant differences in DAST-10 scores when examined in relation to gender identity, sexual orientation and age (Figure 5.7).

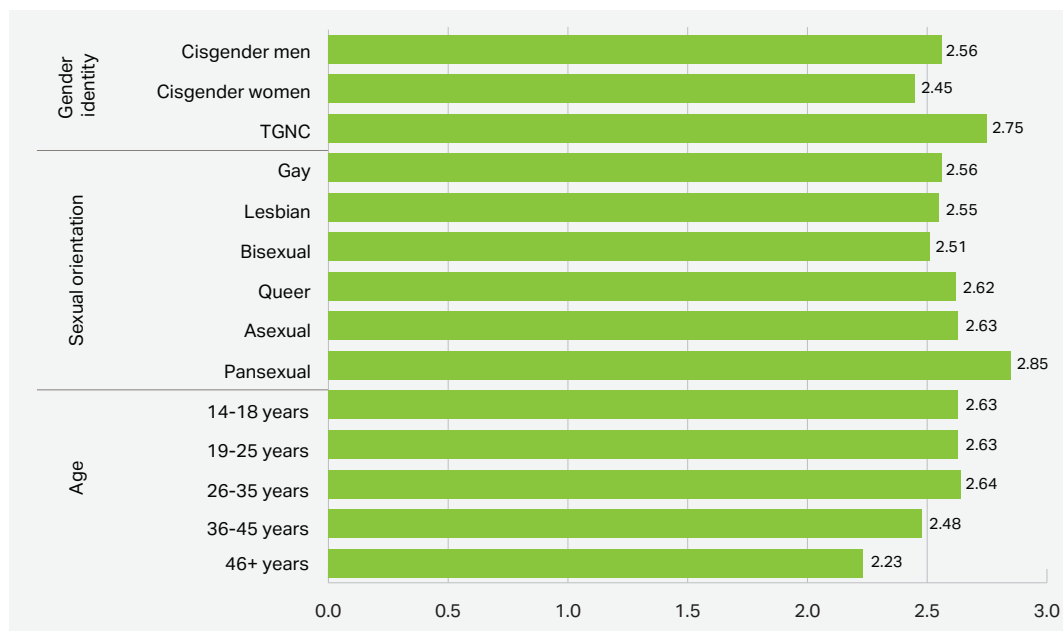


Figure 5.7: Mean DAST-10 scores by gender identity, sexual orientation and age

Of those who had taken drugs within the last year (N=857), the three drug types used most often were: 1) hashish/marijuana/cannabis; 2) codeine-based drugs (e.g. oxycodone, nurofen plus, solpadine); and 3) cocaine, with the majority of those who took the first two doing so in the past month. The top three reasons for taking drugs were: 1) To get high/for fun/for pleasure; 2) To reduce stress/relax; and 3) To socialize, which indicates that most people were using them for recreational purposes. However, as Table 5.8 shows, a number of responses were also for reasons relating to treating depression, anxiety, stress and sleep disturbance. In relation to 'other' reasons not on the list, these included because a partner or friends/acquaintances were doing it, to access insights/learn/self-explore, to meditate, to treat ADHD, to gain confidence, to overcome fears of flying, in the context of a party/festival, as part of routine or to satisfy craving, to hurt oneself, to numb some feeling, to feel something, to stay drinking longer, to dance and to open up to another person.

Table 5.8: Reasons for drug use

	n
To get high/for fun/for pleasure	688
To reduce stress/relax	490
To socialize	452
To treat depression/anxiety	275
Out of curiosity/to experiment	259
To improve sleep	253
To enhance sexual pleasure*	178
To reduce pain/inflammations	177
To reduce psychological barriers to sexual performance*	58
Other reason/s	33
To enhance school/work performance	28
To reduce physiological barriers to sexual performance (e.g. lack of erection)*	20
To enhance physical body appearance	14
To enhance athletic performance	5

NB: Participants could choose multiple categories

*Response option only displayed for participants aged 18 and over (n=776)

The top three settings in which drugs were used were: 1) At home; 2) In a club/pub; and 3) At a concert/music festival. In terms of 'other' settings not covered by the list, these included a friend's house, house party, on holiday, camping, at pride, at a wedding celebration, at a birthday party and at a retreat (Table 5.9).

Table 5.9: Drug use setting

	n
Home	617
Club or pub	337
Concert/Music festival	266
Public space (street, park, etc.)	243
Organised party ('rave')	206
Chemsex party/Sex party/After party*	79
School/university	41
Sauna or sex clubs or other sex on premises*	39
Work	35
Other setting	33

NB: Participants could choose multiple categories

**Response option only displayed for participants aged 18 and over (n=776)*

Impact of COVID-19 on mental health

While the study was conducted in what might be considered the post-pandemic period, given the recency of COVID-19 and evidence that it had a negative impact on the mental health of LGBTQI+ populations, questions on its impact were included. Nearly half of the sample reported that their mental health had worsened since the start of COVID-19 (47.9%), around one fifth indicated that it had improved (18.1%) while around one third of the sample perceived that the pandemic had no impact on their mental health (34%).

TGNC participants and the youngest participants (those aged 14-18) were more likely to report that their mental health had worsened due to COVID-19 compared to cisgender and older participants. In terms of sexual orientation, gay participants had the lowest proportion reporting worse mental health (41.4%). By comparison, 54% of pansexual and 58% of 'queer' identified participants reported worse mental health (Figure 5.8).

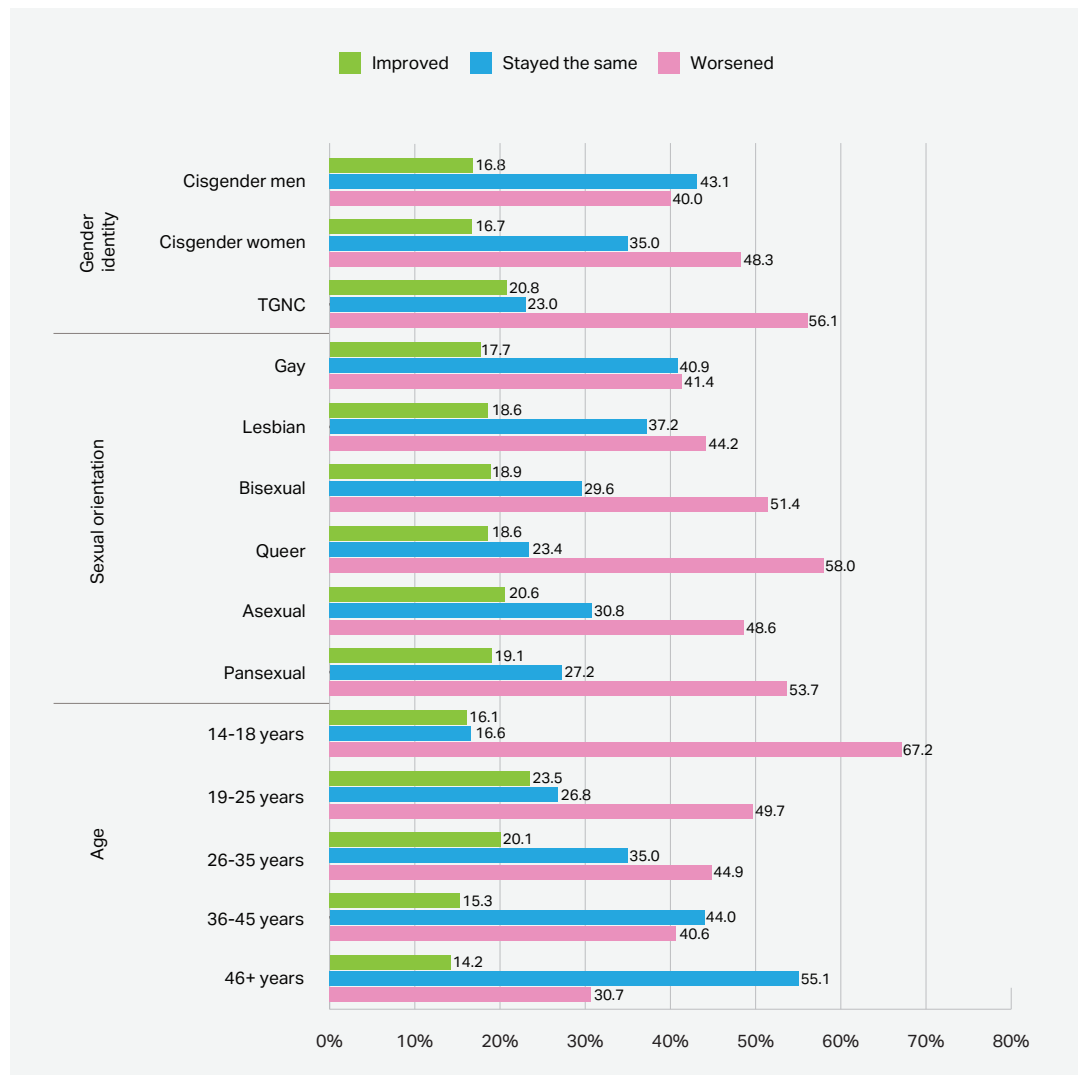


Figure 5.8: Mental health since COVID-19 by gender identity, sexual orientation and age

Qualitative findings: Impact of COVID-19 on wellbeing and mental health

Qualitative comments provided by participants gave further insight into the quantitative findings with participants writing about: i) Negative impacts (n=1088) and ii) Positive impacts (n=402). Some participants indicated that it had mixed impacts (both positive and negative) (n=93) while others noted that it had no impact on their wellbeing (n=119) (Figure 5.9).

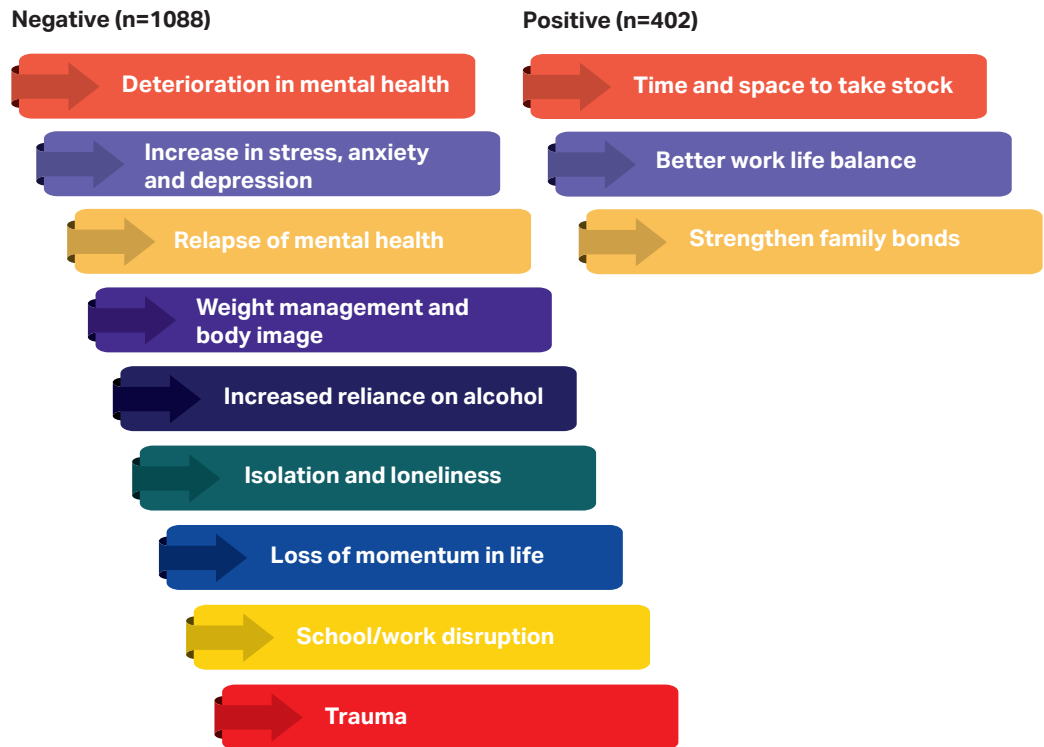


Figure 5.9: Impact of COVID-19 on wellbeing and mental health

Negative impact

A significant number of people reported that their mental health deteriorated or relapsed during the pandemic and lockdowns with increased stress, anxiety, and depression frequently mentioned.

"I was doing quite well in my mental health recovery prior to COVID, but everything crashed as soon as the pandemic began. I relapsed into self-harm and went through by far the most severe self-harm episode of my life. My first (and thus far only) suicide attempt also happened during the pandemic." (22, Non-binary, ID 370)

"I developed anxiety really badly and I get into pits of depression, especially in winter." (14, woman, bisexual, ID 1359)

For others the pandemic caused issues with weight management, body-image and disordered eating and increased reliance on alcohol.

"I gained a lot of weight during COVID because I couldn't go to my personal trainer who was helping me with my eating disorder and now, I completely hate my body." (24, woman, queer, ID 1643)

"The lack of socialising got me down and I found myself drinking more at home to cope with the loneliness of the pandemic." (36, woman, lesbian, ID 568)

The loss of support networks, feeling confined, constrained and a sense of missing out on life were also identified as contributing to the negative impacts. Some participants reported being stuck in places they were unable to extricate themselves from, which for some participants meant being confined with family who were not supportive of their LGBTQI+ identity.

"I felt as though two years were taken from my youth. I entered the pandemic at 19 and left it at 21. I feel like I've missed out on really fun formative years.... I feel stunted romantically and sexually as a result. It also made college impossible to enjoy. I feel younger than my actual age and now I feel pressure to make up for lost time by constantly going out." (22, woman, lesbian, ID 810)

"At the beginning of Covid-19 I got stuck with unsupportive family and it felt like I had gone back to square-one, to the past, and the uncertainty of when I would be free to be myself again made me go back into a depressive near-suicidal state, until I was free to go back to living with friends again." (22, man, transgender man, bisexual, ID 1321)

Many participants wrote about loneliness and isolation which lead to a loss of momentum in life and rumination.

"Isolation made me feel like I was freezing solid and slowing down until I became so paralyzed with loneliness, I couldn't do anything." (23, man, gay, ID 818)

"Negatively, Humans are social creatures and I do think it slowed down development." (17, woman, bisexual, ID 2793)

"I felt even more isolated, spent more time on the internet which only impacted me worse." (16, genderfluid, orientated (demi) aromatic asexual, ID 1651)

Disruption to school/college learning and changes related to work, including job loss and higher workloads, were identified as contributing to poor mental health. Other factors that negatively impacted mental health were related to strain or breakdowns in romantic relationships, the trauma associated with working in healthcare environments, having to deal with family bereavement with minimal support, and seeing people not wear masks or abide by restrictions.

For many, the ending of COVID-19 restrictions brought new challenges, in terms of readjusting and relearning social skills. It also brought increased stress for people who were immunocompromised:

"Much more insular, find it harder to engage, don't go to events or gatherings to see people." (60, woman, lesbian, ID 2111)

"As someone who is immunocompromised, I've basically been trapped in my home since the start of 2020. I have managed to avoid catching Covid so far (as far as I know), however, leaving my home has become extremely stress-inducing, particularly now that no one seems bothered to even wear so much as a mask." (35, non-binary, queer, ID 1458)

Positive impact

The positive impacts written about were mainly related to the way the restrictions afforded participants time and space to review and take stock of aspects of their lives, including their sexual and gender identity. For some, the restrictions enabled them to get away from unhelpful people and places, which afforded them time to reflect without the imposition of others' views. This period of self-reflection and self-discovery meant that some emerged from the 'cocoon' stronger and freer from societal expectations, with some participants reporting that they had transitioned during that time.

"At first it was difficult, having all that time being forced to listen to my thoughts. Then I realised that I wasn't cis or straight and from there it led to a large amount of self-reflection and the lack of stress allowed me to breathe and actually realise how poorly I viewed myself. I believe that the time I was given due to Covid-19 assisted in my self-discovery." (17, non-binary, asexual, ID 1505)

"COVID-19 gave me the time and space away from my family to process my trauma and come to terms with my gender identity. This was a very positive change and allowed me to transition." (24, non-binary, transgender man, queer, ID 671)

"The isolation initially worsened my mental health massively but gave me more time to self-reflect and eventually become certain that I was trans and bisexual. I am now in a better mental state than at the start of the pandemic." (19, woman, transgender woman, bisexual, ID 196)

"The pandemic gave me the time to make life changes (e.g. my gender transition, and moving back to Ireland) so it's not all bad. Also spent more time with my family (wife and daughter) has been a net positive, eating dinner together etc." (45, transfemale, transgender woman, questioning, ID 756)

Positive impacts also included having a better work life balance, as people experienced less stress as they were commuting less, which also afforded people an opportunity to strengthen family bonds. Other beneficial aspects identified included, changing jobs, saving money, as well as establishing healthier self-care habits, which impacted positively on mental health.

"The onset of COVID gave me the time and space to stick to a strict diet and exercise regime which enabled me to get in shape and hence improve my mental health." (26, man, gay, ID 2216)

Other factors that have impacted on mental health in the past five years

Participants were also asked about a list of other factors that had impacted their mental health in the past five years (Table 5.10). Many of the factors ranked as highly positive, including legal changes with the introduction of the Marriage

Equality and Gender Recognition Acts; LGBTQI+ representation in media as well as engagement with LGBTQI+ media; coming out as LGBTQI+ and making new LGBTQI+ friends; and joining or visiting LGBTQI+ groups/centres. All of these were deemed positive by over 83% of participants. While coming out to friends was positive for 87% of participants, coming out to family was positive for 66%. In total, 19%, 18% and 17% respectively felt that calling a non-LGBTQI+ helpline, engaging with the mental health services and coming out as LGBTQI+ to family members had a negative impact, which may indicate a lack of acceptance and understanding among family and services with regard to LGBTQI+ identities.

Transgender and non-binary participants were asked about the impact of transitioning (socially/legally/medically). For the majority who responded, the impact was perceived positively (n=456, 90%). However, twenty-eight participants indicated that transitioning (socially/legally/medically) had a negative impact on their mental health. On closer examination of the data for these participants it became clear that the negative impact was not directly associated with medical transition, as twenty-seven of these participants reported that they either have not, and do not plan to medically transition, or have not, but do plan to medically transition in the future. Transgender healthcare access barriers were the issues that stood out the most in terms of negative impact on mental health, mainly those of long waiting lists, a lack of transgender related knowledge by health care professionals, cost, and the likelihood of having to travel abroad to access a transgender health service. One participant had medically transitioned, and this person referred to having since medically de-transitioned due to having experienced discrimination and violence.

"Harrasment. I'm FtM (female to male) and I've resorted to medically detransition due to physical assault and harassment." (19, man, transgender man, gay, ID 1336)

Table 5.10: Factors that have impacted on mental health of the survey sample

	Positive impact		Negative impact		No impact at all	
	n	%	n	%	n	%
Changes in law like the Marriage Equality Act (n=2546)	2388	93.8	29	1.1	129	5.1
Making new LGBTQI+ friends (n=2428)	2247	92.5	55	2.3	126	5.2
Seeing more LGBTQI+ people in the media and on TV (n=2590)	2348	90.7	48	1.9	194	7.5
Transitioning (socially/legally/medically) (n=506)*	456	90.1	28	5.5	22	4.3
Changes in legislation related to gender identity like the Gender Recognition Act (n=2151)	1897	88.2	69	3.2	185	8.6
Coming out as LGBTQI+ to friends (n=2215)	1935	87.4	63	2.8	217	9.8
Engaging with LGBTQI+ media (e.g. GCN) (n=2044)	1786	87.4	68	3.3	190	9.3
Joining an LGBTQI+ group (n=1231)	1029	83.6	59	4.8	143	11.6
Visiting an LGBTQI+ centre (n=852)	707	83.0	32	3.8	113	13.3
Acquiring/changing job (n=1476)	1154	78.2	142	9.6	180	12.2
Joining a Non-LGBTQI+ club (n=1114)	870	78.1	41	3.7	203	18.2
Using a general (not LGBTQI+ specific) support group or service (n=815)	575	70.6	88	10.8	152	18.7
Engaging with the mental health services (n=1595)	1076	67.5	285	17.9	234	14.7
Coming out as LGBTQI+ to family members (n=1832)	1209	66.0	305	16.6	318	17.4
Calling an LGBTQI+ helpline (n=315)	181	57.5	26	8.3	108	34.3
Family joining an LGBTQI+ support group or service (n=198)	90	45.5	15	7.6	93	47.0
Calling a non-LGBTQI+ helpline (n=475)	195	41.1	89	18.7	191	40.2

NB: Non applicable answers were excluded from the analysis

* Only asked of those trans and non-binary participants

Qualitative findings: Factors that positively impacted mental health

A high number of participants (n=1,168) responded to the open question that asked if there were other things that positively impacted on participants' mental health in the past five years. While 52 participants noted that 'nothing' had positively impacted on their mental health, analysis of the other comments identified the following themes: (i) Supportive relationships; (ii) Awareness and acceptance; (iii) Engaging with health care; (iv) Societal and legislative changes; (v) Leaving unhelpful spaces; (vi) Being actively engaged; (vii) Having a sense of achievement; and (viii) Feeling physically and financially secure (see Figure 5.10).



Figure 5.10: *Factors that positively impacted mental health in the past five years*

Supportive relationships

Supportive relationships was the factor that people identified as most positively impacting their mental health. The types of relationships identified were with a variety of people, including the presence of a long-term romantic relationship, entering a new romantic relationship and getting married, while the support of friends was seen as most important.

"I met my current partner (who is a trans man) about four years ago. He is my absolute rock and I love him to the ends of the earth." (29, woman, transgender woman, questioning, ID 185)

"For me, friendships have been huge and especially queer friendships." (27, woman, bisexual, ID 400)

"Being surrounded by a supportive and loving partner, good solid friends, family support and security in my job where I am accepted and valued." (55, man, gay, ID 1081)

Having access to LGBTQI+/queer spaces and events and having the opportunity to become actively involved in the community through volunteering and activism, were viewed as hugely positive.

"Socialisation with others who are in the queer community, as well as others who share similar experiences re: trauma, pathology and neurodivergence. Most of this can be traced back to feeling less alone in my experience, less abnormal and more like I do belong somewhere. Community is key." (35, non-binary, queer, ID 1458)

Participants acknowledged the role of a supportive family, a supportive workplace or support from the local community to their mental health, as well as the positive impact of pets.

"Becoming a Church Warden in the Church, [they] were welcoming and accepting." (59, man, gay, ID 758)

"My husband and I adopted a pet, she saved my life." (51, man, gay, ID 762)

Awareness and acceptance

A growing self-awareness and acceptance of one's sexual and gender identity was identified as positive in terms of being able to have a positive sense of self, being able to articulate and have a language to describe oneself, and finding connection with people who shared a similar identity.

"Finally figuring out who I am and how to accurately describe myself, my gender, and my orientation." (38, non-binary, demisexual-panromantic, ID 1175)

"Realising that I am trans and that there are words for how I feel. It made me understand that there are many, many other people I can relate to and that I am not alone in my feelings." (14, man, transgender man, pansexual, ID 1521)

In this context, in particular viewing content that was LGBTQI+ inclusive on TV and media, was significant for some people's journey, as described in this quote:

"Seeing asexuality on 'Sex Education' on Netflix was the first time I could see someone that I could relate to and was going through the same struggles as myself... It led me to look into it and find communities of people online who were asexual, who I identified so strongly with. Seeing it wasn't just something wrong with me and was something others felt as well was honestly the best thing that ever happened to me." (25, man, asexual, ID 388)

Engaging with health care

Engaging with health professionals (including therapists and counsellors) who were supportive or in particular if the therapist was part of the LGBT community was highlighted by some as significant.

"Having and attending regular psychotherapy (not CBT) has been unbelievably helpful for me. Having a gay therapist who understands my lived experience has helped me massively." (No age given, man, gay, ID 2551)

Similarly, using self-help programmes, mindfulness and meditation practices were also identified as positive. The use of prescription medication was seen as helpful for a minority, with nineteen people singling out antidepressants specifically.

"Being prescribed proper medication for the treatment of my anxiety disorder." (26, non-binary, bisexual, ID 152)

Some people who identified as transgender, identified health interventions, such as transition surgery and commencing hormone treatment, as impacting positively. For others (n=26), finally getting a diagnosis of ASD (Autistic Spectrum Disorder) or ADHD (Attention Deficit Hyperactivity Disorder) helped in terms of putting their life experiences into context.

"Finally getting a diagnosis for ASD and ADHD. My mental health issues and feelings of not being normal were never related to my sexuality. I've always recognized LGBTQI+ as normal. It was more about me as a socially awkward person who couldn't think speak or communicate like others. I masked and made it 38 years but once my son got his diagnosis, I just knew I would be the same." (39, woman, pansexual, ID 341)

Societal and legislative changes

A positive shift in social attitudes meant that there was greater acceptance of LGBTQI+ identities in small communities, rural places and schools, and this helped with coming out and feeling like one had a place and a future in their communities. It was felt that this greater visibility helped to normalise LGBTQI+ identities. Similarly, a greater acceptance of people experiencing mental health issues was seen as helping some participants to feel more comfortable in addressing their mental health.

"I feel less stigmatised than I once did. More comfortable to speak about my mental health." (32, woman, bisexual, ID 1630)

"More people have started to come out even in rural areas, such as where I am originally from, and it has a huge impact on me knowing that LGBTQ people do actually exist in real life, everywhere, and that it's not a fantasy to think that I might have a life and a family of my own and even grow old. People need to see these things. They need to be normalised everywhere." (20, man, transgender man, queer, ID 740)

Legislative changes, such as being recognised as a parent and having the ability to legally change one's name impacted positively.

"The change to the Families Act allowing two mothers to be recognised as parents on a child's birth cert." (34, woman, gay, ID 195)

"Legally changing my name had a huge positive impact both from a gender and trauma perspective." (28, non-binary, bisexual, ID 147)

Leaving unhelpful spaces

For some people (n=121) what benefitted their mental health most was leaving unhelpful spaces or relationships. Examples of this included relocating to a different town, city or country or finding space away from family.

"Not keeping in contact with people family members and former friends that were toxic to my mental wellbeing and not hating them, just wishing them well on their journey." (48, man, gay, ID 792)

"Moving away from conservative area for the majority of the year." (21, non-binary, bisexual, ID 1173)

"Moving out of the city, relocating to Ireland from the UK." (49, man, gay, ID 2490)

"Moving into a safe place." (26, non-binary, queer, ID 219)

Changing career pathways (n=20) was also seen as beneficial, as was leaving or transferring to a different school (n=15). For others, it was the positive impact of (n=4) leaving or "turning off social media" (43, woman, bisexual, ID 2523).

"Getting out of my old career path and finding what I really want to do with my life had a huge positive impact." (28, woman, bisexual, ID 2286)

"Leaving secondary school and realizing that real life is not as homophobic as an all-boys secondary school makes you think it is." (23, non-binary, gay, ID 784)

Being actively engaged

Being active and engaged with activities focused on improving physical health, such as exercise, diet, and joining an LGBT sports club were frequently mentioned as helpful to people's mental health, as was being absorbed in hobbies such as gaming, music, reading, art, travel and taking holidays.

"Joined LGBTQI running club - exercise and socialising." (43, man, gay, ID 2358)

"Creating art. Art I believe is a fantastic outlet and to be able to create something reflective of my own experience as a bi trans man has been very therapeutic". (22, man, transgender man, bisexual, ID 701)

Having a sense of achievement

For some people passing exams, starting in/returning to college, graduating, beginning a new job, and getting a promotion, were all identified as achievements that boosted their self-esteem and positively impacted mental health.

"Personal achievements, e.g. completion of master's degree and 5k run for charity!" (44, man, gay, ID 1167)

Feeling physically and financially secure

This theme related to finding secure accommodation and achieving a state of having financial security. For most people finding 'my home' gave them independence and stability, especially in the context of the current housing and rental crisis. In addition, having access to supports, such as welfare entitlements, were also identified as positive.

"I have recently just found a new apartment after more than a year of searching. I love it and I have hope for the first time in a long time." (53, man, gay, ID 720)

"Having a stable and secure job that pays me above a living wage." (38, woman, bisexual, ID 850)

Comparison between LGBTIreland (2016) and Being LGBTQI+ in Ireland (2024)

One of the objectives of this study was to assess how LGBTI people's mental health has changed since the initial *LGBTIreland* report by comparing mental health outcomes (self-harm, suicidal behaviour, depression, anxiety, stress, and alcohol use) for both cohorts¹⁰. This section of the report addresses this objective.

Participants in 2016 reported a lifetime prevalence of 59.1%, 41.2% and 21.4% for serious suicidal thoughts, self-harm and suicide attempt respectively, whereas the lifetime prevalence for these measures were higher, at 64.4%, 50.6% and 26.2% in 2024 (Table 5.11). The lifetime prevalence of serious suicidal thoughts was 1.09 times higher in 2024 whereas the lifetime prevalence of self-harm and suicide attempt were each 1.23 times higher. These observed differences were largely explained by differences in the LGBTI identities and sociodemographic profile of the participants from the two studies. Little difference remained after taking these factors into account.

It was evident across a range of measures that a higher proportion of study participants had poorer mental health in 2024 compared to 2016. Severe or extremely severe symptoms of depression was affecting 20% in 2016 and 26.5% in 2024, a relative increase of 33%. There was a 48% increase in the prevalence of symptoms of severe/extremely severe anxiety, from 22.6% to 33.5%, and symptoms of severe/extremely severe stress, from 15.2% to 22.5%.

The poorer mental health of participants in 2024 was partly explained by how they differed from 2016 participants in terms of their sexual orientation, gender identity and sociodemographic profile. However, even after taking the influence of these factors into account, there was significant evidence of worsening mental health with a 17% higher prevalence of symptoms of severe/extremely severe depression, a 30% higher prevalence of symptoms of severe/extremely

¹⁰ In this analysis, the mental health for the 2024 sample of LGBTI people is reported, as this excludes some participants the percentages reported will vary slightly from the percentages reported earlier in respect of the mental health of the total sample of LGBTQI+ people for 2024.

severe anxiety, and a 33% higher prevalence of symptoms of severe/extremely severe stress.

In contrast, the prevalence of alcohol problems was very similar among participants in 2016, at 43.8%, and in 2024, at 42.0%. No difference was evident whether adjusting for the LGBTI identities and sociodemographic profile of the participants or not.

Table 5.11: *Lifetime prevalence of suicidal behaviour, point prevalence of symptoms of severe/extremely severe depression, anxiety and stress, and point prevalence of alcohol problems in 2016 and 2024*

	2016		2024		2024 vs. 2016	
	n/N	Prevalence (95% CI)	n/N	Prevalence (95% CI)	cPR (95% CI)	aPR (95% CI)
Seriously thought about taking your own life	1129/1910	59.1% (56.9-61.3%)	1408/2188	64.4% (62.3-66.4%)	1.09 (1.01-1.18)	1.03 (0.94-1.11)
Deliberately harmed yourself, not intending to take your life	794/1926	41.2% (39.0-43.5%)	1111/2196	50.6% (48.5-52.7%)	1.23 (1.12-1.34)	1.09 (0.99-1.20)
Made an attempt to take your life	407/1906	21.4% (19.5-23.3%)	551/2103	26.2% (24.3-28.1%)	1.23 (1.08-1.39)	1.08 (0.94-1.23)
Severe/extremely severe depression (DASS-42 score 21+)	372/1863	20.0% (18.2-21.9%)	582/2197	26.5% (24.7-28.4%)	1.33 (1.16-1.51)	1.17 (1.02-1.35)
Severe/extremely severe anxiety (DASS-42 score 15+)	425/1883	22.6% (20.7-24.5%)	738/2203	33.5% (31.5-35.5%)	1.48 (1.32-1.67)	1.30 (1.14-1.48)
Severe/extremely severe stress (DASS-42 score 26+)	283/1863	15.2% (13.6-16.9%)	498/2215	22.5% (20.8-24.3%)	1.48 (1.28-1.71)	1.33 (1.13-1.55)
Alcohol problems (AUDIT score 8+)	712/1626	43.8% (41.4-46.2%)	772/1836	42.0% (39.8-44.3%)	0.96 (0.87-1.06)	1.05 (0.94-1.17)

Note: Respectively, the questions on suicidal thoughts, self-harm, suicide attempt, depression, anxiety, stress, and alcohol problems, were unanswered by 5-12% of participants in 2016 and 6-16% of participants in 2024; CI=confidence interval; cPR=crude prevalence ratio comparing the prevalence in 2024 relative to 2016 without adjustment for the LGBTI identities and sociodemographic profile of the study participants; aPR=adjusted prevalence ratio comparing the prevalence in 2024 relative to 2016 with adjustment for the LGBTI identities and sociodemographic profile of the study participants.

Comparative analysis of the mental health outcomes among young people in Being LGBTQI+ in Ireland compared to My World Survey 2

The National Study of Youth Mental Health in Ireland, titled the *My World Survey 2* (MWS-2) (Dooley et al. 2019), containing responses from over 19,000 young people aged between 12-25 years of age, provides a valuable source of comparison in relation to youth mental health in Ireland (Dooley et al. 2019). Like this study, *My World Survey 2* uses the depression and anxiety scales from the DASS measure, as well as similar questions on self-harm, suicidal thoughts and suicide attempt.

While there is a slight variation in the age categories, a comparison indicated that the rates of symptoms of severe/extremely severe depression and anxiety among 14-18-year-olds in this study were approximately three times higher compared to 12-19-year-olds in *My World Survey 2* (49.7% vs. 15% & 65.9% vs. 22% respectively), while the rates of symptoms of severe/extremely severe depression and anxiety were approximately 1.5 times higher among 19-25-year-olds in this study compared to 18-25-year-olds in *My World Survey 2* (35% vs. 23% & 46.7% vs. 28% respectively). The rates of self-harm, suicidal thoughts and suicide attempt were also much higher in young LGBTQI+ people in this study (14-18: 71.6%, 76.5%, 32.6%; 19-25: 65.1%, 74.5%, 32.5% respectively) compared to adolescents (23%, 41% & 6% respectively) and young adults (38%, 63% & 10% respectively) in *My Word Survey 2* (Figure 5.11).

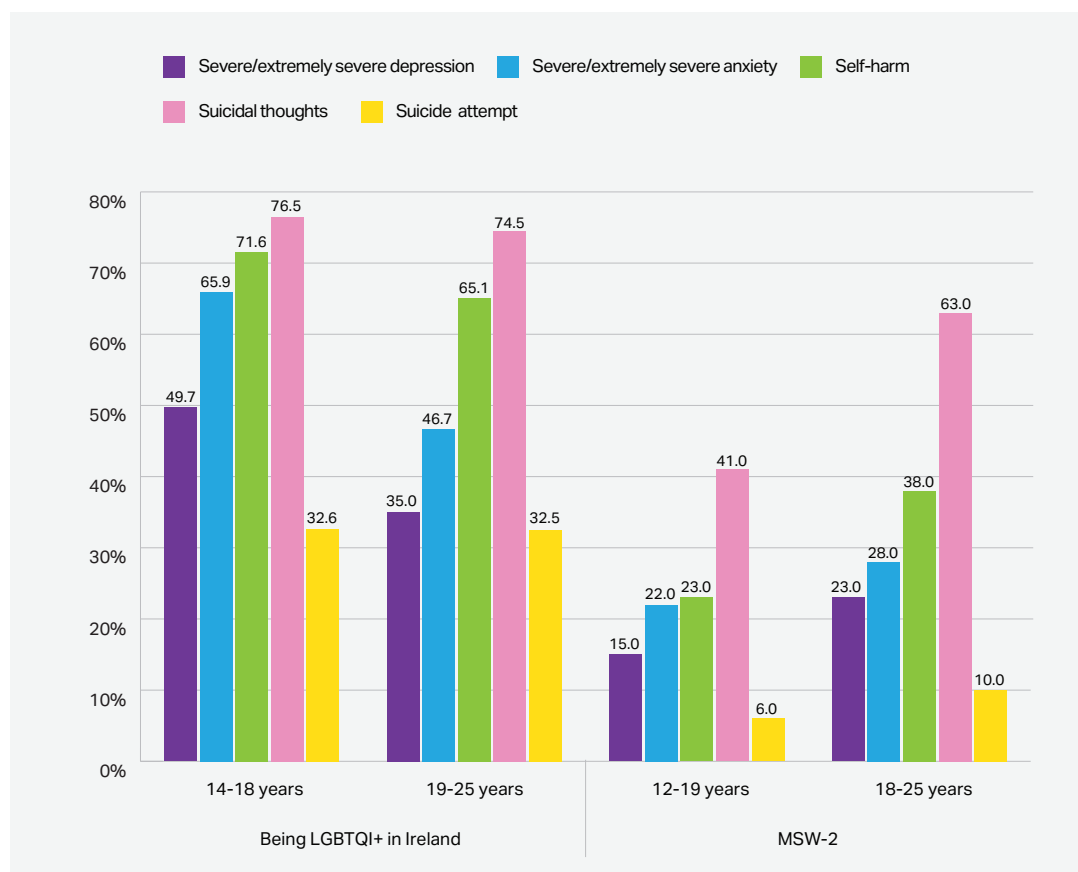


Figure 5.11: Mental health outcomes among young people in Being LGBTQI+ in Ireland compared to MWS-2

Summary of findings and discussion

Between two-fifths and one half of participants scored outside the normal/mild range for depression, anxiety, and stress, with one fifth to one third of participants reporting severe or extremely severe symptoms on all three mental health difficulties. Lifetime prevalence of self-harm, suicidal thoughts and suicide attempt was high at 52%, 65% and 26% respectively. Approximately half of those who had self-harmed had done so in the last year and approximately half of those who had suicidal thoughts had them in the last year. Two-fifths of participants reached the threshold for having a possible eating disorder, as indicated by SCOFF. In total, 22% of the sample reported never drinking alcohol. Of those who reported drinking alcohol, one third of the sample scored within the moderate category of AUDIT, with advice and information to reduce drinking behaviour recommended. Approximately 5% also had scores indicative of a high level of alcohol consumption, with brief counselling and continued assessment recommended and a further 5% had scores indicative of a need for further diagnostic assessment for alcohol dependence by a healthcare provider. Lifetime prevalence of drug use was 54% (non-medical use), with over half of those (57%) taking drugs within the last year. Less than 2% of people who used drugs in the previous year and were screened for drug abuse using the DAST-10 scored as being at no risk, with the majority scoring as being at low risk, with monitoring and reassessment at a later date recommended. However, the results indicated that there was a significant proportion, nearly one third, who scored at a moderate level, while nearly one tenth scored at a substantial/severe level.

One of the key objectives of this study was to assess changes in LGBTI people's mental health and wellbeing since the initial *LGBTIreland* report by comparing mental health outcomes for both cohorts. This assessment concluded that there is a significant increase in the proportion of participants who had scores that fell into the severe or extremely severe categories for depression (+17%), anxiety (+30%) and stress (+33%) in this study cohort compared to the *LGBTIreland* cohort, which could not be accounted for by any of the key demographic differences between the cohorts. The lifetime prevalence of self-harm, suicidal thoughts and suicide attempt didn't change significantly over the same period. Although the rates were slightly higher in this study (+9%, +3% & + 8% respectively), these differences could be attributed to differences in the gender identity, sexual orientation and sociodemographic profile of the participants from the two studies. Overall, the comparative results show that on some indicators of mental health there has been a deterioration, while on others there has been little change in either a positive or negative direction.

Although the rates of self-harm, suicidal thoughts and suicide attempt didn't change significantly since 2016, they are nonetheless comparatively higher than the general population of Ireland. A recent nationally representative survey of over one thousand adults living in Ireland found much lower rates (13%, 30% and 11% respectively), which they found didn't change significantly in the early period of the COVID-19 pandemic (May-Aug 2020) (Hyland et al. 2022).

Rates are also much higher among young people in this study compared to the general youth population in Ireland. As detailed in the findings section, the rates of symptoms of severe/extremely severe depression and anxiety as well as the lifetime prevalence of self-harm, suicidal thoughts and suicide attempt among the younger cohorts of LGBTQI+ participants are much higher compared to the rates among young people in the *My World Survey 2* (Dooley et al. 2019). The self-harm rate for young people in this study is also higher in comparison to international studies, which find prevalence rates of between one-fifth and one-third for non-suicidal self-injury in non-clinical adolescent populations (McMahon et al. 2022). When compared to heterosexual peers, both Irish and international studies find that LGBQ+ young people are more likely to experience symptoms indicative of severe depression and anxiety, and report more self-harming and suicidal behaviours (Dooley et al. 2019, Centers for Disease Control and Prevention, 2023).

One consistency between the last study and this one, is the greater prevalence of mental health difficulties amongst the youngest age cohorts compared to the older cohorts. International research on LGBTQ+ youth populations show similarly high levels. For example, the proportion of young people (14-25) in this study who reported symptoms of anxiety (79.2%) is comparable to the numbers who reported experiencing symptoms of anxiety (73%) in a large US national study of over 34,000 LGBTQ youth aged 13-24, although the figure for symptoms of depression is higher in this study (76.8% vs. 58%) (The Trevor Project, 2022). The figure for symptoms of depression however is similar to the large number of LGBQ+ students (70%) who reported persistent feelings of sadness or hopelessness (proxy for depression) in the Youth Risk Behaviour Survey conducted with high school students in the US (Centers for Disease Control and Prevention, 2023).

Consistent with other research, although less extensive, symptoms of depression and anxiety in this study were higher among people who identified as bisexual and the emerging sexual minority categories (i.e. pansexual, asexual, queer) compared to those who identified as lesbian or gay (Borgogna et al. 2019, Källström et al. 2022). A recent meta-analysis comparing asexual participants with heterosexual and LGB participants in terms of common mental health problems found that asexual and bisexual participants had the greatest risk of higher levels of depressive symptoms (Xu et al. 2023). Another study which compared asexual and non-asexual sexual minority adolescents found poorer mental health among the former as well as higher internalised LGBTQ-phobia (McInroy et al. 2022). This finding highlights the potential adverse role of internal stressors on mental health. The higher symptoms of depression, anxiety and stress among asexual and bisexual participants in our study may also relate to stigmatisation and discrimination from within the LGBTQI+ communities towards these identities (Borgogna et al. 2019) and the invisibility and erasure of these identities caused by binary ideas of gender and sexual orientation (Hayfield, 2020), an issue which was identified in the previous chapter. In relation to suicidality, similar to the aforementioned meta-analysis on mental health

which found that risk for people who identify as asexual varies depending on the mental health outcome being examined, asexual participants in our study had a higher rate of self-harm than LGB participants, however, they had a slightly lower rate of suicidal thoughts compared to bisexual participants, and a lower rate of suicide attempt compared to bisexual and lesbian participants, whose rate was 6% and 2% higher respectively. This may suggest that while people who identify as asexual may encounter unique minority stressors related to stigma and prejudice towards asexuality, they also may be somewhat protected from discrimination due to their relative social invisibility compared to LGB people. This may go some way to explain their lower risks relative to LGB populations on certain mental health outcomes (Xu et al. 2023). Merging sexual identities for statistical purposes, which is often the case in studies involving emerging sexual identities (Borgogna et al. 2019), may disguise important insights in relation to these identities. Avoiding this where possible and more exploratory work in relation to whether minority stressors impact emerging identities in unique ways should be the focus of future research in this area.

The relatively higher rates of psychological distress and suicidality reported by transgender and gender non-conforming participants, who predominately identified as a sexual minority, compared to their cisgender sexual minority counterparts in this study is consistent with the higher rates found in other studies. For example, Borgogna et al. (2019) found that participants who identified as transgender/gender non-conforming in addition to a sexual orientation minority identity had significantly higher scores on measures of depression and anxiety compared with both cisgender heterosexuals and cisgender sexual minority individuals. Similarly, Srivastava et al. (2021) found that transgender and non-binary youth were at higher risk of suicide attempt and depression compared to their cisgender sexual minority peers. A noticeable difference between this study and the LGBTIreland 2016 study is the presence of 'gender dysphoria' coming through in the qualitative data when participants explained in what way their self-harm, suicidal thoughts or suicide attempt were related to their LGBTQI+ identity. This is to some degree accounted for by the higher number of transgender participants in this study. The findings with regard to LGBTQI+ related reasons for self-harm and suicidality underscore the relevance of Meyer's theory (2003) in so far as both internal stressors (discomfort, shame, confusion etc.) and external stressors (negative familial/ societal attitudes, fears of rejection, bullying, discrimination, homophobia, transphobia etc.) were both identified as contributing factors. In addition, not being able to envision a future and having a sense of hopelessness impacted negatively.

Two-fifths of participants in this study had a potential eating disorder, the proportion was even higher among TGNC participants compared to cisgender participants and among the emerging sexual identities, particularly pansexual and asexual, compared to LGB participants. The research evidence on disordered eating among sexual minorities is often conflicting and sexual minority subgroups are often merged for statistical purposes (O'Flynn et

al. 2023), therefore there is little data to compare emerging sexual minority identities to LGB groups in terms of prevalence and risk factors. In relation to TGNC individuals, a systematic review and meta-analysis of eating disorder symptomatology among transgender individuals concluded that there were higher levels of eating disorder symptomatology among transgender individuals compared with cisgender individuals. Among the included studies were two studies which also used the SCOFF measure with the same cut-off point as this study and found a positive screening of 28% among transgender participants in a clinical sample and 35% among transgender and non-binary participants in a community sample of students (Rasmussen et al. 2023). Another study of transgender and gender diverse (TGD) college students found positive SCOFF screen rates ranging from 34% to 39% among the various subgroups of TGD students (Simone et al. 2022). Body dissatisfaction related to body shape and outward gender appearance may increase the risk of disordered eating behaviours in transgender youth, who may strive to align their body image with their gender identity (Obarzanek and Munyan, 2020). Given the finding of a high level of potential eating disorder among TGNC participants, it is important that health professionals screen for ED symptomatology at the earliest opportunity and that they are fully competent to address any issues arising from body image concerns within a gender affirmative care model (Cusack et al. 2022, McGregor et al. 2023). The high rates of potential eating disorder in the youngest participants appear to be much higher compared to general youth population studies which also used the SCOFF measure. While not directly comparable, a representative sample of 11-19-year-olds in Northern Ireland found that 16% of the sample met the SCOFF screening criteria for disordered eating (Nolan et al. 2023), much lower than the 60% found for 14-18-year-olds in this study.

In relation to alcohol use, while 22% of participants never drank, 42% of participants who drank had AUDIT scores of 8 or more which may indicate hazardous and harmful alcohol use, as well as possible alcohol dependence. A similar proportion was reported in the *LGBTIreland* study, with comparative analysis showing that there was no significant change. Cisgender and gay men scored the highest on the AUDIT screening tool of all the gender and sexual minority subgroups. Problematic alcohol use is common among gay and bisexual men as shown in a recent Irish study wherein as many as 27% of gay and bisexual men screened positive for alcohol use disorder (Witzel et al. 2022), and another study wherein 31% of men who had sex with men (MSM) screened positive, with bisexual men more likely to screen positive compared to gay men (Daly et al. 2021). Unlike this study, both studies used CAGE-4 as a screening tool, therefore while the prevalence rates are not directly comparable, together the findings highlight gay and bisexual men in particular as requiring targeted interventions.

Just over half of participants in this study reported ever having taken drugs, other than those required for medical purposes (54%). The 2019–20 Irish National Drug and Alcohol Survey reported a lower prevalence of drug use (23%) (Mongan et al. 2021), however, this was for illegal drug use, whereas our study asked about non-medical drug use, which would include prescription and

over-the-counter (OTC) drugs in addition to illegal drugs. Like the European Web Survey on Drugs Irish Findings and the 2019-2020 Irish National Drug and Alcohol Survey 2019-2020 (Mongan et al. 2021), cannabis was the drug most commonly used in the last year, while cocaine featured in the top three in both our study and the two aforementioned studies. Cocaine use in Ireland has increased rapidly over the last number of years, with users perceiving that it is very easy to access (Mongan et al. 2021) and more recent data suggesting that it is now the most common problem drug in Ireland (O'Neill et al. 2023). Young people and LGBTQI+ people have been recognised as groups that may be more likely to use illegal drugs and/or to binge drink and as such have been identified for targeted interventions by the drug and alcohol reduction policy in Ireland (Department of Health, 2017). These interventions are centred on increased awareness of the harmful effect of drug and alcohol use through education and by improving access to specialist services for LGBTQI+ groups in particular. However, availability of data presents a challenge in terms of assessing the impact of some of these initiatives (Bruton et al. 2021).

With nearly half of the LGBTQI+ participants in this study reporting that their mental health had worsened since the start of the COVID-19 pandemic, it implies that the effects of the COVID-19 pandemic continued to reverberate even though this study was conducted in what might be considered the post-pandemic period. Some international studies provide some evidence for deterioration in mental health among LGBTQI+ populations during the COVID-19 period. A systematic review and meta-analysis of mental health symptoms pre and post pandemic found that depression had worsened for sexual and gender minorities, although general mental health and anxiety were found to be relatively stable (Sun et al. 2023). Similar to this survey, more than half of 34,000 LGBTQ youth aged 13-24 across the United States reported that their mental health was poor most of the time or always due to the COVID-19 pandemic while the same survey found that rates of suicidal thoughts and anxiety symptoms increased between 2020 and 2022, although the rate of suicide attempts remained stable while depression rose in 2021 but decreased in 2022 (The Trevor Project, 2022). While we can't quantify any changes or impacts on mental health related to the pandemic in this study, it is likely that the isolation, loneliness, decreased social support and interactions, and an increased sense of anxiety and depression reported by LGBTQI+ participants in this study and other Irish studies (LGBT Ireland, NXF and GCN, 2020, Belong To Youth Services, 2021) adversely affected participants' mental wellbeing in the short-term and maybe even in the medium or longer-term. Indeed, some participants cited challenges associated with the end of COVID-19 restrictions and the readjustment period thereafter, including having to relearn social skills and deal with the loss of confidence and increased anxiety wrought by COVID-19. While some who experienced worse mental health since the pandemic may gradually recover, others may experience chronic dysfunction, depending on how much it affected individuals or groups, and the responses and adaptations at an interpersonal, community and country levels (Lindert et al. 2021). Given that the LGBTQI+ community has been disproportionately affected by the pandemic (Hunt et al. 2021, McGowan et al. 2021, Mitchell et al. 2022), targeted measures

to support mental health are needed in the immediate aftermath while longer-term data on mental health is also required to better understand the impacts and shape ongoing and long-term responses (McDaid, 2021).

The main factors that people identified as having a positive impact on their mental health were recent legislative changes, such as the Marriage Equality Act and the Gender Recognition Act. For transgender participants, transitioning socially, legally or medically was identified by the majority (90%) as having a positive impact on their mental health, which is in line with the literature on transgender and non-binary children who had socially transitioned (Durwood et al. 2017, Olson et al. 2016), adolescents and young adults who had medically transitioned (puberty blockers/gender affirming hormones) (Tordoff et al. 2022) as well as transgender people who had gender-affirming surgeries (Bränström and Pachankis, 2020). The positive impact on LGBTQI+ people's mental health of LGBTQI+ media cannot be underestimated, both in terms of LGBTQI+ representation (90.7%) as well as through engaging with these forms of media (87.4%). Social media use has been found to be both a protective and risk factor for depression in LGB people (Escobar-Viera et al. 2018).

While participants highlighted the positive impact of connection to the LGBTQI+ communities in terms of making friends, joining groups, visiting spaces, coming out to friends and family, for 17% of participants coming out to family had a negative impact on their mental health. Given how crucial the family environment is in terms of a young persons' adjustment and wellbeing, and the importance of parental support to positive adjustment for LGBT adolescents (Mills-Koonce et al. 2018, Zavala and Waters 2021), the provision of support to both parents and young people as they both navigate the coming out process is critical. It is also important from a policy perspective to consider the range of supports a young person experiencing parental rejection of their identity may require.

In conclusion, high levels of mental health difficulties were found in the study, similar to other studies of LGBTQI+ populations but comparably higher to general population studies. In general, the highest levels of difficulties were found among TGNC participants, young participants and among emerging sexual identity participants, particularly pansexual and asexual participants. With over half of 14–18-year-olds identifying as TGNC, the mental health needs of and supports for this group of young people in particular needs addressing. The results relating to younger cohorts in this study combined with a trend of deteriorating mental health among young people which has been observed both nationally and internationally (Dooley et al. 2019, McMahan et al. 2022, Centers for Disease Control and Prevention, 2023), shows that mental health among young cohorts of LGBTQI+ people should continue to be of particular concern. Given the dearth of research on emerging sexual identities, there is scope to expand our understanding of the risks and protective factors which impact their mental health in future research endeavours. While self-reported symptoms of severe/extremely severe depression, anxiety and stress have increased since the 2016 study, suicidality measures showed no significant change, suggesting that overall mental health in the LGBTQI+ population has not improved significantly in the intervening period.

Chapter 6: Being LGBTQI+ in School

Introduction

Secondary school and the last years of primary school coincide with adolescence, a critical period of transition from childhood to young adulthood. During this transition significant physical, cognitive, social, emotional, and sexual changes occur (World Health Organization, 2017). Hormonal changes and the onset of puberty introduce adolescents to new sensations and emotions, including concerns about body image. It is also a time of awareness of sexual and gender identity, with 12 being the age at which adolescents most commonly realise their LGBTI identity (Higgins et al. 2016). Feeling at home and supported in school is important to the mental health and wellbeing and ultimately the potential to thrive among LGBTQI+ young people.

While it is important not to allow a victimizing narrative to dominate when discussing the wellbeing of LGBTQI+ young people, it should be noted that findings from several studies suggest identifying as LGBTQI+ is associated with minority stress and adverse mental health outcomes in adolescents (Költő et al. 2021, McDermott et al. 2018, World Health Organization, 2020), which may be compounded by adverse experiences, such as bullying and social exclusion from peers (Költő et al. 2021).

Given that adolescents spend a substantial amount of their time at school, the climate and culture of the school has an important role to play in enhancing mental health and wellbeing and supporting them to reach their full potential. It is recognised in Irish policy that 'young LGBTI+ people can flourish when they have consistently positive interactions with those around them and supportive experiences in the services with which they most engage' (DCYA, 2018, p. IV). In schools when young people feel supported and included they are less likely to miss school because of safety concerns and more likely to complete the leaving certificate and finish post-primary school (Pizmony-Levy and Belong To, 2019). It has also been suggested that LGBTQI+ mental health and suicide inequalities could be reduced if schools introduce both universal interventions to tackle bullying and discrimination alongside targeted support interventions for LGBTQI+ students (McDermott et al. 2018).

Findings from the 2016 *LGBTIreland* report suggested that many LGBTI young people did not feel safe, supported, or welcome in schools. Only one in five participants felt they completely belonged and less than half indicated that their LGBTI identity was positively affirmed within the school. Almost half of the participants (48%) had experienced LGBTI bullying and over two-thirds (67.3%) had witnessed other LGBTI people being bullied, with 24% reporting that they had missed or skipped school due to negative treatment. When asked about the one thing they would do to improve their school the most for LGBTI students, the most common answers focused on the creation of safe spaces (34%), where

bullying was addressed and where it was safe to be out, be themselves, and have support from LGBTI peers and allies.

Since the publication of the *LGBTIreland* study a considerable amount of practice and policy work has been undertaken to protect and support LGBTIQ+ young people in Irish schools. In 2016, GLEN published *Being LGBT In School A Resource for Post-Primary Schools to Prevent Homophobic and Transphobic Bullying and Support LGBT Students* (GLEN, 2016). Community organisations, such as Belong To, TENI and ShoutOut have also continued to tirelessly advocate for LGBTIQ+ young people and campaign for change, delivering capacity building workshops to staff and providing education to young people. In the context of policy, the *LGBTI+ National Youth Strategy* (2018-2020), the first *LGBTI+ National Youth Strategy* in the world, was published in 2018 (Department of Children and Youth Affairs, 2018). This three-year action-orientated strategy proposed actions specific to creating a more supportive and inclusive environment for LGBTI+ young people in formal education settings. This included a whole school policy on LGBTI+ inclusion, professional development for teachers, evaluation of SPHE/RSE curriculum, development of peer support models for LGBTI+ students and allies in post-primary schools, and development of an inclusion policy template with an emphasis on transgender and intersex students for use in further education and training provision services (Department of Children and Youth Affairs, 2018). While this strategy was being developed the Department of Education and Skills commissioned the National Council for Curriculum and Assessment (NCCA) to undertake a major review of Relationships and Sexuality Education (RSE) (National Council for Curriculum and Assessment, 2019). The report concluded that the implementation of the SPHE/RSE in schools has significant issues, including the teaching of LGBTQ+ matters, and made several recommendations for improvement. In December 2022, the Department of Education published *Cineáltas: Action Plan on Bullying*. It is a whole-education, rights-based approach to preventing and addressing bullying in schools and provides a collective vision for how school and society can work together to prevent and address bullying. The overarching goal of this plan is to 'ensure that there is zero tolerance of bullying in Irish schools and that schools are places where every single child and young person feels welcomed, valued and understood' (Department of Education, 2022, p 4). An Implementation Plan for *Cineáltas* was published in April 2023 and commits to implementing each of the 61 actions contained in *Cineáltas* within a 5 year period.

Given the many policy and practice actions since the publication of *LGBTIreland*, including the *Wellbeing Policy and Statement for Practice 2018-2025* which also promotes inclusion, it is timely to explore if these actions have impacted the lives of LGBTIQ+ young people in schools, hence the focus of this chapter is on participants' school experience. First the quantitative findings are presented, and this is followed by the qualitative response to the question on how school can be improved for LGBTIQ+ students.

Similar to the 2016 report, almost 40% of the participants (36.6%; n=1025) were currently enrolled in secondary school in the Republic of Ireland or had attended school in the Republic of Ireland within the past five years. This cohort was asked a series of questions about their outness in school, the LGBTQI+ friendliness of school, their sense of belonging, LGBT bullying, and experiences of inclusion, visibility, support and safety within school.

Outness in school

To get a sense of to what degree people were 'out' about their LGBTQI+ identity in school, participants were asked to estimate what percentage of people (staff and students) in the school were aware of their identity. Participants reported awareness among an average of 40% (M=39.5, N=968, SD=31.7) of people.

LGBTQI+ friendly rating

In terms of LGBTQI+ friendliness, the average rating given was 4.79 (SD=2.6, N=1024, Range=0-10, Median=5), just below the midpoint of 5 on the scale of 0 to 10 (0= 'not at all friendly'; 10= 'extremely friendly'). The lowest rating was given by TGNC participants, statistically significantly lower than both cisgender men and women. Although there was no statistically significant differences in the rating according to sexual orientation, those who identified as queer gave the lowest rating while those identifying as LGB and asexual gave similar ratings ranging between 4.89-5.03 (Figure 6.1).

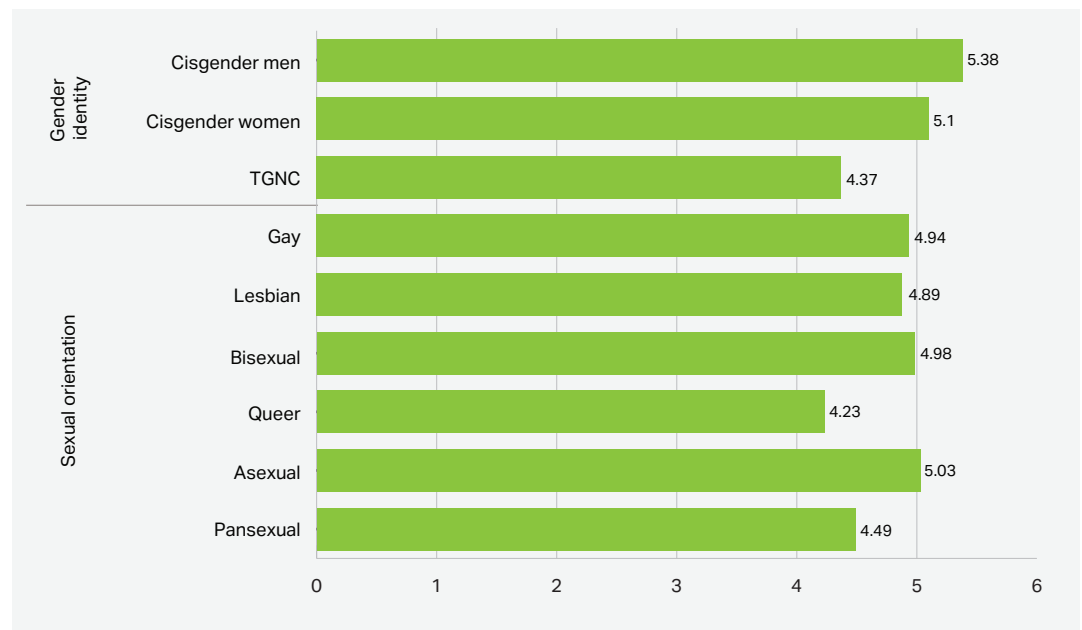


Figure 6.1: LGBTQI+ friendly rating by gender identity and sexual orientation

Sense of belonging

In terms of belonging, a fifth of participants reported that they felt they 'completely' belonged (19.2%, n=197) in their school as an LGBTQI+ person, half (49.8%, n=510) reported that they felt they 'somewhat' belonged and just under one third (31%, n=317) felt that they didn't belong at all. A significantly greater sense of not belonging in school was reported by TGNC participants at 43%, double that reported by cisgender men and women. In terms of sexual orientation, queer, pansexual and gay participants reported the highest levels of 'not belonging at all' at approximately 40%. This compared with around a quarter of lesbians and bisexual participants who reported that they didn't belong at all, and around a third (31%) of asexual participants who reported the same. These differences did not reach the level of statistical significance (Figure 6.2).

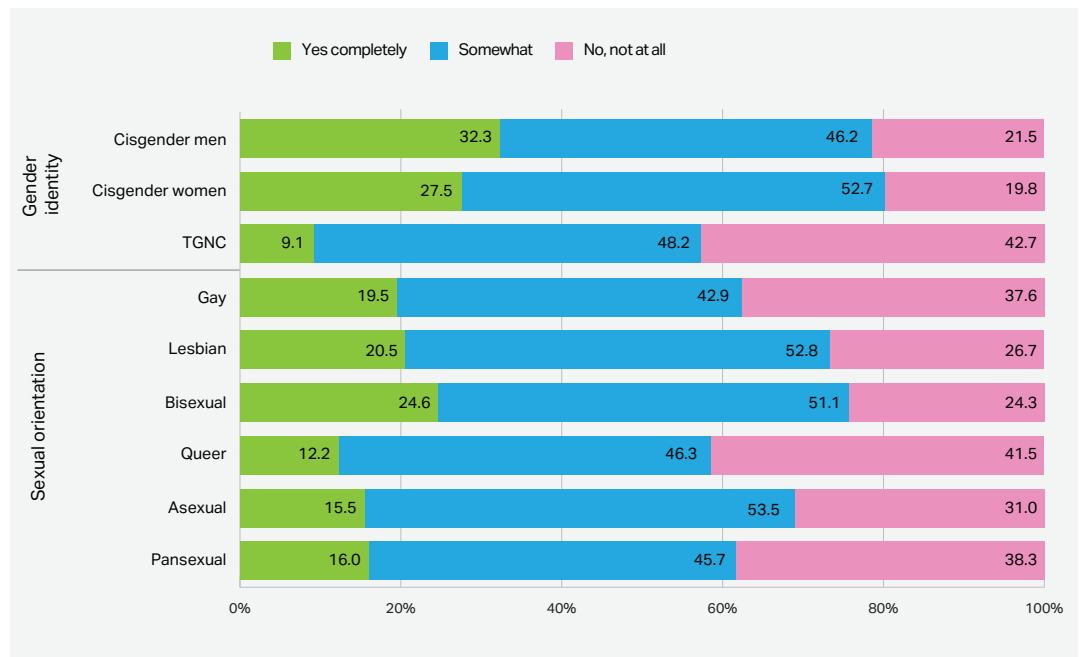


Figure 6.2: Sense of belonging in school by gender identity and sexual orientation

Bullying in school

Just under half (48.7%, n=498) of participants reported experiencing homophobic, biphobic or transphobic bullying in school. Just over three quarters (78.6%, n=805) reported witnessing such bullying. Around one quarter (26%, n=266) reported that they had missed or skipped school to avoid such bullying. Although 32% (n=326) reported that they thought about leaving, 6.5% (n=66) reported that they had left school early due to negative treatment. TGNC participants were more likely to have experienced LGBT bullying, missing or skipping school due to bullying, and leaving or thinking about leaving school early compared to cisgender men and women. In relation to sexual orientation, there were no statistically significant differences in witnessing bullying and leaving school early. However, gay and queer identified participants reported higher levels of experiencing LGBT bullying (58% & 64% respectively) compared

to other sexual orientation groups, with lesbian and pansexual participants reporting the next highest level at approximately 49%. Similarly, gay and queer participants reported higher levels of missing or skipping school (37% & 33% respectively) followed closely by pansexual participants at 31% (Table 6.1).

Table 6.1: Bullying and early school leaving by gender identity and sexual orientation

Characteristic	Category	Experienced homophobic, biphobic or transphobic bullying in school	Witnessed homophobic, biphobic or transphobic bullying of other LGBTQI+ people in school	Missed or skipped school or school events to avoid negative treatment?	Left school early as a result of negative treatment	Thought about leaving but remained/
Gender identity	Cis men	39.2%	72.8%	18.4%	4.4%	21.5%
	Cis women	35.8%	76.4%	14.0%	3.3%	21.5%
	TGNC	61.3%	82.0%	37.7%	9.5%	42.9%
Sexual orientation	Gay	57.9%	77.4%	36.8%	8.3%	31.6%
	Lesbian	49.0%	78.4%	21.1%	4.1%	31.4%
	Bisexual	39.7%	79.0%	18.0%	5.9%	24.6%
	Queer	64.2%	87.0%	32.5%	6.5%	34.1%
	Asexual	35.2%	71.8%	22.5%	7.0%	35.2%
	Pansexual	48.9%	73.4%	30.9%	7.4%	42.6%

LGBT bullying and wellbeing and mental health outcomes

We examined how LGBT bullying related to the wellbeing, mental health and substance abuse indicators in the study. Those who had experienced LGBT bullying in school had statistically significant higher mean scores for symptoms of depression [t(950)= 5.286, p<.001], anxiety [t(945)= 6.837, p<.001] and stress [t(944)= 6.305, p<.001], and lower happiness [t(975)= -5.808, p<.001], self-esteem [t(1005)= -4.692, p<.001], resilience [t(1018.821)=-4.922, p<.001] and gender identity comfort [t(1019)= -5.767, p<.001] scores compared to those who hadn't experienced LGBT bullying. There were no statistically significant differences in relation to alcohol use as measured by AUDIT [t(581.350)= 1.751, p>.001], drug use as measured by DAST-10 [t(258.177)=2.527, p>.001] or sexual orientation comfort [t(1020)=0.440, p>.001] (Table 6.2). In relation to potential eating disorder as measured by SCOFF, those with experience of bullying had a higher rate (65.0%) than those without (45.9%) [x2(1)=33.863, p<.001].

Table 6.2: LGBT bullying and wellbeing and mental health outcomes

Measure	Experienced homophobic, biphobic or transphobic bullying within school	N	Mean	SD
Happiness	Yes	478	4.83	2.1
	No	499	5.60	2.0
Rosenberg Self-Esteem Scale	Yes	492	22.44	5.7
	No	515	24.20	6.2
Brief Resilience Scale	Yes	498	2.46	0.8
	No	523	2.72	0.8
Gender identity comfort	Yes	498	6.87	2.2
	No	523	7.68	2.2
Sexual orientation comfort	Yes	498	7.53	2.0
	No	524	7.47	2.2
Depression subscale of DASS-42	Yes	465	21.88	11.7
	No	487	17.84	11.9
Anxiety subscale of DASS-42	Yes	467	21.02	11.1
	No	480	16.04	11.4
Stress subscale of DASS-42	Yes	464	23.22	9.7
	No	482	19.18	10.1
AUDIT	Yes	304	7.85	6.6
	No	325	7.02	5.3
DAST-10	Yes	141	2.85	2.2
	No	123	2.24	1.7

There were statistically significant higher rates of self-harm, suicidal thoughts and suicide attempts among those who had experienced homophobic, biphobic or transphobic bullying compared to those who hadn't [$\chi^2(1)=30.666, p<.001$; $\chi^2(1)=38.037, p<.001$; $\chi^2(1)=55.222, p<.001$] (Figure 6.3).

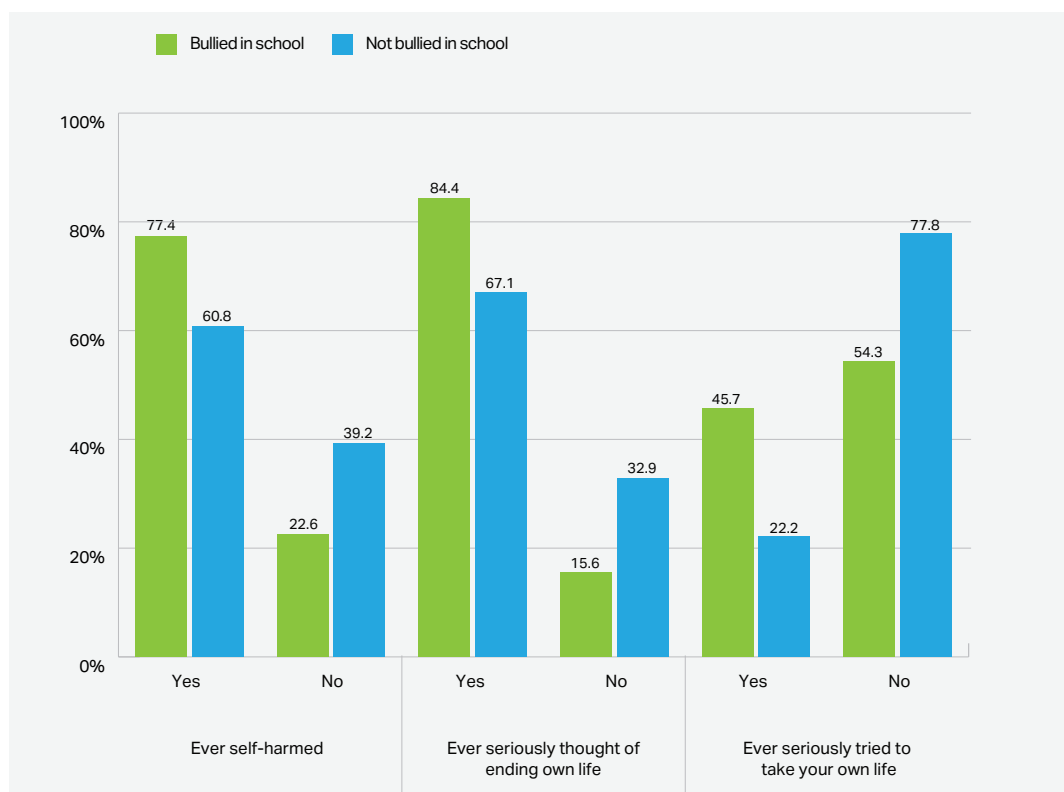


Figure 6.3: Rates of self-harm and suicidal thoughts/attempts for those with/without bullying experience

Comparison between LGBTIreland (2016) and Being LGBTQI+ in Ireland (2024)

The proportion who regarded school as 'LGBTQI+-unfriendly' (score of 4 or less) was unchanged at 47.3% between 2016 and 2024 (Table 6.3).

Table 6.3: School rated as 'LGBTQI+ unfriendly' among current/recent school-goers in 2016 and 2024

	2016		2024		2024 vs. 2016	
	n/N	Prevalence (95% CI)	n/N	Prevalence (95% CI)	cPR (95% CI)	aPR (95% CI)
School is/was 'LGBTQI+-unfriendly'	380/803	47.3% (43.8-50.8%)	396/838	47.3% (43.8-50.7%)	1.00 (0.87-1.15)	0.99 (0.84-1.15)

Note: CI=confidence interval. cPR=crude prevalence ratio comparing the prevalence in 2024 relative to 2016 without adjustment for the sexual orientation, gender identity, age and ethnic profile of the study participants; aPR=adjusted prevalence ratio comparing the prevalence in 2024 relative to 2016 with adjustment for the sexual orientation, gender identity, age and ethnic profile of the study participants

In 2016, approximately 28% of the participants selected 'not at all' to describe the extent to which they felt they belonged in their school compared to 32% in 2024. Although a slight rise of 4%, this was not found to be significant when the sexual orientation, gender identity, age and ethnic profile of the study participants were adjusted for (Table 6.4).

Table 6.4: Belonging among current/recent school-goers in 2016 and 2024

	2016		2024		2024 vs. 2016	
	n/N	Prevalence (95% CI)	n/N	Prevalence (95% CI)	cPR (95% CI)	aPR (95% CI)
Felt that they 'not at all' belong(ed) in their school	222/800	27.8% (24.7-31.0%)	272/839	32.4% (29.3-35.7%)	1.17 (0.98-1.39)	1.07 (0.87-1.30)

Note: CI=confidence interval. cPR=crude prevalence ratio comparing the prevalence in 2024 relative to 2016 without adjustment for the LGBTI identities, age and ethnic profile of the study participants; aPR=adjusted prevalence ratio comparing the prevalence in 2024 relative to 2016 with adjustment for the sexual orientation, gender identity, age and ethnic profile of the study participants.

The proportion of participants who reported having witnessed homophobic, biphobic or transphobic bullying of other LGBTQI+ people, increased 12% from two thirds in 2016 (67.3%) to almost 79% in 2024 and this increase remained significant after adjusting for differences in participant profiles (Risk Ratio 1.19). The proportion who thought about leaving school or actually did leave school early increased from 27.9% in 2016 to 40.7% while actually leaving school early due to negative treatment increased from 4.3% to 6.7%. These increases remained significant after adjusting for differences in participant profiles (Risk Ratio 1.24, Risk Ratio 1.49 respectively) (Table 6.5). While some changes were

noted in the proportion of people who missed or skipped school to avoid negative treatment or who personally experienced homophobic, biphobic or transphobic bullying between this and the 2016 survey, these changes were not significant when adjusted for differences in the demographic profile of both groups.

Table 6.5: Lifetime prevalence of school problems among current/recent school-goers in 2016 and 2024

	2016		2024		2024 vs. 2016	
	n/N	Prevalence (95% CI)	n/N	Prevalence (95% CI)	cPR (95% CI)	aPR (95% CI)
Witnessed homo/bi/transphobic bullying of other LGBTQI+ people	536/797	67.3% (63.9-70.5%)	660/838	78.8% (75.8-81.5%)	1.17 (1.04-1.31)	1.19 (1.05-1.35)
Experienced homophobic, biphobic or transphobic bullying	378/795	47.5% (44.0-51.1%)	418/838	49.9% (46.4-53.3%)	1.05 (0.91-1.21)	1.04 (0.89-1.21)
Missed or skipped school to avoid negative treatment	192/797	24.1% (21.2-27.2%)	235/838	28.0% (25.0-31.2%)	1.16 (0.96-1.41)	1.04 (0.89-1.29)
Thought of or did leave school early due to negative treatment	221/791	27.9% (24.8-31.2%)	341/838	40.7% (37.3-44.1%)	1.46 (1.23-1.73)	1.24 (1.02-1.50)
Did leave school early due to negative treatment	34/791	4.3% (3.0-6.0%)	56/838	6.7% (5.1-8.6%)	1.55 (1.02-2.38)	1.49 (0.92-2.43)

Note: CI=confidence interval. cPR=crude prevalence ratio comparing the prevalence in 2024 relative to 2016 without adjustment for the LGBTI identities, age and ethnic profile of the study participants; aPR=adjusted prevalence ratio comparing the prevalence in 2024 relative to 2016 with adjustment for LGBTI identities, age and ethnic profile of the study participants.

Note: Those who thought of leaving school early and those that did leave were combined for the purpose of analysis as these groups could be considered as having had a distressing time in school.

School experiences of inclusion, visibility, safety and support

In order to gauge what the school environment was like for LGBTQI+ students, a series of questions were asked around inclusion, visibility, safety, and support. Participants who identified as either trans or non-binary were asked four additional questions pertaining to the expression of their gender identity in school. The responses can be seen in Figure 6.4.

In terms of inclusion and visibility, the most positive response of all the items was that 60% of participants reported the presence of posters and activities related to Pride or Stand-Up Awareness Week against LGBTI+ bullying.

Regarding the school curriculum, around two-fifths (43.8%) reported that gender and sexual diversity wasn't addressed in Social, Personal and Health Education (SPHE), and similar numbers disagreed with the statement that there 'are/were positive statements and representations of LGBTQI+ people within the curriculum' (41.4%).

Regarding safety, nearly half (47.5%) reported avoiding certain spaces, such as bathrooms or locker rooms, due to feeling unsafe. A third (33.5%) disagreed with the statement that their 'school is/was a safe place for LGBTQI+ students', while 62% reported that LGBT bullying was not actively addressed within their school.

In terms of support, few schools appeared to have resources (e.g. LGBTQI+ support groups/LGBT champion) (15.1%), or supportive spaces for LGBTQI+ students (27.9%). Few schools appeared to have openly LGBTQI+ identifying teachers (23.2%), while less than one third (29.3%) perceived that their teachers were informed about LGBTQI+ identities.

Over half of trans and non-binary people reported that they were not addressed by their correct name and pronoun(s) in school (56.4%). Three quarters (74.6%) reported not having access to gender-neutral bathrooms and facilities. Although 42% reported that they were able to wear clothing that aligned with their gender identity, over two-fifths indicated that this was not the case (46%). In response to the statement whether teachers supported their wishes in relation to their gender identity, 24% reported that they were supported, approximately two-fifths reported that that they were not supported, and over one third reported that they didn't know.

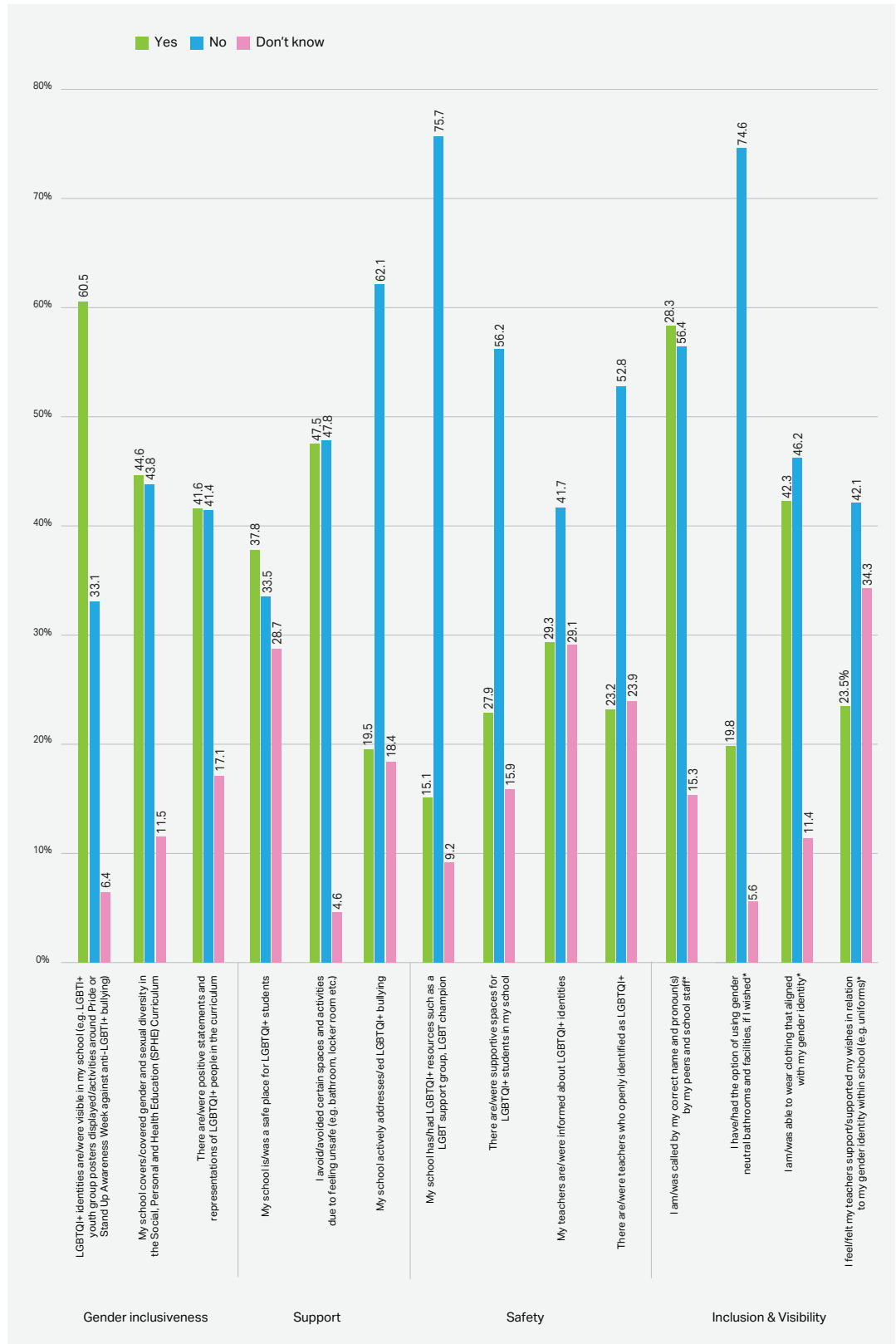


Figure 6.4: School experiences of inclusion, visibility, safety and support
 *Response option only displayed for participants identifying as non-binary or trans

Qualitative findings: One thing that could be done to improve school for LGBTQ+ students

Many of the participants (n=909) who responded to the open-ended question on one thing that could be done to improve your school offered more than one recommendation. Five recurring themes emerged from the responses: i) Safety and support; ii) Equality for LGBTQI+ students; iii) Education of staff and students; iv) Raising LGBTQI+ visibility; and iv) Removing religious influence (see Figure 6.5).



Figure 6.5: Participants' recommendations on improving school for LGBTQI+ students

Safety and support

Participants emphasised the need for schools to be a place where LGBTQI+ students feel safe and supported, often in strong terms. To this end, managing bullying and harassment toward the LGBTQI+ community was the most common suggestion. Participants provided examples of behaviour and attitudes towards LGBTQI+ students that they felt needed to change.

"Stop all the lads in school using 'fag', 'queer', 'gay', 'dyke' and 'lesbo' in a derogatory way. It's SO normalised in Ireland for teens and they say it so casually it's so disheartening." (17, woman, omniseual, ID 798)

Of the participants who wanted bullying and harassment addressed, some highlighted how bullying and harassment toward LGBTQI+ students is often ignored or not taken seriously and would like schools to do more.

"Taking the complaints of LGBTQI+ students seriously. My primary challenge was that when issues arose, they were not dealt with in an effective, timely, or decisive manner by my school, causing them to continue to even escalate. While most people were supportive across the board, the lack of action when things went wrong really negatively affected my experience." (22, man, transgender man, gay, ID 814)

The need for a much stricter stance against homophobic/transphobic bullying and harassment was also voiced. Several participants would like to see a zero-tolerance policy, with serious consequences for students who break the rules.

"Not tolerating homophobia & actually doing something about bullies, not just letting the bullies off with a 'slap on the wrist'." (17, woman, bisexual, ID 2503)

Most recommendations made were towards addressing the behaviour of students, however a small number of participants made suggestions specific to managing homophobic/transphobic behaviour from teachers.

"Fire or severely punish queerphobic teachers. Homophobia and transphobia amongst students isn't going to be addressed if the teachers don't care or actively encourage it." (18, woman, asexual and aromantic, ID 1908)

Participants wanted to see more support for LGBTQI+ students, with a small number indicating that it is needed and others suggesting ways the school could provide support. The most common suggestion was to provide groups where LGBTQI+ students can access support and socialise with others who have had similar experiences.

"I often feel like an outsider because of my sexuality, but talking to other members of the community would really help me be more open about my identity." (15, woman, lesbian, ID 647)

Participants also indicated that they would like school to be a place that affirms their identity and indicated how school can support them with this, even without parental consent.

"For trans students to retain a sense of confidentiality in school. If you told a teacher about your gender identity changing, they would tell your parents. I personally have a very transphobic father, and if this happened to me I would fear for my safety." (14, non-binary, asexual, ID 1536)

In supporting the affirmation of their identity, participants highlighted the importance of people using correct pronouns and calling people by their chosen name rather than their birth name, and for teachers to inquire about and respect their chosen pronouns.

"Asking ALL students pronouns!! It's so important and would have made me so much more comfortable." (16, non-binary, bisexual, ID 1526)

Participants also indicated that they would like access to supportive staff and that LGBTQI+ resources should be available. Access to safe spaces was important to several participants.

"Safe room (a room that you can go to if you want to avoid socialising during break or class due to bullying, mental health issues, etc.)" (16, man, transgender man, queer, ID 1478)

Equality for LGBTQI+ students

Participants wanted a school climate that 'normalises' being LGBTQI+, where they could feel welcome and included. Yet there are many aspects of school life where they felt excluded, different, or that created challenges. While some participants made generalised comments about accepting, normalising, and including LGBTQI+ identities, others responded with a specific need to stop exclusion based on gender. Suggestions were made for inclusive bathrooms and changing rooms, changes in uniform and dress code, not separating students based on gender, and the use of more inclusive language.

"There has to be a gender-neutral bathroom." (20, woman, transgender woman, questioning, ID 29)

"Having recently transferred from an unsupportive to a safer school environment, I think that ideally there would be an increase in mandatory gender-neutral bathrooms, as my previous school did not provide even one. That way students would at least have somewhere to go and be in peace without having to worry about others and their judgement." (17, non-binary, asexual, ID 1505)

"Not have schools label as a gendered school, just have it called a school, why should it be a gendered thing. It is a place of learning." (16, genderfluid, pansexual, ID 1405)

"I attend an all-girls school and we are often referred to as 'girls' by teachers. I think using something more gender neutral would be better." (16, woman, asexual, ID 1251)

"Removing gendered uniforms." (16, man, transgender man, bisexual, ID 1760)

The school curriculum was an area that needed to be more diverse and inclusive of LGBTQI+ content across all subjects, as well as normalising the conversation about LGBTQI+ people.

"Adding more queerness to the curriculum, not just SPHE but English, History and Science and other subjects." (22, man, asexual, ID 291)

The Social, Personal and Health Education programme (SPHE) was an area where participants felt more discussion about LGBTQI+ topics could be had, with emphasis being placed on the need for increased and improved sex education that is inclusive rather than cis-heteronormative.

Education of staff and students

Participants felt strongly that the school community as a whole (both staff and students) should be educated about LGBTQI+ identities. Some participants offered suggestions for particular topics that needed to be addressed. This included sexuality and gender identity, homophobia, transphobia, bullying, acceptance and inclusivity, and LGBTQI+ history.

"A set of classes that goes through LGBTQI+ subject matters and issues with a compassionate and engaging lens. Including emphasis on how being queer relates to the difficulties already faced by minorities." (19, woman, transgender woman, pansexual, ID 2167)

The importance of educating staff on LGBTQI+ identities, including equipping staff with the skills to facilitate conversation in a safe and informed manner within the classroom is highlighted by this participant.

"Educate the teachers. They taught us about LGBT topics, but were heavily misinformed. They made those classes dangerous and upsetting for us, they framed our existence as a debate or an open dialogue. They freely let anyone say anything awful they liked about LGBT people." (18, man, transgender man, bisexual, ID 2598)

Raising LGBTQI+ visibility

Participants indicated that the LGBTQI+ community should not be hidden away, there needs to be greater 'visibility,' 'recognition,' 'awareness' and 'representation' for LGBTQI+ students. Suggestions were offered for how the school could go about approaching this, with the most common suggestion being that discussions about LGBTQI+ topics should not be avoided, rather they need to be discussed more openly and more frequently.

"Make LGBTQI+ issues more commonly discussed outside of Stand Up Week, especially trans issues and trans identities." (17, man, gay, ID 387)

Some participants mentioned how they would like to be able to see more people, particularly teachers coming out or being open about their LGBTQI+ identity.

"Teachers being openly LGBTQ+ would be fantastic." (22, non-binary, pansexual, ID 49)

Participants would also like to see more celebrations and campaigns that raise awareness such as a Pride Day or week. A small number suggested that increased visibility could be achieved through the action of displaying flags or being part of activities, such as Stand-Up week.

"Have pride events such as diversity week specifically for the LGBTQ community to show students it's ok to be different." (23, non-binary, gay, ID 784)

"Let (openly and willing) LGBTI+ students take care of stand-up week and this topic in SPHE. It's not helpful when a cisgender straight person does so since they have no clue how lucky they are." (16, non-binary, bisexual, ID 1880)

Although many participants indicated a need to raise the profile of the LGBTQI+ community, there were a small number of participants who did not want 'a big deal' made out of being LGBTQI+.

“Stop making such a big deal about LGBTQ, it only makes people think they are different to everyone else.” (16, man, bisexual, ID 1703)

Remove religious influence

Some participants also wanted to see less religious influence in school, with suggestions ranging from less focus on religion, the removal of religion from the curriculum, the removal of church from management of the school, to the removal of all religion from the school.

“Religion is far too ingrained in Irish public schools. It has no business there, especially when certain religious ideologies openly threaten the safety and comfort of LGBTQI+ people.” (19, woman, bisexual, ID 1305)

Summary of findings and discussion

Overall findings suggest that school continues to be a challenge for many young LGBTQI+ students. The mean rating for LGBTQI+ school friendliness was below the midpoint of the scale used with about a third of participants reporting ‘not belonging at all’ in school. Just over three quarters reported witnessing homophobic, biphobic or transphobic bullying, while nearly half reported experiencing these forms of bullying. Just over one quarter reported that they had missed or skipped school to avoid bullying, with about one third reporting that they thought about leaving but remained. A small but notable percentage did leave school early due to negative treatment related to being LGBTQI+.

These issues impact TGNC participants most. They gave the lowest rating to LGBTQI+ school friendliness and reported the highest rates of not belonging, experiencing LGBT bullying, missing or skipping school due to bullying, and leaving or thinking about leaving school early. In relation to sexual orientation, participants who identified as queer gave the lowest rating to LGBTQI+ school friendliness and those who identified as queer, pansexual and gay reported the highest levels of ‘not belonging at all’.

The negative impact of school bullying is further highlighted in the findings, as those who had experienced LGBT bullying in school had statistically significant higher symptoms of depression, anxiety and stress, and lower happiness, self-esteem, resilience and gender identity comfort scores compared to those who hadn’t experienced LGBT bullying. There were no statistically significant differences in relation to alcohol use, drug use or sexual orientation comfort. There were also statistically significant higher rates of potential eating disorder, self-harm, suicidal thoughts and suicide attempts among those who had experienced LGBT bullying compared to those who had not.

When compared to the 2016 cohort (adjusted for differences in demographic profile) there was no difference in those who experienced homophobic, biphobic or transphobic bullying in school. However, the prevalence of witnessing this form of bullying increased. The number of participants thinking about leaving school early due to negative treatment and the proportion who actually left school early also increased significantly. Although avoiding school could be

potentially considered as an act of resilience by LGBTQI+ students as it is a means to keeping safe, it has negative consequences for school performance and completion (Atteberry-Ash et al. 2019). Early school leaving is not only associated with increased health issues and risk-taking behaviours such as getting arrested and using illicit substances (Lansford et al. 2016), but it also deprives young people of the educational capital needed to access a range of material and social resources in later life (Hutzell and Payne, 2018).

In terms of inclusion and visibility, displaying materials containing LGBTQI+ symbols such as rainbow posters can increase positive feelings and a sense of affiliation in LGBTQI+ young people within certain settings (Wolowic, 2017). Within Ireland, an approach to discouraging LGBTQI+ bullying that is gaining traction is Belong To's Stand Up Awareness Week. Introduced into schools in 2010, this campaign supports schools to celebrate and recognise LGBTQI+ communities. It is heartening to note in the current study 60% of participants reported the presence of posters and activities related to Pride or Stand-Up Awareness Week against anti-LGBTQI+ bullying. However, school continued to be perceived as an unsafe place, with nearly half of participants reporting that they avoided certain areas due to safety concerns and six out of every ten reporting that LGBTQI+ bullying was not actively addressed within their school. Few schools appeared to have resources (e.g. LGBTQI+ support groups/LGBT champion), or supportive spaces for LGBTQI+ students, including gender-neutral bathrooms and facilities, and an ability to wear clothing that aligned with their gender identity. Visibility and positive representation of LGBTQI+ identities within the curriculum continues to be an issue in some schools, as is the correct use of name and pronoun(s).

The suggestions for change emerging from the qualitative question related to schools were similar to the 2016 report, and were mostly related to safety, support and inclusion. Other suggestions encompassed including and normalising LGBTQI+ identities, students and staff being educated on LGBTQI+ identities and related topics and ensuring that LGBTQI+ communities in the school are not hidden away.

While it is not often perceived in this way, the treatment of youth who identify as LGBTQI+ is a human rights issue. According to the United Nations Convention on the Rights of the Child, ratified in Ireland in 1992, all young people have the right to learn and develop in a school that is safe and free from discrimination (Government of Ireland, 2022). Our findings show that this is not (yet) achieved in Ireland. Other recent studies into LGBTQI+ young people's experiences of Irish secondary schools (Fullerton et al. 2017, Pizmony-Levy and Belong To, 2019, Pizmony-Levy, 2022b) reach the same conclusion. Even more worrying is that there are signs that things are not getting better. In addition to our findings, other Irish studies reveal a slight increase in all LGBTQI+ students feeling unsafe at school, especially among those who identified as non-binary or transgender (Pizmony-Levy, 2022b). These findings are also in line with the findings of the McBride et al. (2020) study, in which participants reported experiencing direct prejudice from peers after transitioning, with bullying being experienced in

various spaces. These findings are not unique to the Irish context with similar findings reported in the UK, USA and Australia (Stonewall, 2017, Conron et al. 2022, Kosciw et al. 2022, Ullman, 2022).

In terms of mental health and wellbeing, those who had experienced LGBT bullying in school continue to report significantly higher symptoms of depression, anxiety, and stress, and lower happiness, self-esteem and resilience compared to those who hadn't experienced LGBT bullying. The urgent need to address the risks arising from the relationship between the experience of bullying in school and suicidal behaviour among young LGBTI people informed the recommendations for the 2016 *LGBTIreland* report. It is troubling that findings from the current report continue to highlight that those who experienced LGBT bullying have much higher self-harm and suicide attempt rates than those who did not experience LGBT bullying. In addition, sixty-two percent of participants reported that LGBTQI+ bullying or harassment was not actively addressed or taken seriously within their school. The need for stricter rules and a zero-tolerance policy was emphasised by participants. This suggests that while policy and practice recommendations such as *LGBTI+ National Youth Strategy (2018-2020)* and the *Wellbeing Policy Statement and Framework for Practice* (Government of Ireland, 2019) are available to support schools to keep LGBTQI+ students safe, there appears to be a policy to practice gap. An implementation plan for the *Cineáltas: Action Plan on Bullying* was published by the Department of Education in April 2023 and commits to implementing each of the 61 actions contained in *Cineáltas* within a 5 year period. Implementation of these actions which includes the development and implementation of updated anti-bullying procedures for schools, roll-out of a new inspection model to evaluate the promotion of wellbeing in schools and publication of an updated *Being LGBT in School* Resource, should help to address many of the issues raised in this report, especially if the target of 5 years as outlined in the implementation plan is achieved. Echoing recent findings from other studies (Bowen, 2019, Pizmony-Levy and Belong To, 2019, McBride et al. 2020, Pizmony-Levy 2022), participants in this study highlighted how school structures and systems do not provide the same rights or opportunities for gender diverse students, leaving them feeling invisible, excluded or othered. Over half of trans and non-binary participants reported that they were not addressed by their correct name and pronoun(s) in school. Three quarters reported not having access to gender-neutral bathrooms and facilities which is concerning given the potential for adverse effects on physical health (Wernick et al. 2017), and just one quarter reported that teachers supported their wishes in relation to their gender identity.

It has been argued that when the curriculum does not recognise, validate and positively affirm LGBTQI+ identities, LGBTQI+ young people are likely to feel alienated, resulting in experiences of minority stress and mental ill health (Glazzard and Stones, 2021). Therefore, it is concerning the number who disagreed with the statement that there 'are/were positive statements and representations of LGBTQI+ people within the curriculum', indicating that

sexuality education is delivered in a manner that creates an inequality of access to inclusive and comprehensive sexual health education for LGBTQI+ young people. Not only does this result in health inequalities for LGBTQI+ young people, but it also contributes to feelings of shame and exclusion. By contrast, inclusion of LGBTQI+ content in sexual health education increases feelings of inclusion and helps foster self-esteem, limiting negative mental health outcomes (O'Farrell et al. 2021). Indeed a major barrier to inclusive delivery of LGBTQI+ sexuality education is teachers who are not equipped or comfortable in delivering the content (O'Farrell et al. 2021), with the previous *LGBTIreland* report and policies all recommending building staff capacity in LGBTQI+ issues (Higgins et al. 2016, GLEN 2016, Department of Children and Youth Affairs, 2018).

In conclusion, schools have the potential to make great differences in the lives of Irish young people. In a consultation with over 4,000 young people, changes to school was the area that many felt would most improve the lives of LGBTQI+ young people in Ireland (Department of Children and Youth Affairs, 2018). However, the findings in this chapter have further confirmed what is already known about LGBTQI+ young people's experiences of secondary school; school is perceived as a place that is not welcoming, supportive or safe. While some progress has been made in terms of awareness campaigns such as Pride and Stand Up Awareness Week, findings from this study indicates that the work being undertaken is having minimal impact on the lives of LGBTQI+ young people in schools. These findings while similar to the School Climate Study (Pizmony-Levy and Belong To, 2019, Pizmony-Levy, 2022a,b) are in contrast with the report on the progress of the implementation of the first year of the *LGBTI+ National Youth Strategy (2018-2020)* which found that 86% of actions to create a more supportive and inclusive environment for LGBTI+ young people in formal education settings had been initiated or planned (Department of Children and Youth Affairs, 2019). Given our current findings and a lack of a follow-up report, more work is needed to determine if the actions that were reported as initiated were sustained and if those planned were implemented. Reasons for actions not initiated from the *LGBTI+ Youth Strategy* need to be identified.

Chapter 7: Safety Within Irish Society

Introduction

People who identify as LGBTQI+ face largely the same safety risks as all people, but in addition to this, like other minority groupings they are at greater risk to infringements on safety due to animosity within society. Notwithstanding the advancements in human/legal rights and protection, European research highlights how LGBTQI+ people continue to hide their identities and alter their behaviours due to fear of discrimination, and the risk of harassment and violence (FRA, 2020). Indeed, comparisons in surveys carried out by the European Union Agency for Fundamental Rights between 2012 and 2019 showed an increase in the percentage of LGBT people that felt discriminated against in all areas of life (rising from 31% to 43%), including work, social settings, healthcare or social services and education (FRA, 2020). In comparison to cisgender gay, lesbian and bisexual individuals, evidence suggests that transgender people are more at risk of experiencing discrimination (FRA, 2020, Bayrakdar and King, 2021), and harassment and violence (Bayrakdar and King, 2021).

In the *LGBTIreland* study, 75.2% of participants reported having been verbally hurt over their lifetime, and one fifth of participants had experienced physical violence due to being LGBTI. The groups most at risk of victimisation, discrimination and harassment in that study were gay men, transgender and intersex persons (Higgins et al. 2016). More recent findings from an Equality and Discrimination Survey in Ireland (CSO, 2019) reveal that 33.2% of people who identified as LGBTQI+ (18+ years of age), reported experiencing discrimination. More specifically 19.6% of people who identified as LGBTQI+ reported experiencing discrimination in accessing services, and 10.9% of LGBTI+ people experienced discrimination in the workplace (CSO, 2019).

These findings are based on self-reports, but the actual occurrence of hate crimes is confirmed by the annual hate crime statistics compiled in Ireland by An Garda Síochána which also show an increase in the number of hate crimes & hate related (non-crime) incidents between 2021 and 2022, rising from 448 to 582, an increase of 30%, and a corresponding increase in the proportion of discriminatory motives related to sexual orientation rising from 15% in 2021 to 22% in 2022 (An Garda Síochána, 2022).

Currently, the expansion of social and other media forums seems to be exacerbating the problem. Despite claims from social media companies that they do all they can to reduce discriminatory and hateful communications, expressions of these are actually on the increase (Mathew et al. 2019). A 2021 US survey exploring people's experiences and views of online hate and harassment found that in comparison to non-LGBTQI+ participants, LGBTQI+ people were subject to higher overall harassment rates on social media

including sexual harassment, stalking, physical threats, swatting, doxing and sustained harassment (Anti-defamation League, 2021). In comparison to other sexual and gender minority groups, transgender people are also more likely to experience online hate speech (Stefănită and Buf, 2021).

In terms of impact, research clearly demonstrates that harassment and discrimination have a range of negative consequences on LGBTQI+ people's lives. As well as emotional, psychological, and wellbeing impacts such as depression and anxiety, harassment and discrimination can lead to physical injuries, financial costs, and behaviour changes (Hubbard, 2021, FRA, 2020, Walters et al. 2019, Puckett et al. 2020). Hate speech and cyberbullying on social media is also a problem with real psychological consequences for the LGBTQI+ communities, ranging from anger and depression to suicidality and suicide (Stefănită and Buf, 2021, Escobar-Viera et al. 2018). Not surprisingly, these experiences can affect LGBTQI+ people's sense of safety, causing many to fear living openly and partaking in everyday life (FRA, 2020). An exploration of these issues is the focus of this chapter. The chapter begins with a presentation of findings on perceptions of safety and current and past experiences of harassment and violence. This is followed by findings in relation to media, including impact of anti-LGBTQI+ hate speech on participants and on the LGBTQI+ communities. Subsequent to this, findings in relation to people's experiences of harassment for reasons other than being LGBTQI+ are presented. The chapter closes with a summary of the response to the question (qualitative): 'Name one thing that would make participants feel safe as an LGBTQI+ person in Ireland'.

Sense of safety as LGBTQI+ person

Participants felt least safe being out in public with a partner, with the majority reporting that they would feel unsafe/very unsafe showing affection with a same sex partner in public (51.3%, n=1241), and over one tenth reporting that they would not do so (12.3%, n=297). A significant proportion also reported feeling unsafe/very unsafe holding hands with a same sex partner in public (45.3%, n=1094), with around one tenth (9.6%, n=232) reporting that they wouldn't do so. However, on other items, over two-thirds of the sample reported feeling safe/very safe reading an LGBTQI+ publication in a public space (73.5%, n=1831), using public transport (73.2%, n=1882), being seen going to or leaving an LGBTQI+ venue (69.2%, n=1664), and checking an LGBTQI+ website on a public computer (67.1%, n=1620) (see Figure 7.1). For transgender and non-binary participants, more than half (54.1%, n=398) reported feeling unsafe/very unsafe expressing their gender identity in public. Notably, as stated in Chapter 3, safety within society and in their place of residence, was one of the reasons (n=15) given by transgender and non-binary participants about why they don't live openly as their gender.

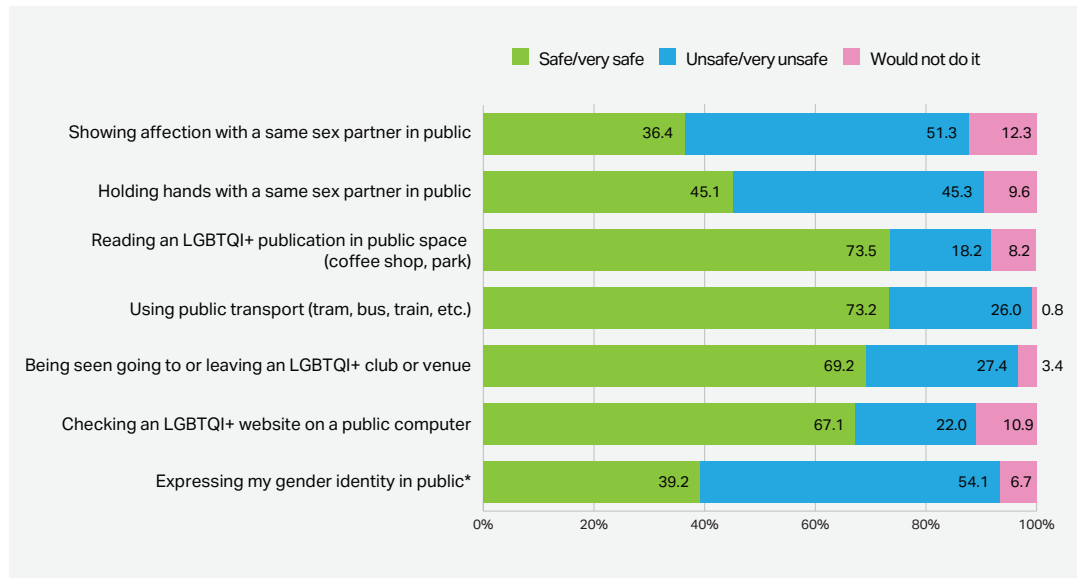


Figure 7.1: Sense of safety

Note: Non applicable answers excluded from analysis

**Analysed for participants identifying either as non-binary or transgender*

Prevalence of harassment and violence due to being LGBTQI+

As outlined in Figure 7.2, almost a quarter of participants (24.1%) reported having experienced physical assault due to being LGBTQI+ with 16.5% reporting sexual assault at some point in their lives. The majority of participants (71.7%) had experienced verbal harassment due to being LGBTQI+ at some point in their lives, with most having experienced it more than one year ago (36.1%). A third of participants reported being threatened with being outed (33.2%) in their lifetime. Just under a third (30.2%) had experienced being touched in a sexual manner without their consent because they are LGBTQI+. Furthermore, 28.3% had experience of having hurtful things written about them on social media. Participants who identified as transgender or non-binary were asked if they had experienced someone purposely using wrong pronouns when talking about them, to which 68.1% reported that they had, with the majority reporting that they had experienced it within the last year.

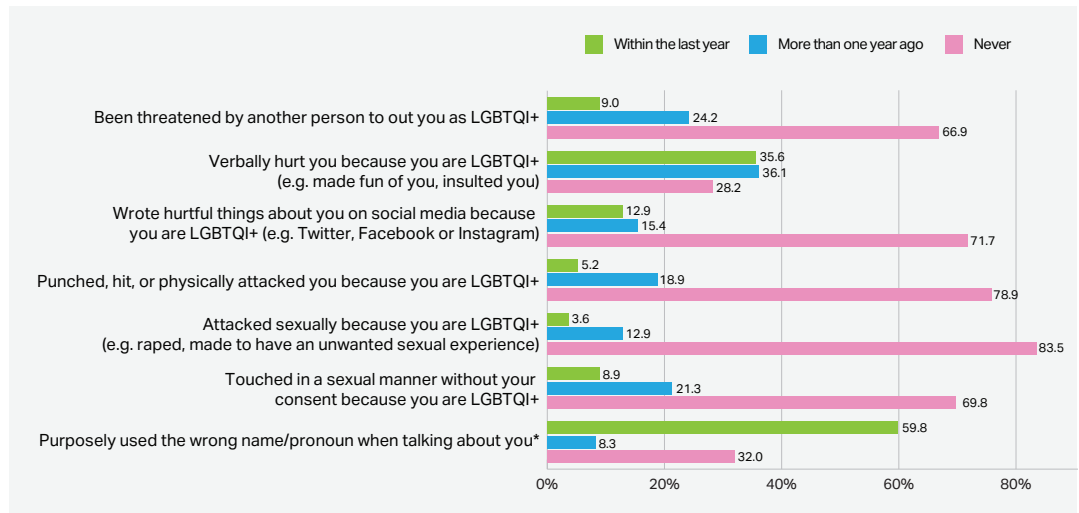


Figure 7.2: Experiences of harassment and violence

**Response option only displayed for participants identifying as either non-binary or trans*

There were statistically significant differences in violence and harassment depending on one’s gender identity. Cisgender men reported the highest level of physical attacks and non-consensual touching. On all other instances of violence and harassment, transgender and gender non-conforming (TGNC) participants reported the highest prevalence (Table 7.1). Cisgender women were statistically significantly less likely to experience any of these forms of harassment. In relation to sexual orientation, there were no statistically significant differences between the subgroups on the ‘threatened with being outed’, ‘social media’, and ‘sexual attack’ items, but the remaining items were statistically significant. Gay participants, who were predominantly cisgender men, were more likely to report physical attacks and non-consensual touching. Asexual and bisexual participants reported the lowest levels of verbal attacks compared to the other sexual orientation groups. There were statistically significant differences in all violence and harassment items, apart from verbal attacks, by age group. The oldest age group were more likely to have experienced physical attacks in their lifetime while the youngest age group was least likely. The highest proportion of sexual attacks and non-consensual touching occurred amongst the 26-35 age group. Those aged under 35 were more likely to have experienced verbal harassment on social media compared to those aged over 35 while the youngest age group was more likely to have been threatened with being ‘outed.’

Table 7.1: Lifetime prevalence of violence and harassment by gender identity, sexual orientation and age group

Characteristic	Category	Been threatened by another person to 'out' you as LGBTQI+	Verbally hurt you because you are LGBTQI+	Wrote hurtful things about you on social media because you are LGBTQI+	Punched, hit, or physically attacked you because you are LGBTQI+	Attacked sexually because you are LGBTQI+	Touched in a sexual manner without your consent because you are LGBTQI+
Gender identity	Cis men	33.4%	72.7%	25.6%	32.9%	17.5%	37.8%
	Cis women	27.2%	64.3%	18.5%	12.0%	11.9%	22.4%
	TGNC	39.9%	80.0%	43.2%	29.5%	20.6%	32.1%
Sexual orientation	Gay	36.2%	76.1%	27.5%	34.8%	18.9%	39.1%
	Lesbian	32.6%	72.9%	24.6%	16.0%	14.5%	24.8%
	Bisexual	30.4%	63.3%	26.7%	15.8%	15.0%	25.2%
	Queer	33.1%	81.4%	32.9%	28.1%	15.5%	30.2%
	Asexual	24.0%	57.7%	31.4%	13.3%	11.5%	18.1%
	Pansexual	40.8%	72.4%	33.5%	25.5%	19.1%	32.9%
Age	14-18	40.4%	68.5%	30.8%	15.2%	10.8%	17.7%
	19-25	34.0%	72.6%	33.3%	20.4%	16.3%	31.5%
	26-35	29.5%	75.0%	32.6%	25.9%	20.3%	36.9%
	36-45	27.8%	73.3%	20.7%	28.9%	18.1%	34.6%
	46+	32.1%	69.0%	19.5%	32.7%	16.1%	29.4%

Media and anti-LGBTQI+ hate speech

To ascertain participants' experience of media and anti-LGBTQI+ hate speech, people were asked if they had either experienced or witnessed anti-LGBTQI+ hate speech in the last year. Just over one fifth (22.9%) of the sample reported that they had experienced anti-LGBTQI+ hate speech either online or in public media within the last year, whilst almost 60% had witnessed it (59.0%). TGNC participants as well as those aged 14-18 were more likely to have experienced it compared to cisgender and older participants. In relation to sexual orientation, participants who identified as queer and pansexual reported more experience of it than other sexual identities (Table 7.2).

Table 7.2: Experienced or witnessed anti-LGBTQI+ hate speech either online or in public media in the last year by gender identity, sexual orientation and age

Characteristic	Category	Yes experienced it	Yes witnessed it	No
Gender identity	Cis men	20.2%	54.5%	25.4%
	Cis women	16.0%	64.6%	19.4%
	TGNC	34.0%	57.3%	8.6%
Sexual orientation	Gay	20.9%	53.9%	25.2%
	Lesbian	20.6%	60.9%	18.5%
	Bisexual	21.9%	63.0%	15.1%
	Queer	28.0%	64.5%	7.5%
	Asexual	21.8%	65.3%	12.9%
	Pansexual	29.8%	56.3%	13.9%
Age	14-18 years	29.1%	59.0%	11.9%
	19-25 years	24.5%	62.5%	13.0%
	26-35 years	22.0%	63.8%	14.2%
	36-45 years	20.1%	55.0%	24.9%
	46+ years	16.3%	50.0%	33.7%

Participants were also asked on which platforms anti-LGBTQI+ hate most commonly occurred. The top five were: i) Comment section of a media outlet; ii) Twitter (Now X); iii) International public media; iv) Facebook; and v) National public media (Figure 7.3). Besides those listed, some participants also mentioned other online platforms, including Discord (gaming chat platform), reddit (Online discussion forum), and tumblr (microblogging and social networking website) to name a few. Other comments referred to hate being spread through posters/leaflets/newsletters displayed or disseminated in public places or delivered through the post, and witnessing/experiencing hate at protests/rallies, at public speaking events, and in election campaigning.

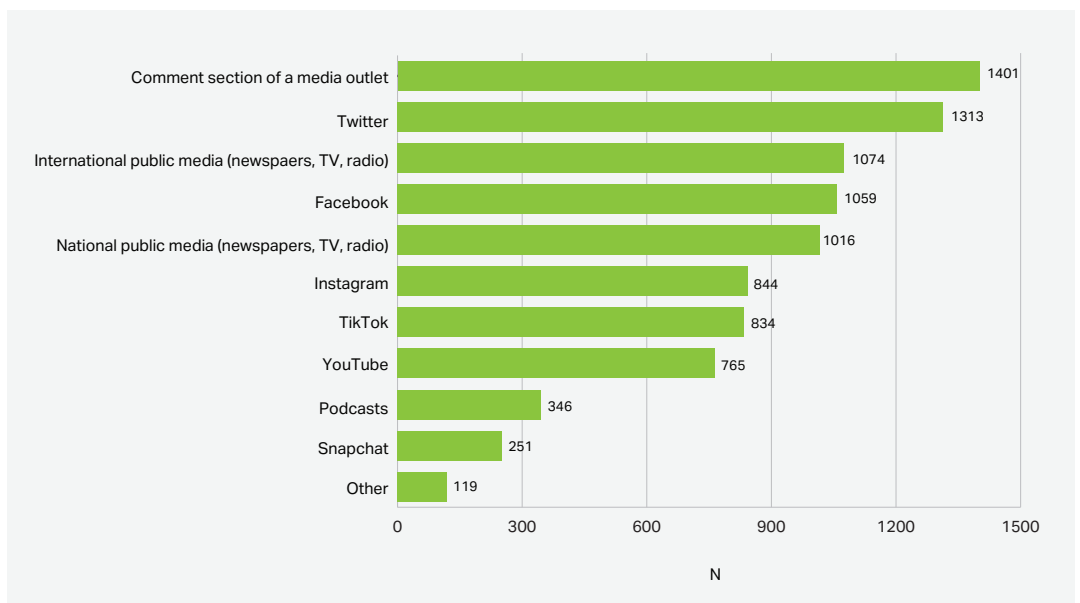


Figure 7.3: Platforms anti-LGBTQI+ hate speech experienced or witnessed

Qualitative findings: Impact of anti-LGBTQI+ hate speech in media and social media on person or the LGBTQI+ communities

There were 1328 responses offered to the open text question; 'What impact, if any has this anti-LGBTQI+ hate speech had on you or the LGBTQI+ communities?' Following thematic analysis, five themes were identified: i) Expanding hate within society; ii) Consequences for LGBTQI+ communities; iii) Consequences for LGBTQI+ individuals; iv) Strategies to manage the consequences; and v) Minimal impact due to habituation (see Figure 7.4).

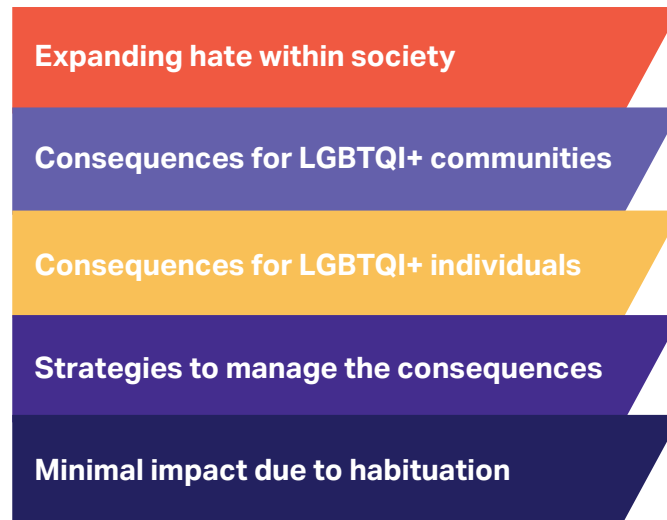


Figure 7.4: *Impact of anti-LGBTQI+ hate speech*

Expanding hate within society

Many participants were of the view that hate commentary in the media/ social media expands hate amongst wider society. Their perception was that media and social media outlets provide space and platforms for a narrative of misinformation to reach a wider audience, amplifying the message of hate which discredits and dehumanizes LGBTQI+ communities. Some participants noted that when national newspapers or RTÉ are the source of the information, it was more likely to be perceived as truth. It was also felt by some that as LGBTQI+ hate speech spreads within media outlets, it normalises homophobia and transphobia and increases acceptability of this behaviour within society. This in turn allows those with existing negative beliefs to feel validated and justified, and therefore safer to voice and defend their harmful opinions.

Participants highlighted that while some people use media as a platform for obvious or overt targeted hate campaigns, other subtler actions are also being used. Of concern to some participants was hate being disguised as freedom of speech and the way their identity was used as a topic of debate.

"Turning our identities (especially the trans community) into a topic for debate has made hate a legitimate respectable viewpoint. It's giving a free pass for prejudice and hate speech and giving hateful people a platform." (26, non-binary, queer and bisexual, ID 15)

Consequences for LGBTQI+ communities

Participants identified a number of consequences for LGBTQI+ communities, including increasing worry and fear amongst the communities and in identifying with the communities for fear of violence. Using terms such as 'second-class citizens,' 'less accepted,' 'unwelcome,' 'outcasts,' 'othered,' and 'not-human', participants illustrated the hateful language used to disconnect LGBTQI+ communities from society by making them feel different and discriminated against. While participants noted that homophobia remains ever-present, they also noted that hate is now more commonly directed at the transgender community. They were also fearful that the progress made in terms of LGBTQI+ rights e.g., marriage equality and other legal and policy advances, were coming under threat. Specific concern was expressed about the implications for certain members of LGBTQI+ communities, specifically transgender people, young people and those not yet comfortable with their identity.

While most participants focussed on societies' negative perception of the communities, some indicated that hate speech gives LGBTQI+ communities a negative perception of wider society. Some participants also indicated that disconnection and division has also spread into LGBTQI+ communities.

"Transphobia is being used to divide and conquer LGBTQI+ communities and it's depressing and scary how it is given credence in the media and selectively reported ... It's genuinely a wedge issue that I fear will be used to back pedal on wider rights. Ireland has had gender recognition as settled law for almost a decade, yet transphobic groups are now gaining a foothold..." (32, woman, pansexual, ID 1469)

Consequences for LGBTQI+ individuals

Participants indicated that hate speech generates strong emotional reactions in LGBTQI+ people. The single most cited emotion was anger. Participants also used words such as 'annoyed,' 'frustrated,' 'furious,' 'incensed,' and 'rage' to communicate this emotion. Feelings of worry and upset were also portrayed, with some participants directing negative societal attitudes about the community towards themselves. This included feeling like they were 'not normal', 'less than everyone else', 'not welcome', 'didn't belong' and 'ashamed'. (see word cloud for words used: Figure 7.5).

"It's hurtful but it makes me want to be myself even brighter and louder so that some scared LGBT+ kid who's hearing all of the violence can hear a voice out there advocating for them." (23, non-binary, ID 1057)

Minimal impact because of habituation

A small number of participants indicated it had minimal or no impact on them, although they did acknowledge that it may, however, impact others. Some mentioned that it had affected them in the past but does not affect them now because they are used to it, or they brush it off.

"I'm so used to it that it's just noise to me at this stage. Going online means seeing hate speech." (22, woman, bisexual, ID 1582)

Qualitative findings: Positive impact of media on person and LGBTQI+ communities

There were 1162 responses given to the open text question that asked, 'how the media can or does have a positive impact on you or the LGBTQI+ community'. It is important to note, that this response rate is only slightly less than the response to the question on the impact of online hate speech (n=1328), suggesting that the benefits of media are as well considered as the problems it creates. Only a small number of people noted that the media has little or no positive impact. Thematic analysis of the remaining comments resulted in three themes: i) Representation & visibility; ii) Creating space for belonging, inclusion and solidarity; and iii) A source of education and information (Figure 7.6).



Figure 7.6: *Positive impacts of media*

Representation and visibility to wider society

The media was viewed as an important vehicle of representation and visibility of positive LGBTQI+ role models and possibilities for LGBTQI+ people's lives, which has a positive impact for several reasons. First, role models and positive stories not only foregrounded diversity, but they normalised LGBTQI+ lives and made visible to all of society aspects of people's lives, such as having families and children. Many referred specifically to the positive impact respectful coverage of LGBTQI+ content, and LGBTQI+ lives in TV shows, films and documentaries, including discussion on LGBTQI+ rights, has on society and LGBTQI+ communities. Some noted however that a positive impact only comes from programmes where LGBTQI+ characters are not traumatised, evil, killed-off, or sensationalised.

"Representation matters and the increase in visible LGBTQI+ characters has had a positive impact. However, the majority of LGBTQI+ characters still experience trauma on screen and I think it is rare to see them get a positive ending." (30, man, gay, ID 1493)

"By increasing the visibility of same-sex couples in programmes - films - adverts it can assist normalising such relationships within society and lowering the occurrence of prejudice as a result." (55, man, gay, ID 1281)

LGBTQI+ related content was also viewed as offering positive role models for children growing up. In particular, positive LGBTQI+ role models within the media were seen as particularly beneficial for people struggling with their gender identity or sexual orientation, with many reflecting on the absence of representation while growing up themselves and how different their lives might have been if more positive representations had been more common during that time.

"If I knew that being trans was an option when I was growing up I might have realised that I was trans much earlier. Trans characters and actors in children's media might help fix that for future generations." (19, woman, transgender woman, bisexual, ID 196)

Also mentioned was the positive impact that media representation offered in terms of opening up channels of communication within families about being LGBTQI+ as well as providing a space for self-discovery and acceptance.

"It creates a space in which more people can come to terms with their sexuality or even discover it." (18, woman, bisexual, ID 1966)

Many participants also noted how LGBTQI+ representation/visibility was of direct benefit to themselves, such as enabling them to 'feel reassured', 'seen', 'valid', 'belonging', 'normal', 'happy', 'comfortable with themselves', or 'safer'.

"Being represented in the media gives me a sense of euphoria I can't explain." (15, man, gay, ID 900)

"It can [be positive] if it shows queer joy!" (18, man, transgender man, asexual, ID 349)

Creating space for belonging, inclusion and solidarity

Many participants pointed to ways the media (mainly social media) offer a (safe) space of belonging, connection, support, and communication between LGBTQI+ people. Media was also described as offering access to a 'queer friendly bubble', where the discrimination that exists in wider society can be actively avoided.

"Engaging with LGBT+ media online helps foster a sense of community which can be hard to feel in person sometimes." (26, man, gay, ID 2216)

"Social media that can filter and basically put you in your own queer friendly bubble is nice. I obviously know that homophobes- bigots exist but being in control of whether I can see it is great." (25, woman, bisexual, ID 2052)

Seeing examples of allyship or advocacy for LGBTQI+ people was also identified as a way that the media has a positive impact on participants and the LGBTQI+ communities.

"Seeing all the allies who stick up for us is a very big plus too." (21, woman, bisexual, ID 1673)

Being exposed to inclusive media also had a positive impact; inclusivity here primarily referred to media that contained inclusive language and referred to both LGBTQI+ and non-LGBTQI+ content together, thus demonstrating a move away from heteronormative framing of identities or siloing of LGBTQI+ issues.

"When [media] includes [LGBTQI+ people] and are not Heteronormative." (37, man, gay, ID 118)

Being a source of education and information

Media was viewed as having a positive impact through its education and awareness raising on LGBTQI+ issues and LGBTQI+ lives among the wider society.

"There are actually so many educational videos on tik tok regarding so many topics including the LGBTQ+ community it's honestly astounding!" (15, genderfluid, bisexual, ID 1202)

In addition, media was an effective education tool for LGBTQI+ communities. It not only offered people a voice, but was viewed as a vehicle for starting conversations or LGBTQI+ activism or building allyship and support.

"I like when the Media represents us properly and let us do the representing, like give us the mic!! Let us speak for ourselves!!" (16, non-binary, lesbian, ID 592)

"Media can be a positive vehicle for change in a number of ways - for example helping the community to rally behind specific issues affecting us, such as the ongoing monkeypox outbreak." (22, man, gay, ID 1233)

"GCN (Gay Community News) is positive. I think anything created by LGBTQ+ community for the community is positive. Gives us a voice." (34, non-binary, queer, ID 607)

Media was also viewed as a source of information on related campaigns, legislative changes, and debates, as well as a channel for advertising and/or promoting LGBTQI+ related 'ideas and events and services.' (61, woman, lesbian, ID 2572)

"It can be uplifting and provide hope, to read about positive legislative change elsewhere or to read about people who are overcoming discrimination and finding their voice." (52, non-binary, gay, ID 2033)

"It is reassuring seeing footage of TDs arguing for better trans health care in the Dàil." (26, woman, transgender woman, bisexual, ID 1382)

Experience of harassment for reasons other than being LGBTQI+

Participants were asked if they had experienced violence and harassment for reasons other than their LGBTQI+ identity. Around 30% (30.2%, n=810) reported that they had, with 590 participants (21%) providing written comments. Thematic analysis of these comments identified the reasons set out in Table 7.3.

Table 7.3: Experience of harassment for reasons other than being LGBTQI+

Reasons	Number
Gender	137
Due to being a Woman/Misogyny/Sexism	129
Gender/Sexual harassment – no specific gender reason identified	5
Being a man	3
Racism/Xenophobia	109
Neurodivergence	94
Physical appearance	68
Sexual/Physical Assault/Abuse	72
Health/Ableism	60
Being different	31
Personal background	18

The majority of **gender** related reasons for violence or harassment were associated with being a woman, with a few comments referring to experiences of harassment due to being a man. The following are examples of comments made:

*"Being verbally harassed in public and assaulted because I am a woman."
(27, woman, lesbian, ID 21)*

*"I've also been subjected to ill-treatment because I am a male working in a female-dominated profession. I've been groped by a female colleague and had my thoughts and opinions dismissed in team settings while my female colleagues' contributions were taken seriously."
(42, man, gay, ID 2459)*

Responses under the **racism/xenophobia** theme included, 'not being white', being from other countries, being a traveller, being mixed race, being harassed because of one's accent, experiencing anti-Irish prejudice when in the UK, and, for a small number of participants, experiencing antisemitism.

*"Being called names due to my skin colour, even from LGBTQI individuals who should know better about discrimination and minority status."
(28, man, bisexual, ID 2524)*

*"I was always bullied when I was a child for being Polish and weird. Both in and out of school."
(24, woman, transgender woman, asexual, ID 1025)*

The majority of responses under the **being neurodivergent** theme related to 'being autistic', although other specific forms of neurodivergence were reported such as Attention deficit hyperactive disorder (ADHD), Autism spectrum disorder (ASD), dyslexia, dyspraxia, or Tourette's syndrome, along with references to neurodivergence itself. In their comments, many people also referred to being bullied or harassed due to their neurodivergence in school, previously or currently. For some this was part of their everyday lives, and included being excluded from LGBTQI+ communities, or their neurodivergence being weaponized by a partner.

"I have ASD (autism spectrum disorder) as well as dyslexia. For many years my spelling, sensory issues, and lack of social knowledge was made fun of, undermined, and abused." (18, man, demisexual, panromantic, ID 768)

"I was bullied a lot for what I now realise were my Autistic traits. This was emotional and sometimes physical bullying. I also have tended to attract abusive partners in the past." (28, woman, pansexual, ID 1816)

"Being very shy, introverted and quiet as a very mildly autistic person always made me feel out of place in the loud LGBT+ spaces and groups." (27, man, gay, ID 844)

Physical appearance related reasons were also noted, for example, being tall, being small, the way they dressed, hair colour, or being 'too manly'. Notably, thirty-five of the physical appearance responses related to 'body weight', with most citing being harassed for being 'over-weight', and a small number for being 'too thin'.

"Being overweight. People giving you unsolicited advice, comments made on my body, people making faces. Overhearing people say things like "She has such a lovely face, it's such a pity she is so fat." Those things make me feel very uncomfortable, sad and used to depress me a lot and makes the overeating even worse." (40, non-binary, pansexual, ID 962).

Sexual/physical assault/abuse responses were reported as occurring in the context of sexual and/or physical domestic violence, growing up in households that were abusive, violent or chaotic, with five participants indicating past experiences of child (sexual) abuse. Others wrote about experiencing physical assault or sexual assault/rape on nights out, or in college, by a 'friend' or by 'men in positions of power'.

"I was sexually assaulted as a young woman by a man who was older than me." (65, woman, queer, ID 2056)

"I was at the receiving end of domestic violence in a few households. I don't think it was always related to me being gay, more that I was around abusive people." (38, man, transgender, gay, ID 286)

The majority of **health/ableism** responses referred to having a physical disability and/or a disorder, for example, Crohn's disease, eating disorders, or hearing impairments, and ten referred to mental health related reasons for experiencing violence and/or harassment.

"Disability pisses people off and they can get violent in words and actions pretty easily." (48, queer, ID 545)

"Mental health, lack of understanding, thought of as psycho, unstable. Being taken advantage of sexually and financially when very unwell and didn't have the strength or will to say no." (47, woman, lesbian, ID 2306)

Being different comprised a wide range of reasons, mainly occurring in school, for example, 'being smart', 'not smart enough', 'being anxious', 'being shy' or because of pursuing particular hobbies or interests.

"Being shy and quiet in school made me a bullying target before I came out." (18, woman, lesbian, ID 1124)

Personal background related reasons including religion, coming from foster care, being from the countryside, sectarian related intimidation, or being poor.

"I was bullied because I was poor and my mother was mentally unwell, so I wasn't as well presented as other children. This bullying continued on for many years." (35, woman, pansexual, ID 2165)

One thing to make you feel safe as an LGBTQI+ person in Ireland

Participants were asked "What one thing would make you feel safer as an LGBTQI+ person in Ireland?" In total, 1,837 participants gave responses to the question. Following thematic analysis eight themes were identified: i) Protections and consequences; ii) Safe spaces and support; iii) Media management and accountability; iv) Visibility and diversity of representation; v) Education and awareness; vi) Acceptance, inclusion and recognition by all; vii) Normalisation of LGBTQI+ lives; and viii) Wider level change or reform (Figure 7.7).



Figure 7.7: Themes on improving safety for LGBTQI+ people in Ireland

Protections and consequences

The theme of protections and consequences broadly contained references to legal protections; policing protections; and consequences for discriminatory acts.

Legal protections: Many participants identified the need for strong hate crime legislation, including passing and enforcement of the hate crime bill, and other hate crime laws. Others called for stronger consequences including a zero-tolerance approach to verbal and physical abuse, including prosecutions and sentencing.

"Hate crime legislation. There is a rise in attacks and people are getting away with it." (30, woman, transgender, bisexual, ID 851)

"Stronger sentences – arrests from those who incite hate or violence on LGBTQI+ people." (30, woman, gay, ID 150)

"Zero tolerance for street harassment and violence, not just on the part of state bodies like the Garda but in the part of the general public. All of us need to stand up to and not tolerate any form of violence or harassment." (50, woman, lesbian, ID 353)

Other legal protections identified, included gender recognition for non-binary people, and people under 16 years of age, and legal recognition for parents of non-biological children. Highlighted also, was the need to protect and prevent any backsliding on the protection of LGBTQI+ rights gained to date.

Policing protections: Many participants suggested that more Garda presence in public places, on public transport, at night-time, weekends, and around LGBTQI+ venues, mainly in cities would make them feel safer. A small number referenced the need for more approachable or LGBTQI+ friendly Gardaí and greater consequences for LGBTQI+ hate related crime in terms of response and follow-up by Gardaí. A minority associated being safer with *'reforming the police'*, *'having less police'*, having *'LGBTQI+ and People of Colour (POC) police'*, or *'abolishing the police'*.

"More Garda presence at night-time especially around the gay districts." (40, man, gay, ID 1365)

"Knowing the Guards will take time to help you if you come to them about a homophobic attack." (17, non-binary, bisexual, ID 52)

"Knowledge that if anything was to happen there would be an absolutely zero tolerance approach taken by the Guards." (30, man, gay, ID 1921)

Consequences for discriminatory acts: The need for discrimination and hate crimes to be taken more seriously by all and met with significant consequences, including addressing discrimination or attacks LGBTQI+ people encounter from groups of young people was mentioned frequently.

"If there were actual repercussions for people who attack or commit hate crimes." (31, non-binary, questioning, ID 194)

"Hearing that attacks and assault made on LGBT+ people were being followed up." (20, woman, lesbian, ID 1776)

"Something being done about the gangs of young people in cities who attack and abuse LGBTQI+ people and others. These are the only group who have ever made me feel unsafe." (34, man, homoflexible, ID 235)

Safe spaces and supports

The need for safer streets, public transport (including buses, trains, Luas), and safety around LGBTQI+ venues at night was identified as something that would make participants feel safer. In this context, participants mentioned the need for better security, for example security personnel (rather than specifically Gardaí). Some participants referred to better public space infrastructure in the form of better CCTV (closed circuit television), and better night-time street lighting.

"More security at night in town on weekend, and more security on night buses." (21, woman, lesbian, ID 384)

Participants also requested more LGBTQI+ spaces and/or safe spaces including in rural areas, with a minority referring to wanting women or female only spaces.

"Local gay friendly spaces, not just in Dublin or big cities." (34, woman, gay, ID 195)

"If lesbian spaces were female only." (23, woman, lesbian, ID 321)

Having LGBTQI+ affirmative services was also identified as helping LGBTQI+ people to feel safe. Some specific service types identified were counselling, community services, support centres for LGBTQI+ people, and healthcare services, mainly mental health services and transgender healthcare.

"Medical professionals more open minded and aware of experiences of LGBT people." (31, woman, lesbian, ID 976)

"If trans healthcare were more easily accessible." (28, woman, lesbian, ID 1169)

A number of participants said that having allies among the general public and businesses would make them feel safer. For many this was about offering support when they see incidents of discrimination or harassment occur, or businesses making it known through the use of symbols that they are LGBTQI+ friendly.

"Knowing that if someone saw me being harassed that they would help me." (22, non-binary, pansexual, ID 49)

"I think just business notifying you that you are an ally and will stand up for you etc.." (14, woman, bisexual, ID 352)

Public messaging or campaigns that condemn discrimination and hate crime, and greater support from within the political arena, including economically, for example, in the form of secure housing were also identified as supports which would enhance safety.

"More explicit LGBTQI+ messaging in every area of life – media, shops, state, work, outside of Pride month." (26, woman, bisexual, ID 473)

"Knowing that the Government is taking issues seriously and acting to solve them." (15, woman, bisexual, ID 1328)

Visibility and diversity of representation

Participants suggested a need for more visibility and representation of LGBTQI+ lives across the public realm, for example, beyond pride month, in businesses, on posters or representation among public and political figures.

"More businesses and premises displaying gay friendly signs and receive some training and information re gay-queer friendliness." (43 man, gay, ID 1123)

"LGBT staff members in schools, not just in universities." (19, woman, queer, ID 1122)

"More representation of lesser-known queer identities." (18, woman, asexual, ID 1115)

While participants acknowledged the many ways that media represent the diversity of LGBTQI+ lives, they also mentioned the need for greater representation of asexual people, transgender or intersex people, gender non-conforming people, ethnically and racially diverse LGBTQI+ lives, or better representation of age differences. There were also suggestions about the need for depictions of LGBTQI+ families and more realistic stories about LGBTQI+ lives including the struggles that LGBTQI+ people can encounter.

"More and more representation is seen in the media, but more work should be done for trans visibility, queer POC, LGBTQIA+ people living with disabilities should be seen and heard. We are more than just cis gendered white and would like to see that shown nationally." (34, man, gay, ID 1220)

"Better representation of people who are bi-pan." (28, woman, pansexual, ID 212)

"RTE is fairly inclusive to be fair. Maybe show men in gender non-conforming roles. More variety." (42, non-binary, queer, ID 2316)

"Nuanced representation is really important, and I don't feel like I see myself represented much in media yet. It's certainly better than when I was growing up". (29, transmasculine, pansexual, ID 686)

Media management and accountability

Many participants called for better management of media reporting on LGBTQI+ related topics and media accountability in this regard. This included a call for less negative representation of LGBTQI+ issues, the stopping of: 'anti-LGBTQI+ agendas' and 'pushing of TERF rhetoric and spreading hate', and 'less platforming of right-wing figures under the guise of freedom of speech', with some adding that this kind of reporting was dangerous for them.

"Not giving homophobic, transphobic, racists a platform for their hate." (44, genderfluid, pansexual, ID 1845)

"Increased monitoring of social media platforms and stronger accountability." (41, man, gay, ID 537)

"To have a positive impact on my life, the media needs to stop tolerating bigotry under the guise of openness or freedom of speech." (61, man, queer, ID 1932)

In contrast with those who had emphasised the benefit of more exposure in the media some identified being a topic of debate also as a potential problem. For them, less visibility of LGBTQI+ lives was something that would make them feel safer as an LGBTQI+ person in Ireland.

"Being less overt. One's sexual identity shouldn't be flaunted. It can cause unnecessary offence and anger. We should ALL respect each other – not be provocative." (53, man, gay, ID 1188)

The fact that LGBTQI+ lives are a topic of debate at all was identified as a problem, with many suggesting that their lives not being reduced to a debate topic or 'debate fodder' would help them feel safer (36, *Trans Woman, Queer, ID 538*). In particular, the cessation of debates on trans people lives was identified as something that would have a positive impact. The sense of people's lives being caught up in media debates is clear in the following quotes.

"They can stop "debating" our existence and rights, especially those of the trans community." (40, non-binary, bisexual, ID 1129)

"I feel the trans debate has made me less safe as a queer person. I don't like the drive from both sides, and I hate the media compounding this." (30, woman, queer, ID 553)

Education and awareness

Many participants felt that a more educated and aware population would make them feel safer as an LGBTQI+ person in Ireland. Participants referred to the need for more and better education about LGBTQI+ people's lives and identities, including the discrimination that LGBTQI+ people can face. Participants were of the view that the provision of (better) LGBTQI+ education would go a long way towards the mitigation or elimination of prejudice and discrimination.

"Ireland needs to educate more, teach greater acceptance, teach empathy and an understanding." (36, woman, queer, ID 310)

"More awareness of the violence, harassment and general bullying that happens to members of the community." (14, woman, lesbian, ID 1285)

"Educating people. Most of the hatred I've found has been based on ignorance." (46, woman, bisexual, ID 103)

In addition to identifying a need for education of the public in general, parents, and new communities to Ireland, participants identified the need to target education towards specific service providers such as the Gardaí, healthcare professionals, business staff and security workers, public transport staff, public servants, and teachers.

"Significant training for all public-facing public servants with regards to LGBTQI+ identities and safety concerns." (34, woman, bisexual, ID 860)

"Acceptance through improved education from a young age and throughout school, as well as education for parents." (37, man, gay, ID 434)

Acceptance, inclusion and recognition by all

This theme focused on greater acceptance, inclusion and recognition. There was a call for positive change in social attitudes about LGBTQI+ people, their sexual orientation, identities and expressions of same, in the workplace, schools, and in the public sphere more generally.

"Full inclusion and acceptance of LGBTQI+ students in all schools." (34, man, gay, ID 77)

"General openness in people, to understand, support and celebrate difference." (35, man, transgender man, bisexual, ID 975)

"If men didn't see me being a lesbian as an invitation to 'change my mind'." (25, woman, lesbian, ID 2011)

"To feel equally valued at 70 years of age. I am still affected by the oppressive and controlling country I grew up in." (70, man, gay, ID 960)

Some participants also expressed a wish for greater acceptance within the LGBTQI+ community of each other, despite differences that may exist.

Normalisation of LGBTQI+ lives

In this theme participants identified the normalisation of LGBTQI+ lives, including the normalisation of LGBTQI+ relationships, public displays of affection, identities, including trans identities, gender-neutral language, gender-neutral toilets, and the use of correct pronouns as things that would help them feel safe.

"... normalising different gender identities and expressions." (22, man, transgender man, queer, ID 811)

"Gender neutral language becoming normalised, instead of 'the girls', 'your one', 'good woman', being the default." (23, non-binary, bisexual, ID 713)

Wider level change or reform

This theme comprises responses about wider level change or reform, as this relates to LGBTQI+ lives. Responses here mostly related to religion, and the reduction or elimination of the influence of religion in Irish society. For some this related more specifically to the removal of religion from specific institutions such as schools, while others were more concerned with the complete separation of church and state. A small number of responses were orientated towards religion being more inclusive of LGBTQI+ people.

"Removing the church from any education or care facility." (33, man, gay, ID 776)

"Having churches being ok with queer people." (15, man, transgender man, queer, ID 1235)

A small number of responses (n=30), focused on leadership, group or organisational changes/reforms. Some responses sought 'effective queer leadership', and a further twelve related to existing LGBTQI+ charities, organisations, lobby groups or activists; suggesting either the disbanding of these groups, the separation out of LGB and TQI groups, or felt that some organisations were taking too narrow a focus or were favouring one LGBTQI+ subgroup over others.

"Queer organisations caring about women and their vulnerability especially in medical and support situations. Right now it feels like they only care about gay men and trans women. They act like everything to do with women has been sorted. It hasn't." (38, lesbian, ID 1445)

Other responses pointed to socio-political change or reform as the thing that would make people feel safer. Here a shift to a more 'progressive', 'left', or more 'inclusive' kind of politics was identified, including calls for an end to capitalism, patriarchy, and heteronormativity, while for others equality was the thing that would make it safer for LGBTQI+ people.

"Seeing more LGBTQI+ women making a positive difference in politics." (38, woman, bisexual, ID 232)

"A change in government to more progressive politics." (22, man, gay, ID 692)

"Equality and respect for everyone." (49, man, gay, ID 2482)

A small minority of responses called for an end to gender ideology and/or gender self-identification, the stopping of a rise in Trans Exclusionary Radical Feminism (TERF), an end to the 'gender-critical'¹¹ movement, and the stopping of anti-LGBTQI+ groups.

Others highlighted concerns about right wing views, and the need for a strategy to disrupt momentum in this regard as this related to the recruitment of young people, the hatred perpetuated, and the leveraging of being transgender to further a right-wing agenda.

Finally, some focused on the need for respectful dialogue or constant conversation.

"A calm discussion about the implications of self ID." (65, woman, lesbian, ID 1371)

"I find when you respect all views in a debate and discussion rather than forcefully pushing agendas then people listen. Softly, softly and change happens." (51, man, gay, ID 1791)

Summary and discussion of findings

In terms of reported actual violence and harassment, the findings clearly indicate that sexual and gender minority people continue to face high levels of harassment and violence related to their LGBTQI+ identity. This includes verbal harassment (71.7%), non-consensual touching (30.2%), physical attack (24.1%) and sexual assault (16.5%). Although direct comparison with other studies is difficult due to differences in how harassment is operationalised, by comparison, the figures for verbal abuse and physical attack are higher compared to the

¹¹ The gender-critical movement, refers to 'gender-critical' feminists who oppose 'identity' or gender-based rights, instead arguing that women are oppressed as a biological class and deserve rights based on binary and essentialist understanding of male/female sex categories (Jones and Slater, 2020).

EU-28 wide figure of 58% and 11% for verbal harassment and physical attack respectively among LGBT participants (FRA, 2020) but comparatively lower than the rates reported in Hubbard's (2021) UK hate crime study involving LGBT+ participants, which were 92% and 29% for verbal hurt and physical violence respectively. Compared to the general population of Ireland, approximately 8% more participants in this study reported experiencing non-consensual touching (CSO, 2023a).

Cisgender men, most of whom were gay, and TGNC participants were more likely to be subjected to violence and harassment than cisgender women. Over two-thirds of trans and non-binary participants experienced someone purposely using the wrong pronoun/s towards them. There was no real trend apparent in terms of which age group was more likely to experience violence and harassment, as it varied depending on the form of harassment and violence. For example, people aged under 35 were more likely to have experienced verbal harassment on social media compared to those over 35, perhaps owing to their greater use of social media, while the 26-35 age group were more likely to report sexual attacks and non-consensual touching. Around 30% of participants experienced violence, harassment and sexual violence and abuse for reasons other than because of their LGBTQI+ identity, including gender (especially women), racism, and ableism; highlighting the intersectional nature of people's safety related experiences and response needs.

Several studies highlight an underreporting of anti-LGBT+ harassment and violence to police and a lack of support for victims (FRA, 2020, Hubbard, 2021). While the need for supports for LGBTQI+ people who experience harassment, discrimination and violence in Ireland are clear, the findings of this study also highlight how important prevention orientated national initiatives are, such as Safe Gigs Ireland (www.safegigs.ie), the Women's Aid, Too Into You campaign (www.toointoyou.ie), and the Dublin Rape Crisis Centres' long term national programme We-Consent (www.we-consent.ie), and also, how a special focus on the LGBTQI+ community in this regard is vital.

Approximately half of participants in this study reported feeling unsafe doing certain things in public, including showing affection or holding hands with a same-sex partner, and, for trans and non-binary participants, expressing their gender identity. Other studies also show avoidance of hand-holding among same-sex couples is prevalent with 6 in 10 participants in the FRA, Country data-Ireland (FRA, 2020b) avoiding it and just over one third of LGBT participants in a British study reporting that they were uncomfortable holding hands with a same-sex partner in public (Bachmann and Gooch, 2017). Less people reported feeling safe being seen going to or leaving an LGBTQI+ club or venue compared to the *LGBTIreland* study while the one third who reported safety concerns is similar to the 33% of participants across the EU-28 who often or always avoid certain places or locations for fear of being assaulted, threatened or harassed because of being LGBTQI+ (FRA, 2020a). These findings are worrying not only in terms of the impact on LGBTQI+ people's psychological wellbeing, but also from a visibility perspective. Less visibility of LGBTQI+ people can have a negative

impact on wider societal attitudes, in that visibility can translate into positive day-to-day interactions between LGBTQI+ people and the general population (Haynes and Schweppe, 2019). Participants highlighted several ways their sense of safety could be enhanced including stronger legal protections, policing protections, and consequences for discriminatory acts. The findings around harassment, discrimination, violence, and safety in public not only point to the need for legal protections, but it also supports Concannon's (2022) assertion on the need for improved monitoring procedures, as well as multi-agency working between An Garda Síochána and other state and partner agencies, including engagement with local community if issues around safety are to be addressed in a sustainable manner.

The chapter also placed a spotlight on the theme of media and discrimination by exploring the issue of anti-LGBTQI+ hate speech in online and offline media. Just over a fifth of participants reported having experienced anti-LGBTQI+ hate speech in the media and social media, with a greater proportion of transgender and gender non-conforming participants and younger participants having experienced this. While this finding may look somewhat positive when compared to the prevalence of 64- 68% of anti-LGBTQI+ online hate crime/speech/ abuse reported in other studies (Hubbard, 2019, 2020), the difference may be due to the fact that this study looked at experiences in the last year, whereas other studies inquired about longer timeframes. Indeed, the 30% increase in hate crime and hate related (non-crime) incidents in the Garda Síochána statistics (An Garda Síochána, 2022) between 2021 and 2022 (discussed in the introduction) warn against complacency in the Irish context. The fact that over 59% of participants in this study had witnessed hate speech in the media is itself telling of an environment where the amount of hate content is unfortunately already high and cannot be ignored in the context of the staggering international figures outlined (ADL, 2021). At a legislative level, these findings identify a clear need to deal with hate crime and expand protections to sexual and gender minority communities. While the new proposed laws on hate speech have been published in the Criminal Justice (Incitement to Violence or Hatred and Hate Offences) Bill 2022¹², and at the time of writing is waiting to be debated in the Oireachtas, findings from this study point to the need for the speedy signing of this bill into law.

Similar to this study where over one quarter of 14-18-year-olds experienced anti-LGBTQI+ hate speech either online or in public media in the last year and over half had witnessed it, other studies also show that LGBTQI+ youth are exposed to high levels of anti-LGBTQI+ harassment, hate speech or discrimination online (Pizmony-Levy, 2022, Nominet, 2022), with as many as 87% of young people in Ireland aged 13-20 reporting having experienced or seen anti-LGBTQI+ hate speech (Pizmony-Levy, 2022). This finding is worrying given the well-documented negative wellbeing effects of online hate against LGBTQ+ young people, including sadness, shame, self-blame, and feelings of inferiority and depression as well as negative impacts on relationships and

12 Criminal Justice (Incitement to Violence or Hatred and Hate Offences) Bill 2022 – No. 105 of 2022 – Houses of the Oireachtas

social interaction involving fear and lack of safety, and can include isolation and withdrawal from online and offline spaces (Keighley, 2022). Similar consequences for individuals were found in this study in response to the qualitative question inquiring into the impact of anti-LGBTQI+ hate speech in media and social media. Negative consequences for the LGBTQI+ communities were identified including the creation of a climate of fear, concerns for certain members of the LGBTQI+ communities specifically trans people, young people, and those not yet comfortable with their identity, concern that progress made to date on LGBTQI+ rights is under threat, and concerns about the creation of division between the LGBTQI+ communities and society, and within the LGBTQI+ communities themselves.

Findings in this study also pointed to concerns about the role that media can play as a platform for expanding hate across society and where 'debate' merely becomes a platform for LGBTQI+ discrimination under the guise of free speech. Concerns were raised in this regard with specific reference to transgender and non-binary related discussions. The difficulty of free speech being used to legitimise hatred is also flagged by Hubbard (2020). The problem of media platforms being disproportionately unsafe for sexual and gender minority people (and other marginalised communities) is also recognised internationally (GLAAD, 2023, Hubbard, 2020). Key findings from the annual US based Social Media Safety Index were that anti-LGBTQ hate speech and disinformation is a public health issue, that anti-LGBTQ rhetoric translates into real world offline harms, that these problems are not being properly managed or reported on by social media platforms, and that these platforms are discriminatory by way of suppressing LGBTQ content (GLAAD, 2023). The need for properly functioning monitoring of, and accountability by, big tech is clear. In this context Ireland's role in the newly established broadcasting and online media regulator Coimisiún na Meán (www.cnam.ie), which is tasked with enforcing the Digital Services Act (DSA) as well as its own binding online safety code, is welcome. Based on the findings in this report and the international literature, special emphasis on LGBTQI+ communities would be warranted in Coimisiún na Meán's work programme which is under development at the time of writing.

Findings also document the positive impact that the media can and does have on participants and the LGBTQI+ communities. In line with the literature, participants viewed the media as offering a space to see oneself reflected in the world, reflect on oneself and one's journey as an LGBTQI+ person, and actively explore one's own identity development (Kizer and Hunter, 2023, McInroy and Craig, 2017), experiences that are particularly important for people that are in the process of coming out (McInroy and Craig, 2017). Providing access to community, and supporting inclusion and solidarity, were also indicated as benefits that media can have for individuals and the LGBTQI+ communities, as can its role as a platform for education, information and awareness. Craig et al. (2015) found that positive factors such as positive representation, connection, and education can be a catalyst for resilience building in LGBTQI+ people. In the context of the rise in hate speech/crime that is occurring in the Irish context (An

Garda Síochána, 2022, Cannon et al. 2022), and the sometimes disparate nature of the LGBTQI+ communities as indicated in the 'LGBTQI+ wellbeing in context' chapter (Chapter 4), the media clearly can play a crucial and positive role in negating these issues and their effects.

Notably, accountable management of media was also identified as a factor that participants felt would make them feel safe as an LGBTQI+ person in Ireland, as was greater representation and visibility in society (a small number of people said less visibility would make them feel safer). In addition, the normalisation of LGBTQI+ identities and a positive change in wider social attitudes about being LGBTQI+ were also factors that participants felt would make them feel safe. The call for a change in social attitudes by participants in this study may seem inconsistent with the finding in the FRA (2020a) report where a high proportion of people in Ireland (77%) viewed LGBTI prejudice and intolerance as having dropped in the last five years. Perhaps this inconsistency makes more sense when one considers Haynes and Schweppe (2019, p.21) conclusion following their '*Call it Hate*' survey, where they state that their research, "provides empirical evidence that a gap exists between a widely held public perception of Ireland as a relatively safe and inclusive country for LGBT people, and documented evidence of ongoing experiences of homophobic and transphobic hate crimes." Beyond this, the findings suggest that safety for LGBTQI+ could be achieved with strategies orientated towards education provision and awareness raising about being LGBTQI+, better legal and policing protections for LGBTQI+ people, and more consequences for people that engage in discriminatory acts, as well as diversity of representation within the political arena and public workforces. That the call for better legal and policing protections for LGBTQI+ people was a dominant theme not only in this study, but also the previous *LGBTIreland* study, suggests that safety must remain as a thematic pillar in the next *Irish National LGBTI+ Inclusion Strategy* with safeguarding the LGBTQI+ community being central in all other relevant policies, including health and education.

Chapter 8:

Healthcare Utilisation and Experiences of Healthcare

Introduction

As highlighted in previous chapters (Chapters 4 and 5), this study and previous studies indicate that for a variety of reasons, in comparison to their non-LGBTQI+ cohorts, people who identify as LGBTQI+ experience greater health disparities and have higher rates of physical and mental health problems (Hsieh and Shuster, 2021, Bachmann and Gooch, 2017, Zeeman et al. 2017).

Despite increased healthcare needs, sexual and gender minority individuals are more likely to delay accessing healthcare and screening services for fear of discrimination and stigma by health practitioners (Murphy and Higgins 2022, Romanelli and Hudson, 2017). This reluctance is often greater for transgender and non-binary individuals in particular who wish to access medical transition services but have not done so. These individuals may find it psychologically difficult to seek help or address health concerns associated with reproductive organs that do not match their gender identity (Norris and Borneskog, 2022).

Even when sexual and gender minority people access healthcare services, including mental health services, they sometimes do not receive the support they require (McNamara & Wilson, 2020). Sexual and gender minority individuals report a reluctance to disclose their sexual orientation or gender identity, for fear that health and social care practitioners will be indifferent or hostile towards them, cast their sexualities within the realms of deviance and pathology, and directly or indirectly discriminate against them. Evidence from several systematic reviews reveal discriminatory behaviour, ambivalent attitudes and/or homophobic, biphobic or transphobic attitudes among healthcare practitioners (Rees et al. 2021, Ayhan Balik et al. 2020, Rosenkrantz et al. 2017, Romanelli and Lindsey, 2019), with transgender people being more compromised in their access to healthcare (Kcomt, 2019). In addition, a lack of knowledge among practitioners can result in sexual and gender minority individuals being exposed to intrusive questioning, being confronted with hurtful or insulting language, or feeling they have to repeatedly educate healthcare professionals on LGBTQI+ issues (Ayhan Balik et al. 2020, van Heesewijk et al. 2022). In addition, people with intersex variance report a range of concerns ranging from dissatisfaction with medical treatment, problematic sexual experiences after medical interventions, a lack of respect for the individual's views or a lack of fully informed consent on their or their parents'/carers' part for medical intervention (Zeeman and Aranda 2020, Amos et al. 2023).

In the *LGBTIreland* study, participants indicated a number of systemic and psychosocial barriers to accessing and using mental healthcare, with participants also noting a lack of knowledge, and negative attitudes and behaviours among mental health practitioners. Since then, other Irish studies

have revealed a lack of cultural competence and sensitivity among healthcare staff (Bowen, 2019, MHR, 2022, Hodgins et al. 2023), with staff working in child mental health services reporting a lack of knowledge and experience to support transgender young people and their families with any degree of confidence (Hodgins et al. 2023).

Given the increasing call from international and national organisations for care based on human rights principles (World Health Organisation and United Nations, 2023, Meier and Gostin, 2019, HIQA, 2019) and an emphasis on the provision of culturally responsive healthcare as the pathway to ending the inequities experienced by sexual and gender minorities (DoH, 2020, Margolies and Brown 2019, Rhoten et al. 2022), it was important to explore people's experiences of healthcare within this current study, and in particular transgender people's experiences of accessing healthcare to support medical transition. The focus of this chapter therefore is on participants' overall experience of healthcare, with specific emphasis on transgender participants' experiences of healthcare related to medical transition.

Healthcare utilisation and experience of healthcare support

Nearly 90% of the sample (88.8%, n=2474) indicated that they had used healthcare services/practitioners in the past five years and reported that on average, 52% of healthcare professionals were aware of their LGBTQI+ identity. In terms of support, nearly half reported that healthcare providers were supportive (48.9%, n=906), nearly two fifths (37.6%, n=696) reported them as neither supportive nor unsupportive while 13.6% (n=251) regarded them as unsupportive of their sexual orientation and/or gender identity (Figure 8.1).

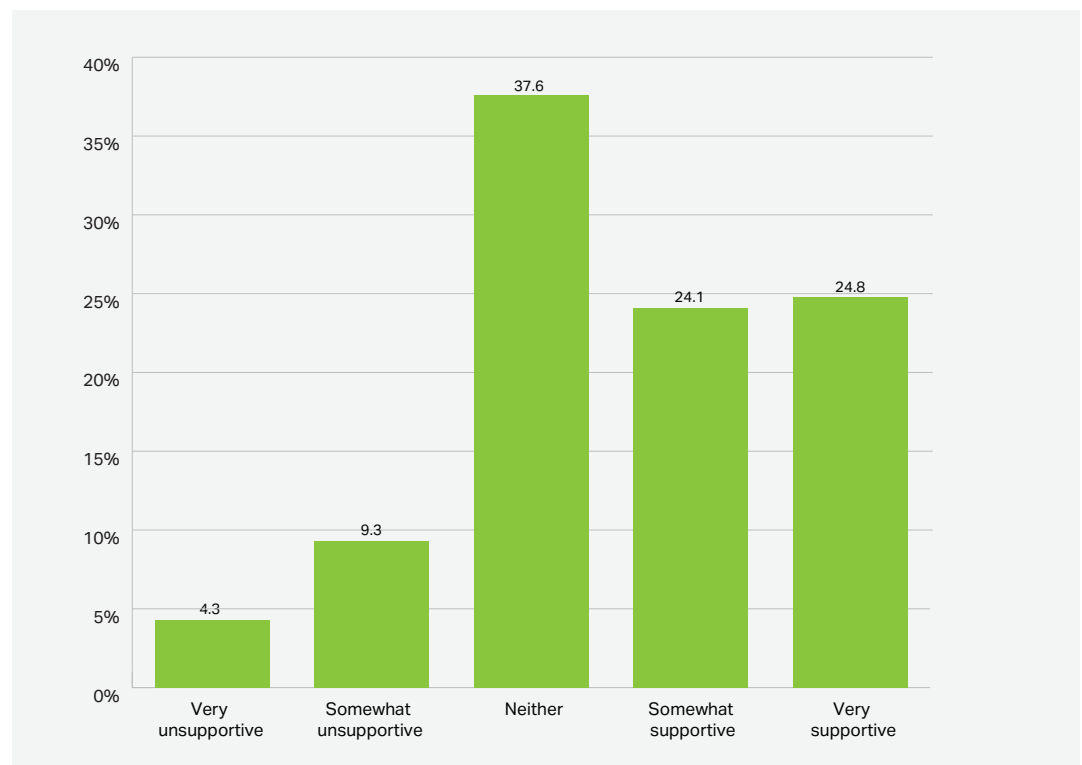


Figure 8.1: Healthcare professional support for LGBTQI+ identity

NB: N=1853. Non applicable answers excluded from analysis

From a positive perspective, most reported never having had a practitioner tell them that their LGBTQI+ identity could be changed (91.4%), were never discriminated against because of their LGBTQI+ identity (83%) and were never asked invasive questions about their identity which were unrelated to their reason for visiting (79%). In terms of healthcare practitioners' knowledge of LGBTQI+ identities, one third of the sample reported educating practitioners about LGBTQI+ identities (34%), with just over one quarter (29%) reporting that healthcare practitioners were knowledgeable about LGBTQI+ identities 'most of the time' or 'always'. This lack of knowledge/awareness of LGBTQI+ identities was also reflected in the number who reported that healthcare practitioners made incorrect assumptions about their LGBTQI+ identity, with around one quarter (25%) stating this 'sometimes' happened and around 17% saying this happened 'most of the time' or 'always'. While 44% felt comfortable most of the time or always disclosing their LGBTQI+ identity, nearly one quarter (23.9%) reported that healthcare practitioners didn't acknowledge their identity when they disclosed it. Half of the participants (50%) reported that services didn't have any posters or information related to LGBTQI+ healthcare while it was reported that one third 'sometimes' had them (Table 8.1).

Table 8.1: Healthcare experiences

When you used healthcare services in the past five years, how often did the following happen?	Never		Sometimes		Most of time/ always	
	n	%	n	%	n	%
Healthcare practitioners told me my LGBTQI+ identity could be changed (n=2376)	2172	91.4	153	6.4	51	2.2
I felt personally discriminated against by a healthcare practitioner because of my LGBTQI+ identity (n=2409)	1994	82.8	321	13.3	94	3.9
Healthcare practitioners asked me unnecessary/invasive questions about my LGBTQI+ identity that were not related to the reason for my visit (n=2435)	1926	79.1	384	15.8	125	5.1
I had to continually educate healthcare practitioners about LGBTQI+ identities (n=2417)	1602	66.3	494	20.4	321	13.3
Healthcare practitioners were knowledgeable about LGBTQI+ identities (n=2360)	624	26.4	1059	44.9	677	28.7
Healthcare practitioners made incorrect assumptions about my LGBTQI+ identity (n=2408)	1384	57.5	618	25.7	406	16.8
I felt comfortable to disclose my LGBTQI+ identity to the healthcare practitioner (n=2426)	646	26.6	707	29.1	1073	44.2
When I disclosed my LGBTQI+ identity to healthcare practitioners, it was acknowledged (n=2326)	555	23.9	585	25.2	1186	51.0
The healthcare service/practitioner had posters/leaflets/information that were relevant to LGBTQI+ healthcare (n=2379)	1192	50.1	817	34.3	370	15.5

Qualitative comments about healthcare experiences were in line with the quantitative data. Many identified positive health service experiences while others commented on challenges and provided some insight into possible reasons for the negative scoring to some of the quantitative statements.

Positive experiences

Positive experiences were generally associated with accessible services, including sexual health services, and non-judgemental, non-discriminatory, respectful, sensitive and knowledgeable LGBTQI+ and cisgender straight practitioners.

"It was positive. Some anxiety around coming out and my GP was very supportive." (29, woman, gay, ID 2007)

"Health services never asked me about any LGBTQ topics which made me comfortable as my judgemental mom was close by. I believe sexual orientation is a personal matter that shouldn't be forced out into the open during a medical procedure unless necessary and patient is alone." (17, man, bisexual, ID 1727)

Negative experiences

In contrast, negative experiences centred on the challenges of engaging with health services that are essentially hetero- and cis-normative, in terms of the nature of the medical data collected, but also in the assumptions made by healthcare professionals due to lack of knowledge about LGBTQI+ identities, and in particular lack of knowledge and awareness on transgender identities. This overall lack of knowledge led to incorrect assumptions, such as assumptions of heterosexuality, that lesbians do not want to have children or when pregnant that they have a male partner, or that gay men's health problems are associated with STIs or HIV.

"Gynaecologists have assumed that because I am lesbian, I didn't want to have children." (50, woman, lesbian, ID 1590)

"My partner and I have both had health issues incorrectly assumed as STI's once our sexuality was disclosed." (30, man, gay, ID 534)

"I find that healthcare professionals just assume you are straight. You are constantly in a position where you have to 'point out' that you are not straight." (50, woman, lesbian, ID 1370)

Not surprisingly, participants highlighted challenges in disclosing their LGBTQI+ identity to healthcare professionals, due to fear of being dismissed, fear of being viewed as deviant, or fearing that the quality of care will be reduced if they disclose their trans identity. Fear of discrimination was also associated with avoiding seeking a service at all for some transgender participants. Participants were reluctant to disclose to some older or rural healthcare providers, and for some, disclosure related uncertainties resulted in them changing healthcare providers.

"I feel scared of disclosing my identity cause I worry about discrimination or that support being stopped. I worry they would assume my problems are associated with my LGBT identity instead of properly diagnosing me. I hate how dismissive healthcare workers can be towards trans identity." (No age given, genderfluid, transgender man, queer, ID 779)

While there were very positive comments about experiences of sexual health clinics, other participants reported challenges in terms of sexual health services, for example, accessibility outside cities, and/or getting treatment for an STI post screening.

"...did find issues with my GP around PREP. They didn't know what it was! Had to explain. Which was crazy." (32, man, pansexual, ID 2429)

"I am HIV+ and live in remote rural Ireland but have to go to Dublin to attend an HIV clinic there. It would be handier if it wasn't as far." (58, man, gay, ID 2129)

Services that offered cervical screening was a particular issue for some participants. Confusion about whether participants should get smear tests and feeling dismissed because of their sexual orientation when accessing these services were both reasons expressed for dissatisfaction.

"Smear tests and lesbians - still can't work out if I need one? Last test, nurse told me (while trying to insert speculum!) that I didn't need one because I had never had sex with a man. I actually have, but she assumed I had not as she knew I am married to a woman. I am not sure that it is true I would not need one, even if I had never slept with a man?" (31, woman, lesbian, ID 976)

Maternity and perinatal health services were also an area where challenges were encountered.

"We all know this, but the maternity services are seriously stifling with the women-mammies-girls stuff and the PINK BABY vs BLUE BABY stuff and the assumptions and also, I have NEVER been so not-listened-to by healthcare professionals as when I was in maternity services. Not just about gender but also about everything else." (32, queer, ID 2372)

Healthcare utilisation for a mental health problem and experience of mental healthcare support

60% of the sample indicated that they had sought professional help for a mental health problem in the past five years (n=1663/2758). Figure 8.2 shows a list of sources of professional help ranked in order of highest to lowest. The top two sources of help accessed were a counsellor/therapist and a GP, which were accessed by 72% (n=1198) and 50% (n=826) of participants respectively. Between 26% (n=444) and 29% (n=479) of participants had accessed a psychologist or a psychiatrist or a school/university counsellor. Notably, general helplines, such as the Samaritans, were utilised more often than online help. With

regard to LGBTQI+ specific help, in person support was utilised slightly more often than support through LGBTQI+ helplines. Sources of online help included online therapy by BetterHelp, Talkspace and Jigsaw; support groups hosted online by organisations, such as the AA, as well as Facebook support groups; and websites and online forums such as Spunout.ie, mymind.ie, brightlineeating.com, soberful.com, gendergp.ie and reddit.com/r/TransIreland were also utilised.

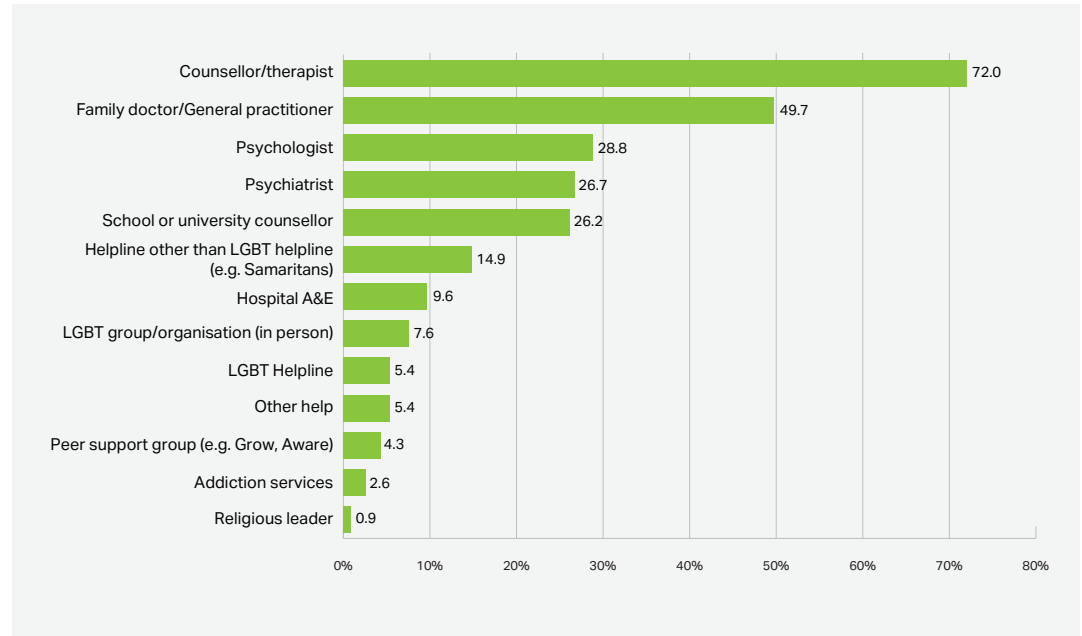


Figure 8.2: Sources of professional help

NB: Participants could choose multiple categories therefore percentages do not add up to 100%

Experiences of mental healthcare support

The reasons for seeking mental health support were not always related to being LGBTQI+, for example, some participants reported attending counselling due to work related issues or generalised anxiety, or no particular reason was specified. Similar to previous comments on general healthcare services, participants recounted both positive and negative experiences of the mental health support they were given. Positive experiences were again associated with respectful, sensitive and knowledgeable practitioners. Negative encounters centred on engaging with mental health practitioners that were unsure how to react to the person's gender identity or sexual orientation, disinterested, or not supportive, with participants writing about incidents when they were disregarded, not taken seriously or misgendered.

"Most GP's I have spoken to in regard to my mental health seem very uninterested and have not helped at all." (25, man, gay, ID 1562)

"..being deadnamed – misgendered (after legally changing everything) has not instilled me with confidence in some psych[iatrists]." (36, woman, transgender woman, queer, ID 538)

"It's very poor. Not many good services available in terms of counselling. Counsellors don't know-aren't educated on LGBTQI+ life-problems." (39, gender non-conforming, gay, ID 1226)

In addition, availability of, and accessibility to, timely, quality mental health services was an issue, with participants commenting on the waiting times and the cost of accessing private mental health support.

"The waitlist for psychologists in Ireland is way too long." (14, woman, bisexual, ID 1681)

"Ridiculous wait times for health services need to be addressed immediately. I had been forced to wait over 2 years to access primary psychological support and diagnostic appointments concerning my physical health. Private healthcare is inaccessible in my salary range." (32, man, gay, ID 2377)

For some, the lack of timely access to a public service meant they were accessing the cheapest option they could afford.

"I cannot afford it. I had to access online mental health services because in-person ones are too expensive and not accessible." (34, non-binary, bisexual, ID 2540)

Others avoided accessing mental health supports because of stigma and shame or because they feared their LGBTQI+ identity being pathologised to the exclusion of alternative reasons for their mental health difficulties.

"Seeking mental health help is very difficult, feels embarrassing and stigmatised so I have chosen not to seek it." (18, non-binary, lesbian, ID 1516)

"There is this stigma that mental health problems are directly related to the LGBT identity and I find it blocking my access to healthcare due to these assumptions." (28, man, transgender man, asexual, ID 2392)

A final accessibility issue for young people was the concern about the need for parental consent/involvement in their use of mental health services, but also the way consent is managed in the school context which can be stigmatising and/or prohibitive.

"I believe I may need mental health services, but I cannot afford it to be relayed back to my parents." (17, man, gay, ID 819)

"Due to events at school, I was assigned a school counsellor. Each class before an appointment my teacher had to sign a bright pink slip in front of all my peers. The counsellor also broke confidentiality with the school head. Getting help should not be the greater evil and a private affair." (18, woman, bisexual, ID 1507)

Recommendations to improve physical and mental healthcare services

The main recommendations for improvement in physical and mental health services were: i) Increased service accessibility; ii) Proactive signalling that services are LGBTQI+ friendly; and iii) Education of healthcare practitioners (n=163) (Figure 8.3).



Figure 8.3: Participants' recommendations on improving physical and mental healthcare services

Increased service accessibility

The highest number of responses about service accessibility related to cost. Suggestions here were for more affordable, low cost or free access to healthcare and in particular psychological supports.

"Therapy should be state funded and anyone who needs it should have access to it." (33, non-binary, queer, ID 2096)

"Need affordable healthcare for mental health!!!" (26, woman, queer, ID 2437)

Further recommendations in relation to accessibility were having a registry of LGBTQI+ healthcare professionals who are LGBTQI+ and/or LGBTQI+ friendly and the facilitation of requests to have an LGBTQI+ or ally doctor when accessing healthcare.

"It would be hugely helpful to have a list of LGBTQI+ counsellors-therapists available nationwide." (52, woman, lesbian, ID 1075)

Proactive signalling that services are LGBTQI+ friendly

Many recommendations related to the need for proactive signalling that services are LGBTQI+ friendly, for example, by having LGBTQI+ related information sheets available, or having (rainbow) stickers or posters visible in the practice.

"They should have information available, posters, info, anything. They should stop making assumptions. In the absence of any of this, it is very intimidating to come out as you have no idea what reaction you're going to receive." (45, woman, gay, ID 1804)

Other suggestions included the need for LGBTQI+ proofing of health services to ensure services demonstrate more acceptance and respect of LGBTQI+ people by proactively inquiring about people's pronouns, having identity inclusive medical records, being cognisant of the intersectional nature of service provision that may be required, having LGBTQI+ champions in health services, an LGBTQI+ buddy system for attending services and having access to LGBTQI+ healthcare providers.

"LGBTQI+ health services need to be more heavily vetted by those identifying as LGBTQI+ to avoid a range of often offensive and inappropriate questions." (22, man, gay, ID 692)

"It would be good to encounter more practitioners who are LGBTQI+ so I don't feel so out of place. There has been no efforts to discuss relevant matters related to my identity by anyone I encounter." (29, woman, queer, ID 1572)

Education of healthcare practitioners

In terms of training and education, most answers suggested that the training of healthcare professionals about LGBTQI+ lives, identities, and health related issues could be substantially improved.

"Better education is needed for both physical and mental healthcare practitioners - doctors have assumed I do not have sex with men because my most recent partner was a woman. Therapists have assumed I am straight because I'm in a relationship with a man. I find this makes it more difficult to disclose my sexuality than if they openly asked how I identify." (29, woman, bisexual, ID 2500)

"Not enough is known about DSDs (Disorders of Sexual Development/ Intersex) to help those with them" (50, man, heterosexual, ID 1341)

Other recommendations included suggestions of anonymous consultations, provision of information on how to access mental health services, and a reduction in health service waiting times, including time required to get an appointment with sexual health clinics. Also suggested was, greater access to HIV-AIDS screening and medication as well as monkeypox vaccines.

"Make anti-HIV/AIDS medication more well known to the public through advertising and media, especially PREP and PEP. Also make monkeypox vaccines more readily available and advertised to the public so more people know about this. Even heteronormative people." (23, non-binary, gay, ID 784)

A small number of participants suggested allowing blood donations, banning conversion therapy, having reviews of any inappropriate care received by young LGBTQI+ people, increased access to peer support groups, the end of state services having any religious ethos, and a call to stop reducing service funding.

Healthcare services to support medical transitioning and experiences of services

People who identified as transgender and/or non-binary were asked if they had ever used healthcare services to support medical transitioning. Of the 787 people who responded to this question, around one fifth had either received (4%) or were still receiving care (16%) for medical transitioning, with around two-fifths (43%) reporting that they planned to, while just over one third (35%) indicating that they had no intention of using healthcare services to support medical transitioning (see Figure 8.4).

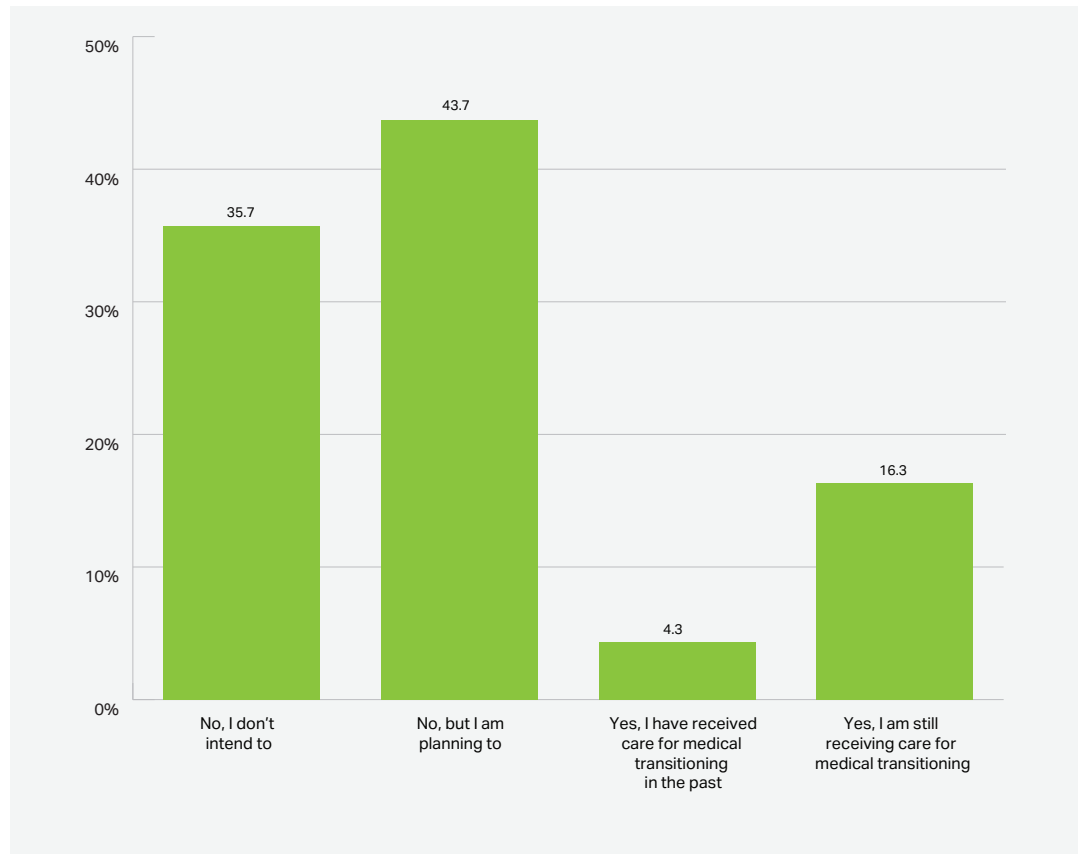


Figure 8.4: Receipt of health care for medical transitioning

Participants who had or were in the process of medically transitioning (n=162) were also asked if they had ever self-medicated using hormones as part of their medical transition, for example buying hormones online or getting hormones from friends. In total, 29.6% (n=48) indicated that they had self-medicated, half hadn't done it but had considered it (n=81), and one fifth (20.4%, n=33) would never consider doing it.

Those who had used or were using services to support medical transitioning were asked about barriers to accessing services. Figure 8.5 shows the responses to a list of barriers ranked in order of the highest number of responses. The three top barriers were waiting times, lack of knowledge among practitioners about transgender healthcare and geographic distance to services.

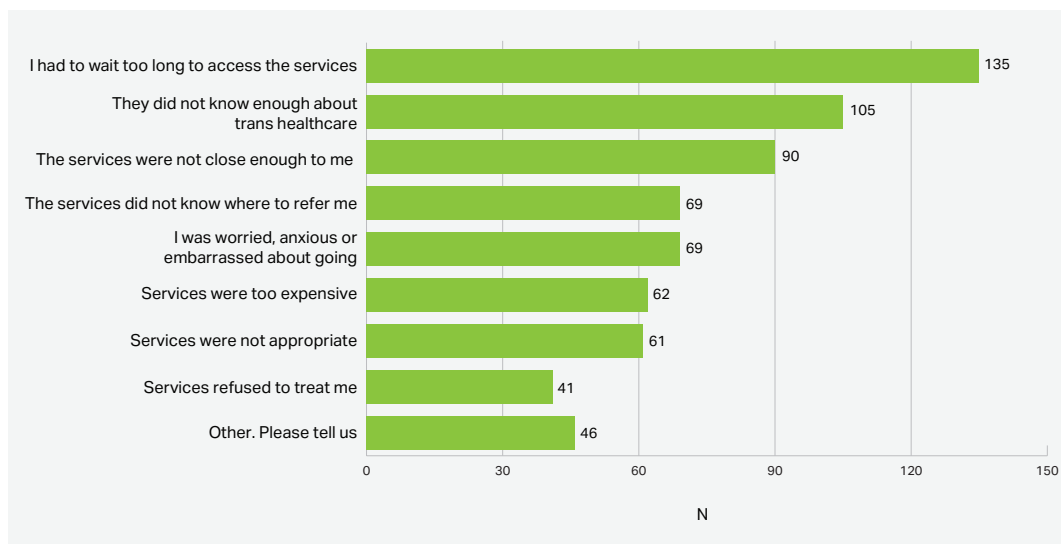


Figure 8.5: Barriers to accessing services

NB: Participants could select multiple responses

Experiences of National Gender Service

In the free text option, numerous comments were made on the overall quality of the National Gender Service. Participants described it as *'inadequate'*, *'outdated'* and *'inaccessible'*. In line with the quantitative findings people wrote about *'the ever-growing waiting list'* and described it as a *'scandal'* *'cruel'*, *'insane'* *'bordering on abuse'*, and *'leaving people without hope'*. Some people mentioned the waiting list that is present even after a person gets access to the National Gender Service and how the lack of communication from the service while they were on the waiting list made them feel that they had been forgotten about.

"Even after starting to access services (the National Gender Service) I have been waiting over 1.5 years to get a surgical referral, after which I'll be on a surgeon's waiting list for at least another year. I have not received clear communication about how long the process would take." (24, non-binary, bisexual, ID 1018)

"Trans people are at high risk of self-harm and suicide and a multiyear wait list is completely unacceptable." (25, non-binary, bisexual, ID 2200)

For many, the absence of *'decent trans healthcare in Ireland'* (71, transgender woman, lesbian, ID 2675) or *'affirming healthcare for women who are transgender in Ireland'* (50, transgender woman, bisexual, ID 924) forced them, to access services outside of Ireland if they wanted *'healthcare in a timely manner'* (24, transgender woman, asexual, ID 1025). There were repeated references made to using Gender GP (an online health service which provides support to the trans community, <https://www.gendergp.com/>), or resorting to purchasing hormones online, and/or seeking surgery abroad (in UK, Spain, Poland, Turkey, USA, Netherlands) which imposed a significant financial burden on people.

"I had to leave the country to get top surgery and had to pay for it myself." (28, non-binary, lesbian, ID 1436)

"I have had to access Hormone Replacement Therapy (HRT) abroad as I was not mentally able to wait years in Ireland to risk the possibility of rejection from the gatekeeping doctors monopolising transgender healthcare in the public system." (22, transmasculine, asexual, panromantic, ID 1523)

While some were lucky to have a supportive and knowledgeable GP, others commented on the challenge of finding a GP that was informed about transgender issues, with others noting how *'the constant gatekeeping leaves people in limbo for years'* (no age given, woman, transgender woman, pansexual, ID 2575). For example, this participant commented:

"I have not been referred to a gender clinic or to a psychiatrist by my GP, who insists on blocking my access to trans healthcare." (28, man, transgender man, asexual, ID 2392)

Participants were also critical of the psychological assessment process used by practitioners within the National Gender Service. The assessment process was described as *'intrusive', 'inappropriate', 'pathologizing', 'upsetting', 'disrespectful'* and *'traumatising'*. The following is reflective of some of the comments made.

"I was forced to dredge up every single painful detail of my life and talk about the most distressing things in my life for the sake of them ticking a box. I had been seeing the service for years, and they had been providing me with medical care already. I had received two diagnoses of gender dysphoria, but they traumatised me for the sake of ticking boxes." (32, woman, transgender woman, bisexual, ID 120)

"I was questioned extensively, and it was suggested that I undergo more psychiatric evaluation, or quit transition outright, because I dated a cis woman, and it was expected that I should be strictly heterosexual. I was also dissuaded from medical transition, and it was repeatedly suggested that I should detransition, because my family did not support me." (26, woman, transgender woman, pansexual, ID 981)

Use of healthcare services outside of Ireland to support medical transitioning and experiences of aftercare services

Of the 162 participants who had or were in the process of medically transitioning, 68.5% (n=111) indicated that they had used healthcare services outside of Ireland to support their medical transition. Of the one-third who had not used services outside of Ireland, one quarter have considered using them (25.9%, n=42) while just 6% (5.6%, n=9) reported that they wouldn't consider it.

In total 100 participants provided responses about the quality of aftercare services on their return to Ireland. In terms of people's experiences of aftercare, two subthemes emerged, namely i) Feeling lucky to have some supportive practitioners; and ii) Non-existent or poor-quality aftercare (Figure 8.6).



Figure 8.6: Experiences of aftercare in Ireland following medical transition abroad

Feeling lucky to have some supportive practitioners

A small number of participants provided positive comments on the aftercare from medical professionals, in particular GPs, noting that they were 'lucky' to have a knowledgeable and supportive person. However, some of them noted knowledge deficits on the specific health needs of transgender people among health professionals, even among those who were willing to provide varying degrees of support.

"My GP has a shared care arrangement with a centre I use in London, very positive experiences with the Irish GP." (34, transgender man, queer, ID 1842)

"I did find a GP willing to perform blood tests and prescribe testosterone as per GenderGP guidance, but she is completely ignorant and has no idea about anything relating to trans healthcare, sorry for being harsh, but she's very unreceptive and uninterested in learning." (29, transmasculine, pansexual, ID 686)

"For my chest surgery (double mastectomy) I went to Turkey... My GP was concerned but was happy with my research. He didn't know much about it but looked at my incisions upon my return and was pleased for me." (21, transgender man, bisexual, ID 1236)

Non-existent or poor-quality aftercare

The vast majority of those who responded to the question on aftercare wrote comments that consisted of a single sentence or phrase such as "No aftercare here." (23, man, transgender man, gay, ID 89), "Complete lack of aftercare." (29, trans male, transgender man, queer, ID 210), "Didn't get any of that." (22, non-binary, gay, ID 450), "Practically non-existent, frantically searching to find aftercare." (57, woman, transgender woman, lesbian, ID 832), "I didn't really get any." (22, man, transgender man, bisexual, ID 701), "There is no aftercare

for transgender surgery abroad, which makes planning fun." (37, trans female, transgender woman, asexual-questioning, ID 1147), "Experience of aftercare... what aftercare? I have no experience of receiving aftercare in the ROI after procedures abroad." (52, woman, transgender woman, questioning, ID 2672). A number of participants who did receive some aftercare described a range of negative experiences, ranging from delay in organising tests, challenges in accessing care for infections, to misgendering.

"I had surgery in Spain which was a great experience, but my GP and other healthcare providers here were awful. I had an infection and the surgery team sent directions for my GP to organise a CT scan and prescribe medications. I was left waiting for over a week without treatment because of issues with the GP. So, the surgical teams afterward were great, but my GP was not." (32, woman, transgender woman, bisexual, ID 120)

An issue that exacerbated people's negative experiences was the practice by medical personnel of using the person as a 'teaching tool' for other healthcare professionals. This practice made the person feel degraded and a 'spectacle', as the following comment indicates.

"Complete lack of aftercare. Have, however, on multiple occasions through the years, been asked to show the results of a surgical procedure to doctors in the national gender service who have made inappropriate comments." (29, transgender man, queer, ID 210)

Recommendations to improve healthcare services for people who identify as trans

Over 700 people responded (many with multiple responses) to the question on things that could be done to improve healthcare for transgender people. The overwhelming tone in the comments was frustration, dissatisfaction, and anger with some recommending the abolition of the current service. In terms of recommendations three key areas emerged (Figure 8.7): i) The development of a more comprehensive model of care related to medical transition; ii) The education of healthcare practitioners in trans related issues; and iii) The provision of a proper state funded service.

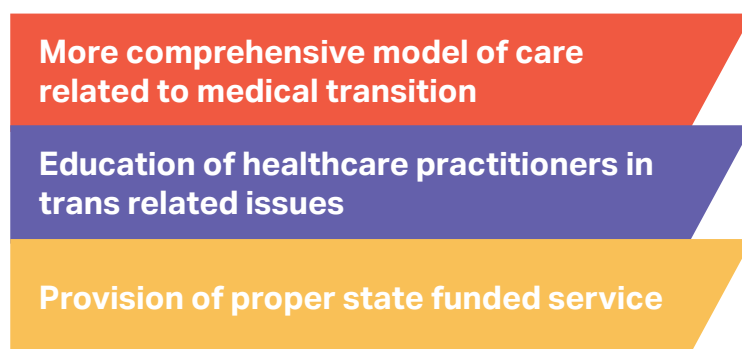


Figure 8.7: Participants' recommendations on improving healthcare for transgender people

Participants requested the development of a more comprehensive timely model of care with a call for healthcare related to medical transition to be decentralised and provided at a more regional and community level. This was seen as a way of reducing the waiting list. In addition to having more localised clinics through increasing the number of clinics providing medical transition related care around the country, participants requested that clinics be staffed by a multidisciplinary team (Medical doctors, endocrinologists, counsellors/therapists, peers), with expertise in trans health as well as physical and mental health. People recommended greater and easier access to psychological supports, especially in the early stage when one is exploring and coming to terms with one's gender identity, with many emphasizing that the services needed to be more supportive and affirmative.

"A model based on supporting trans people and working with them to create the right treatment plan, rather than a model of discouraging people to transition by making it as difficult and distressing as possible to access treatment." (26, non-binary, queer and bisexual, ID 15)

Another recommendation included the availability of surgeons to perform gender-affirming surgery within the country. This included the provision of surgery to people who identified as non-binary.

"I am non-binary and don't want to use hormones etc.. as part of my journey but would like to access top surgery - that's impossible here. I will have to go overseas which adds significant costs." (40, non-binary, queer, ID 998)

The introduction of an informed consent model¹³ of accessing healthcare to support medical transitioning, together with the devolution of responsibility to GPs or local hospitals for prescriptions and follow-up blood tests was seen as a way of making access to hormone treatments easier and timely.

"Put prescription of puberty blockers (for aged 12 to 18), hormones (for aged 18+).... into the hands of GPs. They're capable of doing these prescriptions and monitoring blood work. Remove the need to see one of just two overloaded endocrinologists." (48, non-binary, pansexual, ID 88)

For many the abolition or reappraisal of the current assessment process was essential, with a call for practitioners working in the current system to believe people and stop, what some referred to as, 'making people jump through hoops'. While looking for change, some participants recognised the need for some form of assessment given the life changing significance of decisions being made. For example, this participant wrote:

"I believe that a transition that requires medical intervention does actually call for medical assessment beforehand. So my view is that people

13 An informed consent model refers to a shared decision-making process between the transgender person and healthcare provider (usually a GP), in a context where the healthcare provider has spoken to the transgender person about the risks and benefits of hormonal treatment.

who want to/have to go down the road of medical intervention, whether hormone treatment or surgery or whatever, need to accept - and will benefit from - a detailed and ongoing medical assessment, AS WELL AS positive assistance from the medical profession.” (76, woman, transgender woman, lesbian, ID 2099)

Some participants placed emphasis on services following internationally recognised standards of care and referenced the World Professional Association for Transgender Health guidelines for transgender healthcare (Coleman et al. 2022). Others emphasised the importance of developing the service in partnership with trans people, the inclusion of trans peer support workers within the support team, as well as having the service led by a trans person.

“I would feel more comfortable if I’d seen people I identify with as part of the service.” (31, non-binary, questioning, ID 194)

A small number of participants referenced ‘gatekeeping’ and the challenges experienced by people with autism, mental health challenges, or teenagers, in accessing services.

“The entire system requires a COMPLETE overhaul. There is no ONE thing that can be improved when it is so utterly broken, overwhelmed and offensive in the hoops it makes trans people jump through, especially autistic trans people and trans people with mental health issues.” (34, non-binary, transgender man, pansexual, ID 168)

Others recommended having more written information/guidelines that would make the ‘trans healthcare systems and process clearer and less confusing’ for people, including the person themselves and for their family members. Participants requested clear information on issues such as: ‘how to access trans healthcare’, ‘the transition process/hormones/surgery and other options’, ‘where to start/pathways of care’, ‘how to change name/gender markers’, ‘list of GPs that are trans friendly’, and ‘where to get binders/packers’.

All of these recommendations were viewed as a means of increasing accessibility to a service that was respectful, empathetic and gender-affirming as well as a way of decreasing waiting times, financial costs, inequity associated with ability to pay, and the physical and psychological risks associated with a system that forced people to travel abroad for surgery or to access hormones online.

Provision of a proper state funded service

A large number of people wrote about the cost implications that arose for them as a result of not having comprehensive, timely, and free services within Ireland. Costs mentioned included costs associated with: i) travelling abroad for surgery; ii) accessing private psychological therapy because of waiting times; iii) purchasing hormones, speech therapy, electrolysis, and other items such as binders; and iv) travelling within the country to the National Gender Service.

Hence, people requested *'that services be fully funded by the state'* and in the meantime while a fully funded service is being developed, people recommended that some level of financial support be given to people who were required to purchase services/supports either within or outside the country, including binders/packers.

"More public affordable clinics. It's not fair that there's only one public transition clinic in Ireland, so I will have to go through GenderGP or pay an absurd amount of money just to get hormones." (16, man, transgender man, gay, ID 525)

"Provide for free material items (not hormones or surgery but products or items) that help young teens beginning their transition. For example, chest binders are very important. A chest binder helps bind breasts so that they appear more masculine. Providing free and good quality binders would be a great improvement to many trans youth. These products should be available at GPs and other healthcare organisations." (18, man, transgender man, bisexual, ID 1640)

Education of practitioners in trans related issues

Similar to recommendations made for all healthcare, there was a strong feeling that all staff, including GPs and people working within the National Gender Service require education on trans issues. Education for GPs was particularly emphasised as they were seen as the first port of call for young people and their families.

"Have medical professionals actually know what they are taking about!! I understand GP's are stretched thin but I believe there is no excuse for not keeping up with the times-knowledge. They are the first port of call for all things not just LGBT-trans related but when you're going to a doctor about your trans identity you're terrified and the last thing you want is to either be educating them on everything or for them to not be 100% and have to look into things etc.. it makes you feel like you're being put on the long finger." (27, questioning, gay, ID 2158)

Participants wrote about the need for education to focus, not just on care pathways, medical transitioning, hormone therapy, care after surgical procedures, mental health risk factors, and use of pronouns, but emphasis was also placed on communication and teaching practitioners how to engage with trans people in an empathetic, respectful, and informed manner. Some participants emphasised that education needed to be developed and delivered in conjunction with the trans community, with a small number suggesting it should be compulsory for all healthcare workers. Education was viewed as a means of reducing the discrimination, misgendering and insensitive practices that people were currently being exposed to.

"Education on the trans experience as some medical practitioners are dismissive, discriminatory or invasive. Trans people should not be afraid to go to the doctor because they feel uncomfortable or misplaced." (16, non-binary, questioning, ID 1512)

Education was also seen as a way of increasing access to services and supports as the more educated GPs and other practitioners became, the greater the likelihood that they would offer a more expansive service, or at least be able to provide more informed up-to-date information to people seeking help. More informed practitioners were also perceived as being more likely to be proactive in using symbols or images to communicate to people that there was a culture of inclusivity within their organisation or team.

“More education to get more knowledgeable doctors into the field, to reduce the monopoly that the current endocrinologists treating trans people have on providing hormones or other such services.” (21, non-binary, queer, ID 726)

Healthcare experiences for participants with an intersex variation/s

Participants were asked if they had experienced any medical interventions for their intersex identity. In total, thirty-one participants responded to this question, eight indicating they had a non-consensual intervention and four reporting that they had a consensual intervention. Nearly half reported (45.2%, n=14) that they hadn't experienced a medical intervention, while 16% (n=5) did not know. In total eleven (n=11) participants provided additional information on the medical interventions received. Three (n=3) reported having surgery for hypospadias repair (surgery to correct a defect in the opening of the penis that is present at birth), one had surgery on their foreskin and undescended testes which were described as non-consensual. Two reported having surgery when younger but were unsure about the details (non-consensual). Of those who indicated they had consensual interventions, one person stated they had invasive examinations and check-ups and another stated that they had breast augmentation. Apart from the breast augmentation surgery, all other participants described having surgery as an infant or a child. Hormone treatment was discussed by three others (n=3) with two receiving testosterone injections, and another prescribed the oral contraceptive pill. All of the participants who were prescribed hormonal treatment stated that they were teenagers when it commenced and provided consent for this treatment.

Overall, there was a general dissatisfaction reported with the care provided especially around the issue of consent, information provided and outcomes. Some participants reported that they would not have consented to medical interventions if they had more information about the potential consequences of the surgery/ treatment at the time. The following are some of the comments made.

“Exploratory laparotomy [abdominal surgery] was performed with little - no explanation given, lacking this information means I could not have consented to the procedure.” (26, transgender man, queer, ID 1427)

"I was put on birth control from age 13-14. I consented at the time, though looking back I wish I'd understood the changes it would make to my body a bit better." (29, transmasculine, pansexual, ID 686)

"Testosterone injections as a teen. I was assured that this would bring me into line with being a typical male. I was lied to." (50, man, heterosexual, ID 1341).

"Hypospadias "repair" that left me unable to urinate and without feeling in my phallus. Hormonal interventions that gave me sleep disorders and worsened my gender dysphoria." (51, non-binary, transgender woman, queer, ID 201).

Summary and discussion of findings

The findings demonstrate that 90% of participants had used healthcare services/ practitioners in the past year and 60% had sought both online and in-person mental health support in the past five years. Counsellor/therapist or family doctor/GP were the most frequently used sources of professional mental health support, with support from LGBTQI+ and peer sources being less frequently used.

While the majority reported positive experiences of engaging with physical and mental health services in terms of their LGBTQI+ identity, which were associated with encountering respectful, sensitive and knowledgeable practitioners, both the quantitative and the qualitative data highlight the challenges that some LGBTQI+ people experience when they engage with healthcare services. In addition to the accessibility issues that the non-LGBTQI+ population experience, such as waitlists and cost, fear of being shamed or pathologized and concerns about the need for parental consent/involvement in mental healthcare were also barriers. Most of these were similar barriers to those identified in the *LGBTIreland* report. Negative encounters were associated with practitioners who lacked knowledge, were disinterested, or were unsupportive in terms of the person's LGBTQI+ identity. The findings reveal how routine healthcare practices infused with paternalistic, heteronormative and/or cisnormative assumptions continue to perpetuate the marginalization of LGBTQI+ people. Common examples include: the assumption of heterosexuality, practices that assume that one's partner is always of the opposite sex, that lesbian women don't require a smear test, the disregarding of some identities, such as bisexuality and gender fluid as invalid identities, and the use of incorrect pronouns or birth names as opposed to people's preferred name. These assumptions, attitudes and behaviours not only increase people's invisibility within the healthcare system, damaging trust and inhibiting communication between the person and the healthcare practitioner, but they act as a barrier to people disclosing their sexual or gender identity and other relevant healthcare information. They also exacerbate feelings of stigma, which has a damaging effect on people's mental health as well as creating negative care expectancies, which can shape future health and help seeking behaviours (Murphy and Higgins, 2022). These

negative encounters may be indicative of a lack of knowledge about LGBTQI+ issues (Poteat et al. 2013), and a lack of awareness of the negative impact that disregarding identity can have on LGBTQI+ people, one being a reluctance to access healthcare in the future (Romanelli and Hudson, 2017).

There is no doubt that the ongoing education provided to healthcare practitioners is demonstrating impact in terms of achieving the outcomes identified under the thematic pillar, 'Healthy' in the *National LGBTQI+ Inclusion Strategy 2019 – 2021* (DCEDIY, 2019). However, interwoven throughout the findings is a lack of LGBTQI+ healthcare related knowledge among health professionals, with one third of participants reporting that they have to educate practitioners about LGBTQI+ identities. This finding highlights not only a need for continued education of health professionals on LGBTQI+ health issues but perhaps more importantly the need to ensure healthcare educators who themselves have been socialised within a hetero/cis-normative world do not perpetuate this discourse in the wider curriculum. While stand-alone modules or content on LGBTQI+ issues will increase knowledge, this approach may also reinforce the idea of LGBTQI+ people as 'other,' separate to the general population (Rees et al. 2021) and perpetuate the idea that LGBTQI+ people are a homogenous group. LGBTQI+ people have diverse histories, experiences, needs and fears. Hence, there is a need to ensure that a life span approach is taken, and that the historical, legal, socio-political, and economic contexts of LGBTQI+ people's lives are addressed in healthcare curricula, as well as how the intersectionality of age, race, ethnicity, religion and other minority statuses (e.g. migrant, Traveller) may impact experiences. Education also needs to move beyond information giving and support practitioners to understand how prejudices are formed but also to recognise the potential impact of their prejudices on the way they work with people. Anything less runs the risk of recreating and maintaining societal inequalities within the health system, and its discriminatory impact on LGBTQI+ people.

Although the number of participants who identified as intersex in this study was small, the sample size and findings are in line with international literature on healthcare experiences of people who identify as intersex. The participants in this study described receiving surgery as an infant or child, while hormonal treatment commenced in adolescence which is similar to what has been reported internationally (Zeeman and Aranda 2020, Berger et al. 2023). Those who had undergone medical interventions in childhood described it as non-consensual, which is also similar to Hill et al.'s (2020) findings from a national Australian study involving 47 intersex participants. Participants who had undergone a medical intervention as a child in Hill et al.'s (2020) study not only reported having insufficient say over the medical decisions related to them, but they also questioned if in the absence of information their parents were able to provide informed consent at the time of surgery.

Rees et al. (2021) assert that the transgender community are one of the most neglected cohorts of the sexual and gender minorities within healthcare. In the EU funded Transgender Europe (TGEU, 2022) ranking of trans-specific

healthcare across the EU member states, Ireland is ranked last (Adams and Ganesan, 2023); scoring worst on waiting times to see a specialist in trans healthcare which was between 3 and 10 years compared to a wait time of less than one year in most other states. The report attributed the delay in Ireland to only having a single referral centre that does not match demand. Findings from our study are also in line with TGEU (2022) rankings (<https://tgeu.org/trans-health-map-2022/>) and with existing literature describing the barriers experienced by trans and non-binary people in accessing healthcare, in particular gender-affirming healthcare in Ireland (Howell and McGuire, 2023, 2019, Kearns, et al. 2024, 2021, Szydowski, 2016).

Among the significant challenges reported by people in accessing healthcare to support medical transitioning, were the absence of timely, affordable, and high-quality care, with people waiting years to see a healthcare professional, encountering health professionals and practices that were not always supportive, and not having (geographically) accessible medical transition healthcare services. Consequently, people were resorting to purchasing hormones online and travelling abroad for surgery, thereby incurring significant financial cost and running the risk of poor-quality aftercare when they returned home. In this study, 30% of transgender and non-binary participants who had or were undergoing medical transition reported using self-medicated hormone treatment as part of their medical transition, and a further 50% had considered it. In addition, 69% indicated that they used or paid for services outside of Ireland to support their medical transition, and 26% had considered it. This may have included accessing services online (e.g. buying hormones or GenderGP) or in person. Participants in this study also referred to the mental health toll of being on long waiting lists, and how for some, this left them feeling hopeless for the future. Additionally, experiences of very difficult consultations on accessing trans healthcare services were recounted; this included experiencing consultations that were intrusive, inappropriate, pathologizing, or made them feel they were being blocked, which for some was traumatising. These findings are similar to trans people's experiences in other jurisdictions (Rees et al. 2021, Hobster and McLuskey, 2020, Pearce, 2018).

The absence of a well-funded and timely gender-affirming healthcare service not only denies people opportunities, dignity, and respect, which negatively impacts their mental health (Rees et al. 2021, Hobster and McLuskey, 2020), but it also raises a number of other concerns. In a service where extensive wait times for individuals seeking gender-affirming care is the norm, not surprisingly, accessing hormone therapy without medical prescription or supervision or DIY HRT, often emerges as a responsive intervention. Additionally, literature demonstrates that DIY HRT often occurs in response to a lack of GP knowledge, financial precarity and pathologizing models of healthcare for trans and non-binary individuals (Baker et al. 2023). While DIY HRT is often a meaningful intervention in response to a lack of, or reduced access to gender-affirming healthcare, DIY HRT can place people at risk of negative health outcomes (Todorovic, 2021), as there may be uncertainty whether the hormone purchased

is the hormone received (Laing et al. 2021). In addition, people taking DIY HRT may not disclose their DIY hormone usage to their healthcare provider (Kennedy et al. 2021, Adams and Ganesan, 2023), putting them at further risk. In addition to the financial burden placed on people who travel abroad for gender-affirming care, travelling abroad also has health implications (Mulhall, 2022). Risks include issues around quality of care in other countries, language/accessibility/consent challenges, getting/managing infections while travelling, risks associated with flying post-surgery and accessing continuing care in one's home country (McCrossan et al. 2021). Participants in this study who had travelled abroad had varying experiences of aftercare on arriving back to Ireland. Some encountered supportive practitioners that provided good care, this sometimes being in collaboration with practitioners abroad. However, for others aftercare was reported as non-existent.

Not surprising, in addition to education of health professionals in trans related issues, participants made a plea for a more decentralised, accessible, multi-disciplinary model of gender-affirming care that is state funded and underpinned by an informed consent model and internationally recognised standards of care.

Chapter 9: Surveying Public Attitudes

Introduction

Public attitudes can influence whether LGBTQI+ people are accepted or rejected in the domains that make up everyday life including work, family, school, religion, health, sport, amongst peers as well as within society more generally (Falck and Bränström, 2023, Flores et al. 2020b). Periodical monitoring of social attitudes among the general public not only provides insight into how views are developing and changing, but it helps identify where there is a need for social and political reform and what the impact is of reforms. Surveying social attitudes is particularly important given the link between negative public attitudes towards LGBTQI+ people, and their experiences of bullying, harassment, discrimination and violence. In turn these impact LGBTQI+ people's mental and physical health, and subsequently their need for health and social care services or support (Falck and Bränström, 2023).

In the 2016 *LGBTIreland* report, attitudes among the public in Ireland about LGBT people were mainly positive, in that most were opposed to discrimination and bullying behaviour towards LGBT people. The representative sample of the general public who took part in a telephone survey expressed being comfortable around lesbian, gay and bisexual people as part of everyday life, in work, as friends, and as their children's teachers. A majority also believed that LGBT issues should be addressed within the school curriculum and in positive messages communicated by teaching staff. In terms of transgender people, attitudes were also mainly positive, with most reporting they would support a family member to transition (sex change), and transgender people's rights to legal recognition. Less favourable attitudes were found with regards to having transgender people as their children's teachers, and around same sex public displays of affection. There was also evidence of people viewing being LGBT as a choice, and something that one can be persuaded to become, with a high number of people believing that equality had been achieved for LGBT people, or that being LGBT is no longer really an issue.

Since then, in recent Irish research on public attitudes to LGBTQI+ people, researchers have described Ireland as having a broad acceptance of LGBT identities (Noone et al. 2022), and being a welcoming and accepting country (DCEDIY, 2023), with an increasingly progressive and open perspective on LGBT rights and freedoms (Haynes and Schwegge, 2019). In the Global Acceptance Index, Ireland was ranked 8th out of 175 countries based on its average acceptance index score of 8.41 (Flores, 2021) and scored above the EU average for a range of measures including comfort if a colleague was GLB (Irl 88%; EU28 average 72%), if their child was in a same sex relationship (Irl 74%; EU28 average 55%), and having a GLB person in the highest elected position in the country (Irl 84%; EU28 average 64%) (EC, 2019). These positive attitudes were also noted by Noone et al. (2022), while researchers in the *Survey on People*

in Ireland's attitude towards diversity (DCEDIY, 2023) found that attitudes to lesbian and gay people were more positive compared to many other minoritized groups. The overall picture appears to be positive, but a more nuanced picture emerges when researchers ask specific questions on the different identities and sexual orientations under the LGBTQI+ spectrum (EC, 2019, Noone et al. 2022). Groups that do not align with traditional gender/sexual norms, such as bisexual, transgender, non-binary and intersex people are less accepted than lesbians and gay men.

Against the backdrop of a fast-changing Irish society in which maintaining the gains made in the acceptance of LGBTQI+ communities is by no means a given, it is evident that in addition to a repeat of the mental health component, the public attitudes module of the *LGBTIreland* study also needed to be replicated. At the time, Trinity College Dublin had partnered with RED C Research and Marketing to undertake a telephone survey of public opinions about LGBTQI+ identities, society, sexuality and gender identity. This collaboration was renewed in the current study.

This section of the report presents findings from the two surveys conducted by RED C. First, the telephone survey was replicated exactly as conducted at the time (in 2014) to ensure that a valid comparison can be made between the public attitudes then and now. In addition, it was considered essential to query the public's attitudes towards transgender and intersex people in more detail. This was done in a separate online survey of the same size. In the online survey several general questions were the same as in the telephone interviews, to allow a comparison of the two methods of surveying public attitudes. Prior to presenting the findings, the remainder of this chapter presents the methodology for both surveys.

Methodology

Aim

The aim of this module was to measure attitudes towards LGBTQI+ people in a nationally representative sample of the public in Ireland. The primary scope was to ascertain whether shifts in public opinion have occurred, and if so to what extent, in the years since the publication of the *LGBTIreland* study in 2016.

Research design

To achieve the above aim and ensure that direct like for like comparisons could be made to the previous study, the exact same survey instrument was used in the repeat of the telephone survey. However, in addition, a second attitudinal survey with a specific focus on attitudes towards transgender and intersex people was developed. Data for these additional attitudinal metrics were collected online.

Inclusion criteria

To be included in the studies a person had to be aged 18 years or over and living in the Republic of Ireland.

Data collection: telephone survey

The telephone survey used was identical to the one previously used for the *LGBTIreland* study and consisted of 39 statements regarding attitudes towards LGBT people, using Likert scales from 1 to 5 (1= disagree strongly and 5= agree strongly). The statements and the answer categories were read out to the participants, who could answer by mentioning the number or response category.

The following demographics were collected: gender, age, social class, area/ geographic region, working status, living arrangements, marital status, urban/ rural, dependent children, and level of education achieved to date. Similar to the previous survey, respondents were also asked how frequently, if at all, in their lives they interact with people who are (a) lesbian, gay or bisexual and (b) transgender. Attitudinal statements within each topic area were read out to respondents in a randomised manner to avoid any potential bias in statement order.

As Computer Assisted Telephone Interviewing (CATI) was the data collection method used previously, it was deemed the preferred choice to allow direct comparability to the previous wave of research.

Respondents were recruited using Random Digital Dial (RDD) telephone interviewing. RDD leads were sourced by RED C from Sample Solutions, with leads split by 46% landline and 54% mobile. Sample Solutions applies a stratified random sampling for landline leads, and simple random sampling for mobile numbers.

Fieldwork was undertaken between 11th and 29th May 2023 and 1,000 interviews were undertaken with quota controls used to ensure a nationally representative sample of ROI adults aged 18+, with interlocking quotas to provide extra confidence in sample profile.

Data were subsequently weighted across gender, age, region, and social class to ensure a nationally representative sample based on the most recent AIMRO (Association of Irish Market Research Organisations) population statistics (comprised of CSO population projections and Irish random route surveys).

Data collection: online survey

The online survey consisted of 37 statements regarding attitudes towards LGBTQI+ people, using a similar Likert scale to the telephone survey (1= disagree strongly and 5 = agree strongly). In addition to the demographics listed above, demographics in relation to sexual orientation were also collected. Respondents were also asked to rate their level of interaction and perceived knowledge on LGBT and intersex experiences. Attitudinal statements within each topic area were displayed to respondents in a randomised manner to avoid any potential bias in statements order.

Data for this survey were collected using RED Line, RED C's online omnibus. Respondents were recruited using RED C Live, RED C's own online panel of over 40,000 members. Omnibus research is where a small number of clients each place a short section of questions on a single survey thereby reducing fieldwork costs. Results are exclusive to each commissioning client.

Quota controls were used to ensure a nationally representative sample of ROI adults aged 18+, with interlocking quotas to provide extra confidence in sample profile. Data were then weighted across gender, age, region, and social class to ensure a nationally representative sample based on the most recent AIMRO (Association of Irish Market Research Organisations) population statistics (comprised of CSO population projections and Irish random route surveys).

Fieldwork for this research took place from 16th – 22nd June 2023.

Data analysis

For both surveys, analysis was undertaken using descriptive statistics, frequencies, and cross tabulations to understand differences between demographic groups based on gender, age, social class, region and education level.

Where the word "significantly" is used in the narrative, it is meant to describe a statistically significant difference at the 95% confidence interval.

For the telephone survey, statistical significance testing was conducted on the differences between the 2014 and the 2023 findings, and differences between demographic sub-groups. For the online survey, statistical significance testing was conducted on the differences between demographic sub-groups.

Where the commentary throughout this report refers to agreement and disagreement with the various attitudinal statements included in the survey, it means that both "agree strongly" and "agree slightly" have been added together for an overall agreement score.

In some instances, the overall agreement figures referenced in the commentary may not be the same as adding the two figures on the graphic due to rounding. For example, an agree slightly figure of 11.3% and agree strongly figure of 38.3% will both be rounded down on the graphic to 11% and 38% respectively, and as such, look like they should sum to 49%. However, when they are added together in reality, they sum to 49.6% which gets rounded up to 50%.

Ethical considerations

Ethical approval for this study was received from the Research Ethics Committees of the Faculty of Health Sciences in Trinity College Dublin. All respondents in the surveys conducted by RED C were reassured that their responses would remain strictly confidential throughout the study.

In total 1,000 interviews were conducted. The profile of the sample is shown in Table 9.1. The profile of the 2014 sample is shown in Appendix 2.

Table 9.1: Telephone survey demographic profile

Gender identity		Work status		Dependant children	
Male	49%	Working full time (30 hours or more)	47%	Any	43%
Female	51%	Working part time	14%	None	57%
Non-binary/genderqueer/ gender fluid	#%	Unemployed	4%		
Transman	#%	Homemaker, housekeeper or houseperson	10%	Ethnic group	
Transwoman	–	Full time student	8%	White	92%
Prefer not to say	#%	Retired	16%	Mixed	1%
		Prefer not to say	1%	Asian	2%
Age				Black	1%
18-24	11%	Marital status		Chinese	1%
25-34	17%	Married/civil partnership	51%	Other ethnic group	2%
35-44	21%	Living as married/co-habiting	10%	Prefer not so say	2%
45-54	18%	Single	28%		
55-64	14%	Widowed/divorced/separated	9%	Sexual orientation	
65+	19%	Prefer not to say	1%	Heterosexual or straight	92%
				Gay or lesbian	1%
Social class		When finished education		Bisexual	2%
AB	13%	No education/only basic education	#%	Prefer to self describe	1%
C1	29%	Primary school level	4%	Prefer not to say	3%
C2	22%	Lower secondary (Junior Cert.)	11%		
DE	30%	Higher secondary (Leaving Cert.)	35%	Note: #% = <0.5%	
F	6%	Post Leaving Certificate (e.g. VEC)	5%		
		Third level non-degree (e.g. Diploma)	8%		
Region		Third level degree	25%		
Dublin	28%	Third level postgraduate degree (e.g. Masters, PhD)	13%		
Rest of Leinster	27%	Prefer not to say	#%		
Munster	27%				
Conn/ULster	18%				

Note: The symbol "#%" is used to denote where the proportion of people who answered amounted to less than 0.5%. A "–" is used to denote where nobody selected that answer option.

In total 1,024 surveys were completed. The profile of the sample is shown in Table 9.2.

Table 9.2: Online survey demographic profile

Gender identity		Work status		Dependant children	
Male	49%	Working full time (30 hours or more)	42%	Any	35%
Female	51%	Working part time	17%	None	64%
Non-binary/ genderqueer/gender fluid	8%	Unemployed	3%	Prefer not to say	1%
Transman	#%	Homemaker, housekeeper or houseperson	9%		
Transwoman	-	Unable to work due to illness or disability	7%	Ethnic group	
		Full time student	6%	White - Irish	84%
Age		Retired	15%	White - English/ Welsh/Scottish/ Northern Irish/ British	4%
18-24	11%	Prefer not to say	1%	White - Eastern European/Polish/ Latvia/Lithuanian etc	5%
25-34	17%			Any other White background	2%
35-44	21%	Marital status		Black Irish	#%
45-54	18%	Married/civil partnership	48%	Black African/ Caribbean/British or any other Black background	#%
55-64	14%	Living as married/co-habiting	13%	Asian/Indian/ Pakistani/ Bangladeshi/ Chinese	2%
65+	19%	Single	32%	Arab	#%
		Widowed/divorced/separated	9%	Mixed/multiple ethnic groups	1%
Social class		Prefer not to say	#%	Any other ethnic group	1%
AB	13%			Prefer not to say	1%
C1	31%	When finished education			
C2	20%	No education/only basic education	#%	Sexual orientation	
DE	30%	Primary school level	2%	Hetereosexual or straight	89%
F	6%	Lower secondary (Junion Cert.)	12%	Gay or lesbian	4%
		Higher secondary (Leaving Cert.)	36%	Bisexual	5%
Region		Post Leaving Certificate (e.g. VEC)	10%	Prefer to self describe	1%
Dublin	29%	Third level non-degree (e.g. Diploma)	13%	Prefer not to say	2%
Rest of Leinster	27%	Third level degree	20%		
Munster	27%	Third level postgraduate degree (e.g. Masters, PhD)	7%	Note: #% = <0.5%	
Conn/Ulster	17%	Prefer not to say	1%		

Note: The symbol "#%" is used to denote where the proportion of people who answered amounted to less than 0.5%. A "-" is used to denote where nobody selected that answer option.

Social Class is defined based on the Chief Income Earner in the household. If the Chief Income Earner is retired and has an occupational pension it relates to their most recent occupation. If the Chief Income Earner is not in paid employment but has been out of work for less than 6 months, it relates to their most recent occupation.

The following classification is used:

- **A:** Higher managerial/professional/administrative (e.g. Established doctor, Solicitor, Board Director in a large organisation (200+ employees, top level civil servant/public service employee)
- **B:** Intermediate managerial/professional/administrative (e.g. Newly qualified (under 3 years) doctor, Solicitor, Board director in a small organisation, middle manager in a large organisation, principle officer in civil service/local government)
- **C1:** Supervisory or clerical/junior managerial/professional/administrative (e.g. Office worker, Student Doctor, Foreman with 25+ employees, salesperson, etc.) OR Student
- **C2:** Skilled manual worker (e.g. Skilled Bricklayer, Carpenter, Plumber, Painter, Bus/ Ambulance Driver, HGV driver, AA patrolman, pub/bar worker, etc.)
- **D:** Semi or unskilled manual work (e.g. Manual workers, all apprentices to be skilled trades, Caretaker, Park keeper, non-HGV driver, shop assistant)
- **E:** Casual worker – not in permanent employment OR Housewife/Homemaker OR Retired and living on state pension OR Unemployed or not working due to long-term sickness OR Full-time carer of other household member
- **F:** Farmer/Agricultural worker

References to “Higher” social grades means ABC1 and lower social grades means C2DE.

Ulster includes only the three ROI counties within the province, in the Republic of Ireland – Donegal, Monaghan, and Cavan.

Connacht and Ulster are typically reported on together to ensure a robust base size for analysis.

Rest of Leinster means excluding Dublin.

Higher Education refers to those who are educated at third level or above. Lower Education refers to those educated up to and including second level (leaving certificate).

Telephone survey results and comparison with 2014 findings

This first part of the report deals with the findings from the telephone survey conducted in May 2023 and compares the findings with an identical survey undertaken in 2014. Please note that the findings from the 2014 survey were first published in 2016.

Education

This first section deals with perspectives on LGBT issues within the context of education whereby respondents were read out a list of 7 statements and asked how strongly they agreed or disagreed with each one.

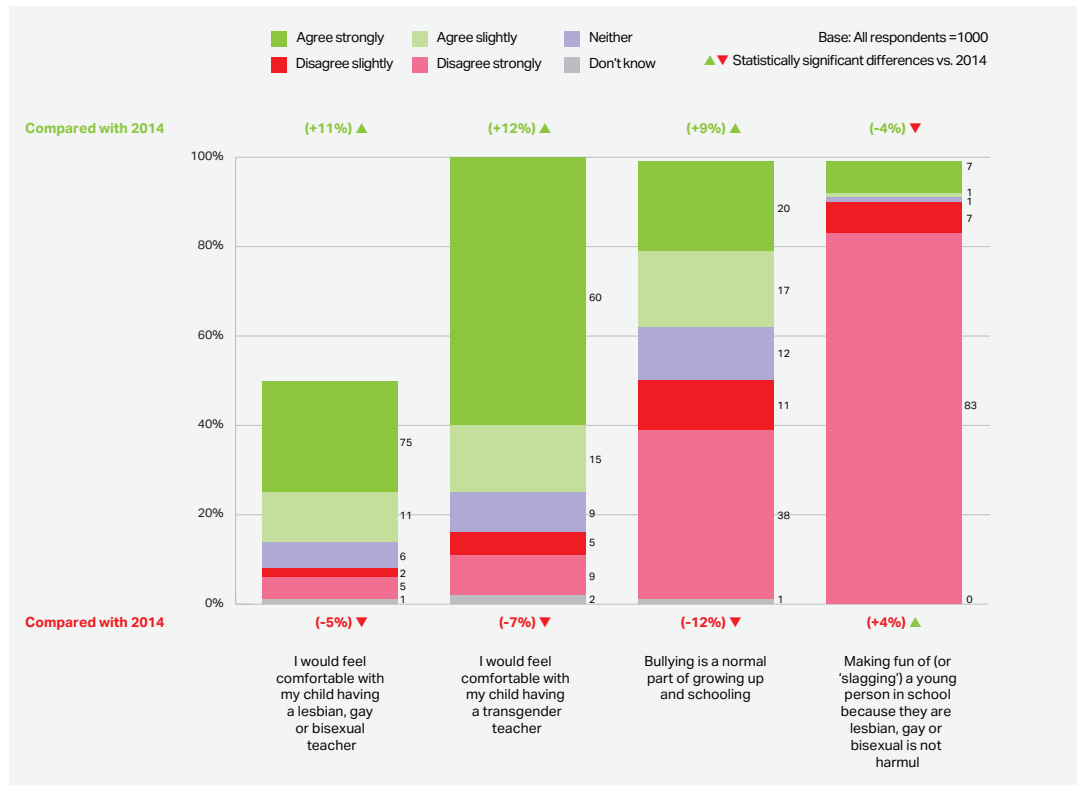


Figure 9.1: Views on LGBT teachers and bullying in school

Almost 9 in 10 adults in Ireland agree with the statement “I would feel comfortable with my child having a lesbian, gay or bisexual teacher.” This is significantly higher than the proportion (75%) who endorsed this sentiment back in 2014. Further analysis by gender, shows that support is strongest among females and younger age cohorts, while the least support for LGB teachers is among C2DE and F social grades.

Three quarters (75%) agree, with the majority agreeing strongly, that “I would feel comfortable with my child having a transgender teacher.” This is significantly higher than the 63% recorded back in 2014. Further analysis by age group demonstrates that only the youngest group (18-24) does not show an increase on the 2014 data. Comfort with transgender teachers is highest among females and lowest among older (55+) age cohorts and farmers. Those in Leinster are more likely to agree than those outside Leinster. Similarly, those who completed higher (3rd level) education agree more strongly than those who completed 2nd level or below.

There is a significantly increased acceptance that *“Bullying is a normal part of growing up and schooling”* with almost 2 in 5 agreeing with this attitude, up 9% points on what was recorded in 2014. Also, fewer participants disagree with this statement (49%), which is significantly down (by 12% points) from the 2014 survey. The most notable increases in agreement are seen among the 45+ age cohort where higher agreement is also evident (significantly so among the 45-54 and 65+ age cohorts). Dublin residents are least likely to increase in agreement since 2014, and they, along with Connacht/Ulster residents are less likely to agree with this statement than those residing in the Rest of Leinster or Munster.

While most (89%) disagree that *“Making fun of (or ‘slagging’) a young person in school because they are lesbian, gay or bisexual is not harmful”*, there is a sizeable minority (9%) who believe being made fun of or slagged, does no harm. This outlook has declined significantly however since 2014 (when it was 13%) and is currently most evident among over 65s (15%), those in the lower (C2DE) social grades (11%) and among those who are widowed/ divorced/separated (15%).

Perspectives of those polled show high acceptance towards teachers who identify as LGBT; higher than in 2014. However, while the harm done by slagging LGB pupils is recognised by a higher majority than in 2014, a somewhat increased acceptance of bullying has emerged.

Support in school

Three questions address support in schools for LGBT identities, their inclusion in the Relationships & Sexuality Education (RSE) curriculum and the perceived impact of this on young people’s developing gender identity and sexual orientation.



Figure 9.2: Views on support for LGBT identities in school

"Teachers should give students positive messages about LGBT identities" is endorsed by three quarters of adults in Ireland, almost on par with the response garnered in 2014. Females are more likely to agree that teachers should give students positive messages. Similar endorsement is present among under 35s and those in higher ABC1 social grades. Limited differences are evident at a regional level, while those with higher (3rd level) education are more likely to agree strongly.

Similarly, attitudes to LGBT issues being addressed within schools are stable in comparison with 2014 with 3 in 4 adults in Ireland agreeing with the statement that *"LGBT issues should be addressed in Relationships & Sexuality Education (RSE) within schools"* with the majority of those agreeing strongly. Those aged over 65 are least likely to be in favour while 18-24s, 45-54s and those in the ABC1 social grades are most likely to be in favour. Those in Leinster (including Dublin) are more likely to agree than those outside of the province. Similarly, those who completed higher (3rd level) education agree more strongly than those who completed 2nd level or below.

"Learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment" received a divided response. While 35% agree, up significantly from the 27% recorded back in 2014, 40% disagree, a significant decline of 9% points on 2014 levels. There are limited differences evident across socio-demographic groups, though Munster residents are most likely to agree that learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment.

Just like in 2014 a strong majority of those polled agree with the need for support of LGBT students and the need for education in schools on LGBT identities. However, there are signs of an increased support for the perception that education on LGBT issues might make young people think they are LGBT.

Discrimination

The next section deals with discrimination towards LGBT people whereby respondents were read out a list of 6 statements and asked how strongly they agreed or disagreed with each one.

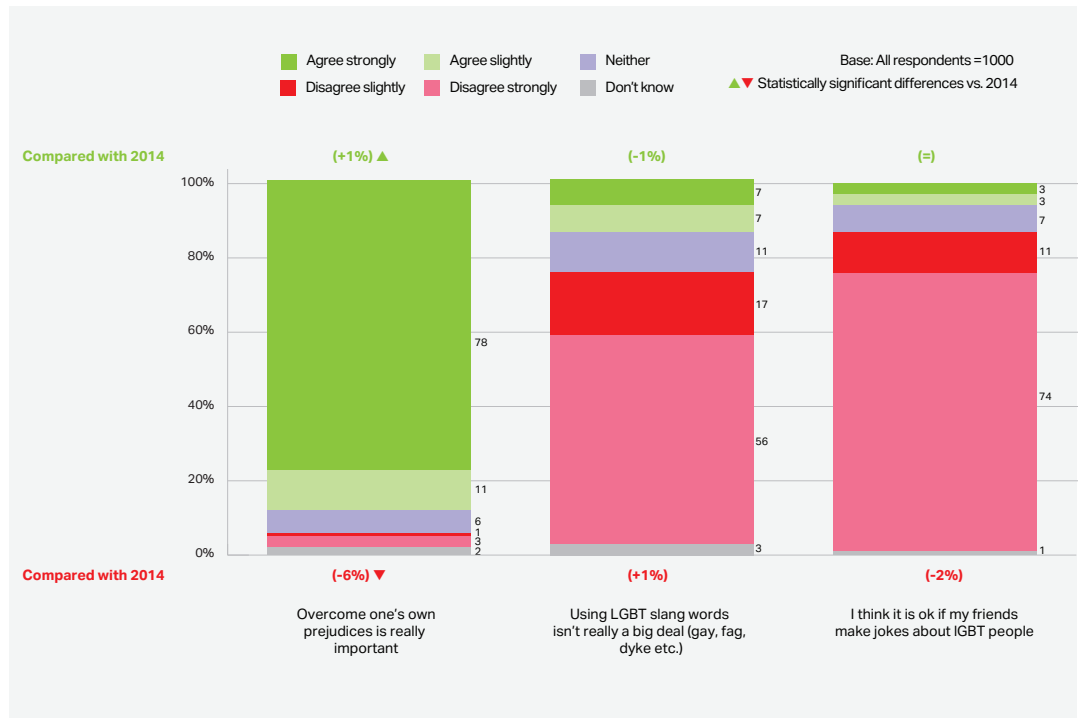


Figure 9.3: Views on prejudices and treatment of LGBT people

Overcoming one’s own prejudices is seen to be imperative, with the overall majority (89%) agreeing that “Overcoming one’s own prejudices is really important”. There is a significant increase in this perception since 2014 at a total level (+8% points), but increases are also seen across most socio-economic groups, and significantly among 45-64-year-olds. Similarly, those who are widowed/divorced/separated (+16% points) and those living in Connacht/Ulster (+17% points) show the highest significant increases on 2014 data.

There are mixed perceptions around the use of LGBT slang words. While the majority (73%) do believe that it is not appropriate to use them, 1 in 7 adults in Ireland currently believe that “Using LGBT slang words isn’t really a big deal (gay, fag, dyke etc.)”, on par with 2014 findings. There are limited differences evident among the various demographic groupings.

Minimal change is evident since 2014 in agreement with the statement “I think it is ok if my friends make jokes about LGBT people” where 7% of adults in Ireland agree, on par with 2014 at an overall level. While stability is noted versus 2014 across the majority of demographic groups, those in the Munster region have risen significantly by 6% points in agreement with the statement that it is acceptable to make fun of LGBT people. In this region, 1 in 10 now believe it is acceptable. Analysis by gender shows that females are much more likely to disagree with this statement than their male counterparts.

Since 2014 an increasingly large majority agrees that one needs to overcome one’s prejudices. The use of slang words or jokes on LGBT people is largely condemned, but this has not changed since 2014.

Explicit discrimination of LGB or transgender people by employers or in the service or hospitality sector is addressed in three questions.

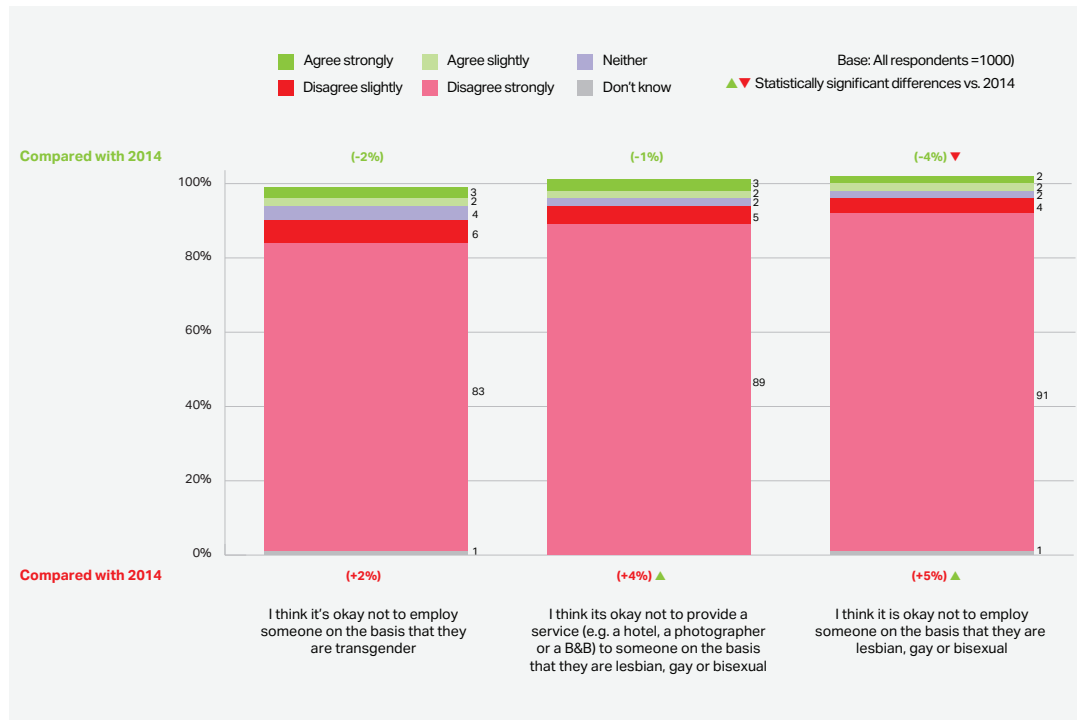


Figure 9.4: Views on discrimination against LGBT people

A majority, 9 in 10 (89%) disagree with the statement “I think it’s okay not to employ someone on the basis that they are transgender”, a slight positive increase on the 87% who disagreed in 2014. The most notable shift in perceptions since 2014 is among 18-24s, significantly (+9% points) more of whom now disagree that employment discrimination against transgender people is OK (currently 94% disagree).

There is similarly high disagreement with “I think it’s okay not to provide a service (e.g. a hotel, a photographer or a B&B) to someone on the basis that they are lesbian, gay or bisexual” with 93% of the adult population in Ireland in disagreement with this statement, up significantly on the 89% recorded in 2014. Only 5% agree and those aged 55+ and farmers are more likely to agree with the statement than other socio-demographic groups.

Only 3% of adults in Ireland agree that “I think it’s okay not to employ someone on the basis that they are lesbian, gay or bisexual”, a significant decline on the 7% who believed this to be the case in 2014. The overwhelming majority (94%) believe that there should not be any prejudice against LGB people for the prospect of employment, with the most significant advances seen in 18-24s, 45-54s and 65+ year-olds, along with farmers. More significant positive advancements are also seen in Connacht/Ulster and among those with a lower education level.

The findings suggest that over 90% of participants think it is wrong if employers or providers of services or hospitality discriminate against people who identify as LGBT. This percentage has increased since 2014.

The following section deals with being in the company of, or around, LGBT people.

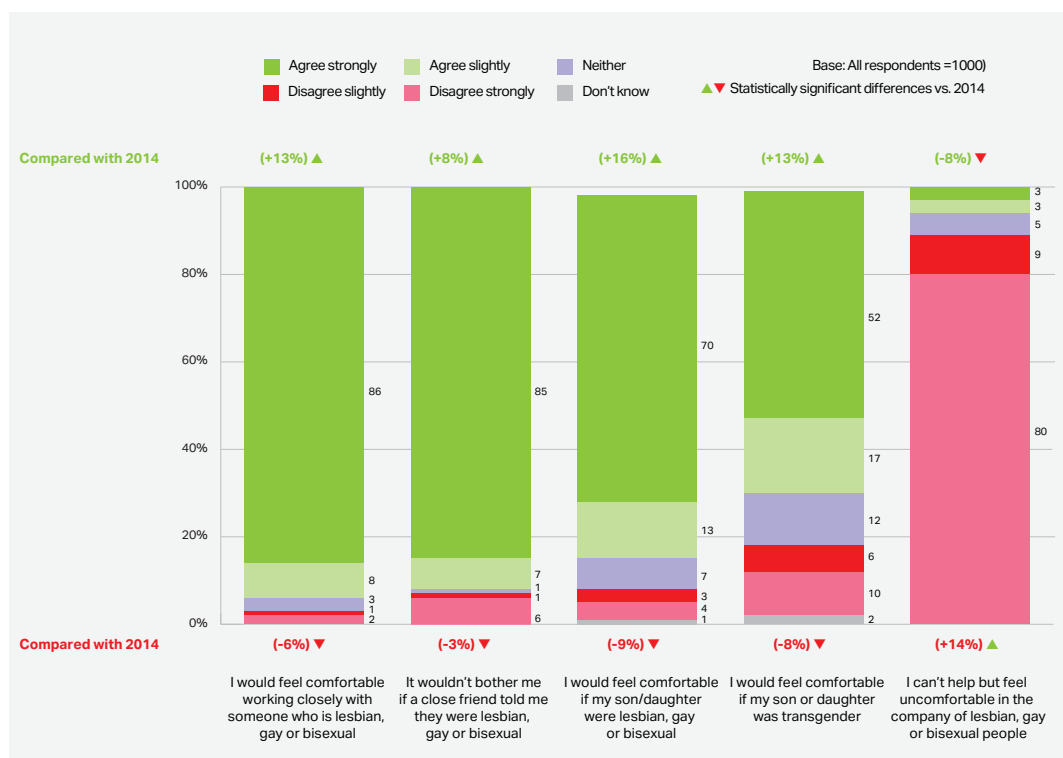


Figure 9.5: Comfort with having LGBT friends or LGBT children, and being around LGBT people

Comfort grows around working closely with an LGBT colleague with a significant increase (+13% points since 2014) in the proportion who agree that *"I would feel comfortable working closely with someone who is lesbian, gay or bisexual"*. Greater acceptance for being comfortable about working with someone who is LGBT, is more significantly noted among those aged 65+ (+18% points) and males (+15% points) since 2014. Those adults living in Dublin are most likely to feel comfortable working with someone who is LGBT (97%). Comfort increased the most significantly since 2014 among those living in Connacht/Ulster (+19% points) and those who are widowed/divorced/separated (+21% points).

A similarly high proportion (92%) agrees that *"It wouldn't bother me if a close friend told me they were lesbian, gay or bisexual"*. This is a significant increase from the 84% agreement recorded in 2014. The greatest significant improvements were recorded among men (+13% points), those living in Connacht/Ulster (+18% points) and those who are widowed/divorced/separated (+15% points).

Over 4 in 5 (84%) adults in Ireland agree that *"I would feel comfortable if my son/daughter were lesbian, gay or bisexual"*, a significant increase of 16% points on the 68% who felt the same way back in 2014. This significant increase is noted across almost all gender, age and social class cohorts. No differences are apparent between those who had dependent children and those who did not.

Almost 7 in 10 (69%) adults in Ireland agree that “I would feel comfortable if my son or daughter was transgender” and this is significantly higher than the score recorded in 2014 of just 56%. Those aged 45-54 (+20% points), living in Connacht/Ulster (+23% points) and those widowed/divorced/separated (+20% points) have recorded the most significant improvements since 2014 in comfort with their child being transgender, bringing them in line with the total average.

The public in Ireland feel significantly more comfortable being in the company of LGB people than they did in 2014. Overall, 9 in 10 (89%) people disagree with the statement “I can’t help but feel uncomfortable in the presence of lesbian, gay or bisexual people”. Farmers (75%), males (85%) and over 65s (82%) are less likely to disagree. Generally there are positive increases across all demographics vs. 2014 on being comfortable in the company of LGB people with the most significant advances seen among 35-44s (+21% points), 55-64s (+21% points), those living in Connacht/Ulster (+20% points) and those married / living as married (+20% points).

The outcomes of these telephone interviews suggest that the public feel significantly more comfortable being in the company of LGB people than they did in 2014. Also, they are more accepting of LGBT people within their families.

Comfort with LGBT identities

The following questions continue to address levels of comfort with LGBT identities but now the focus is on public displays of affection.

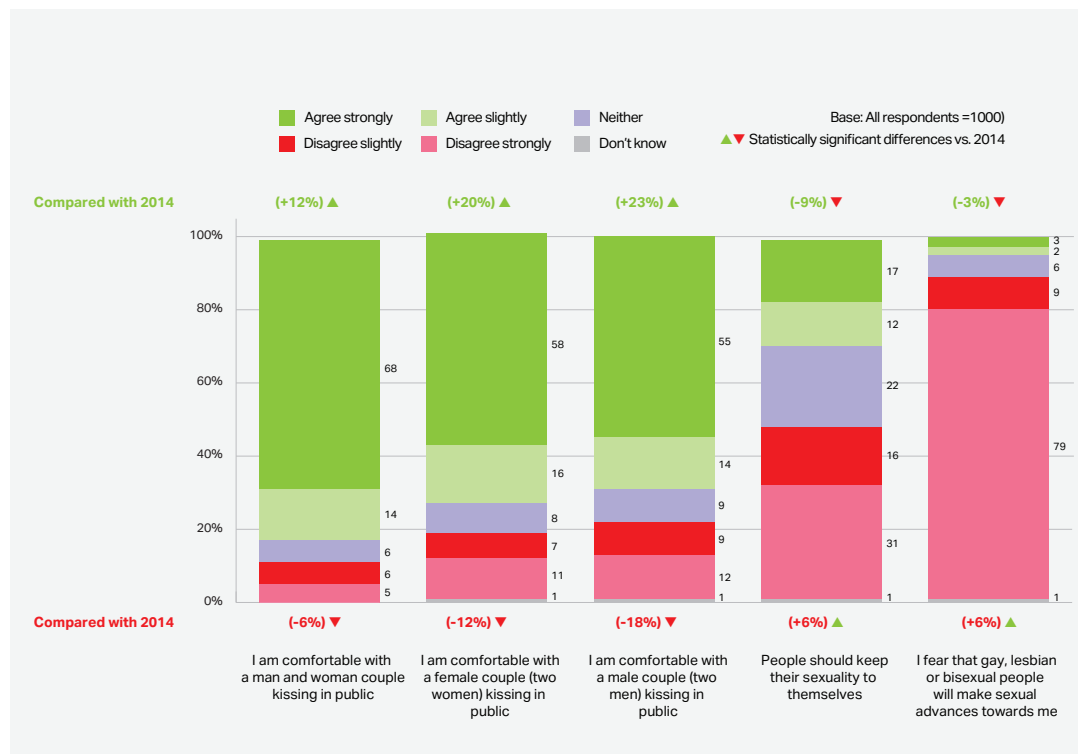


Figure 9.6: Comfort with public displays of affection

Participants are “comfortable with a man and woman kissing in public” (82% agree), and this endorsement is significantly higher than the 70% recorded back in 2014. While the public’s attitude towards a heterosexual couple kissing in public is generally more accepted compared with a same-sex couple, there are 1 in 9 (11%) adults in Ireland who are not currently comfortable witnessing this. Those with lower education (15%) are also more likely to feel uncomfortable with witnessing public displays of affection between men and women.

There is a dramatic increase in the proportion who support the statement “I am comfortable with a female couple (two women) kissing in public” which increases significantly from 54% in 2014 to 74% in 2023. Only half (49%) of over 65s claim to be comfortable with this, though this too has increased significantly by 19% points since 2014. Dubliners, ABC1s and under 45s are all more comfortable than other demographics (all have a score of >80%).

A slightly lower proportion (69%) claim that “I am comfortable with a male couple (two men) kissing in public” and this statement shows the greatest change of all attitudes measured in this study compared to 2014, where it is significantly up by 23% points from only 46%. Only 2 in 5 (41%) over 65s would be comfortable with this, though this too has increased significantly by 17% points since 2014. The greatest progress since 2014 is witnessed among 45-54 year-olds (+38% points), those who are widowed/divorced/separated (+34% points) and those living in Connacht/Ulster (+27% points). Every single socio-demographic group measured shows a significant positive increase in this attitude since 2014.

The perception that “People should keep their sexuality to themselves” is agreed with by 3 in 10 (29%) adults in Ireland, a significant 9% point decline on the 2014 result. By contrast, almost half (47%) disagree with this attitude. The attitude is much more pervasive as age increases, whereby only 12% of 18-24s have this belief, compared to 25% of 35-44s and 47% of those aged 65+. Those living in Leinster, singles, and those with a higher education level have a more relaxed attitude to people expressing their sexuality.

Only 1 in 20 (5%) adults in Ireland say that “I fear that gay, lesbian or bisexual people will make sexual advances towards me”, representing a small but significant decline of 3% points on the view that was held back in 2014. By contrast, 9 in 10 (88%) disagree with this sentiment, up significantly from 82% nine years ago with limited differences evident among different demographic groups.

Acceptance of public kissing between same-sex people has increased dramatically since 2014. Considering that this increase also occurs in the acceptance of kissing in public between a man and a woman suggests that there is a general increase of tolerance towards public displays of affection. Fear of undesired same-sex sexual advances was low in 2014 and has further decreased.

Perceptions of being LGB

The following section deals with beliefs within the general population around 'being' LGB. The responses to a list of ten statements have been addressed in two groups of five.

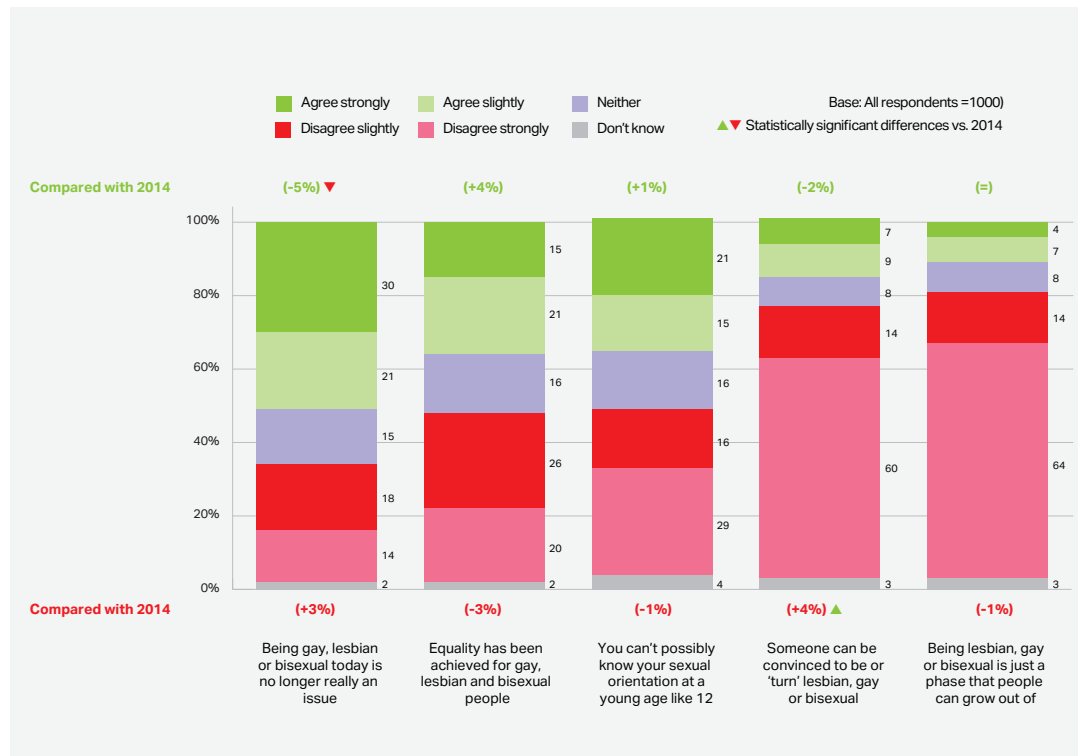


Figure 9.7: Perceptions of being LGB (a)

Just over half (51%) believe that *“Being gay, lesbian or bisexual today is no longer really an issue”*, the standpoint on this has shifted since 2014 with significantly fewer adults agreeing with this statement (down 5% points since 2014).

“Equality has been achieved for gay, lesbian and bisexual people” is a belief held by over one third (36%) of adults in Ireland, and this has increased from the 32% which was recorded in 2014. In contrast, almost half (46%) disagree with this belief. Those aged 55-64 (45%) and 65+ (47%) are much more likely to believe that equality has been achieved. These older age cohorts are also the ones driving the increased perception overall as those aged under 45 are all less likely to believe equality has been achieved than they were in 2014 (those aged 35-44 significantly so).

Just over one third (35%) of adults in Ireland agree that *“You can't possibly know your sexual orientation at a young age like 12”* and this viewpoint is more likely held by men (41%), over 65s (49%) and those with lower education levels (42%). It's a view that hasn't changed to any real degree since 2014 when it was 34%. There have however been some shifts in attitudes noted among different age cohorts. Over 65s have recorded a 15% point increase in this belief up

significantly to 49% while 25-34-year-olds show a significant decline of 11 percentage points down to 25%. Just under half (45%) of the adult population in Ireland disagree with this belief.

While three-quarters (74%) disagree that “Someone can be convinced to be or ‘turn’ lesbian, gay or bisexual”, just over 1 in 7 (15%) do believe that this can be the case, especially true among men (18%), those aged 18-24 (21%) and C2DE’s (18%). Those with lower education levels and those widowed/divorced/ separated are also more likely to hold this view (19% and 20% respectively). This viewpoint has only declined marginally at a national level since 2014 from 17% to 15% though levels of disagreement have significantly increased.

Just over 1 in 10 (11%) believe that “Being lesbian, gay or bisexual is just a phase that people can grow out of”, exactly on par with the view held in 2014. The view is held by almost twice as many men (15%) as women (8%), and is also relatively high among over 65s (15%) and the farming community (23%). By way of contrast, almost 4 in 5 (78%) adults in Ireland disagree with the assertion that being LGB is something that people can grow out of.

Perceptions vary around whether being LGB is accepted in society and equality achieved. Whether one can know one’s sexual orientation at age 12 is also subject to debate. A large majority does not believe one can be turned into being LGB, or that it is a phase. Views on these matters have not changed much since 2014.

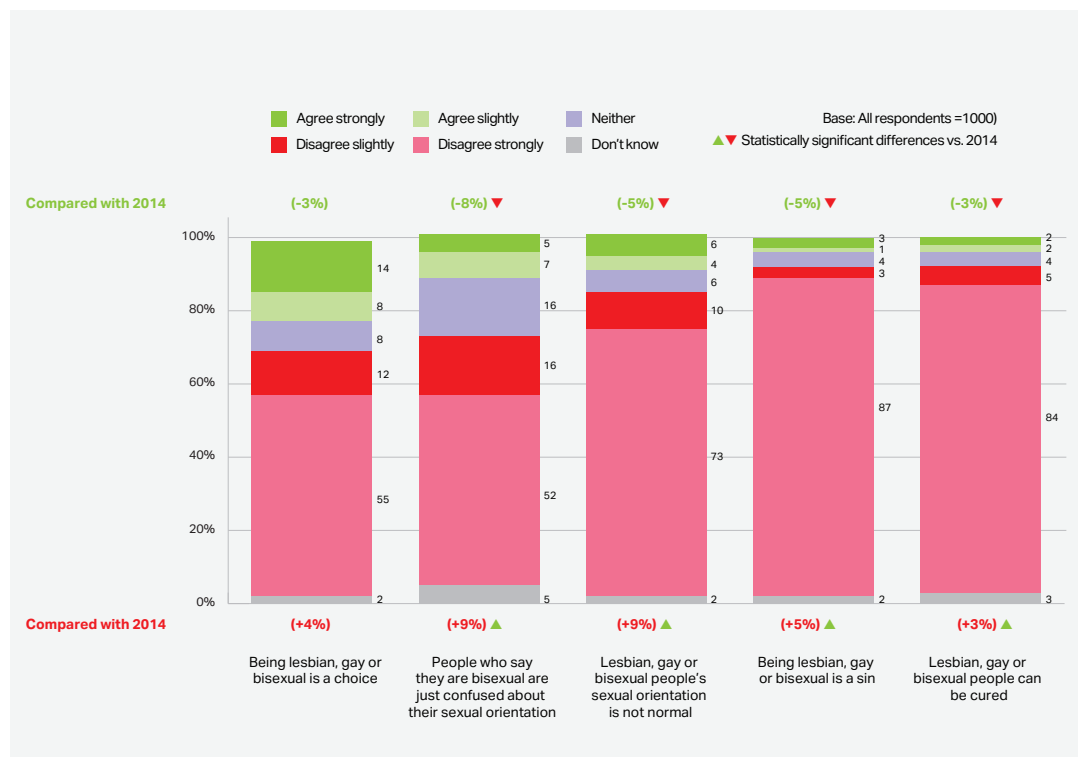


Figure 9.8: Perceptions of being LGB (b)

Currently, only 1 in 5 adults in Ireland (22%) are of the belief that *“Being lesbian, gay or bisexual is a choice”*. This view is most likely to be held by 18-24-year-olds, with over one third (35%) of this age cohort considering this to be the case. Farmers (35%) are also more likely than the national average to hold this viewpoint though this is broadly similar to 2014 levels.

“People who say they are bisexual are just confused about their sexual orientation” is endorsed by just over 1 in 10 (11%) adults in Ireland, though this view has declined significantly since 2014 (19%). Declines in this assertion are seen across all demographic groupings, but notably among 18-24s (significantly down 19% points to 6%), farmers (significantly down 22% points to 4%) and those residing in Connacht/Ulster (significantly down 13% points to 12%). Almost 7 in 10 adults in Ireland disagree with the belief bisexuals are confused, a significant increase of 9% points since 2014.

Over 4 in 5 (83%) disagree that *“Lesbian, gay or bisexual people’s sexual orientation is not normal”*, and this is a significantly higher proportion than the 74% who disagreed with this statement in 2014. There does remain a declining minority of people in Ireland who do still believe this to be the case however (currently 9%, significantly down from 14% in 2014). Those most likely to hold this view are over 65s (15%) and farmers (15%).

The overwhelming majority (90%) disagree that *“Being lesbian, gay or bisexual is a sin”* and this has increased significantly from 85% in 2014. While there are still 4% who do believe this to be the case (down significantly from 9% in 2014), there are limited differences between demographic groups, with no demographic cohort registering higher than 6% on this belief.

A similar majority (90%) disagree that *“Lesbian, gay or bisexual people can be cured”* significantly up from 87% in 2014. Again, there are a tiny minority (3%) who do believe LGB people *“can be cured”* though these have halved from 6% in 2014, a significant decline. Again, there are very limited differences evident between demographic groups.

Most people consider being LGB normal (83%), a significant increase from 2014. Also, very few still believe that being LGB is a sin (4%) or can be cured (3%), a significant decline from 2014. The view that bisexual people are just confused, has significantly fewer supporters now (11%) than in 2014 (19%).

Perceptions around transgender identity

This section deals with perceptions around transgender identity. Before the six statements were presented, the following brief introductory note was read out to respondents: *“Just to remind you, ‘transgender’ is an umbrella term used to describe someone whose gender identity and/or expression differs from the sex assigned to them at birth.”*

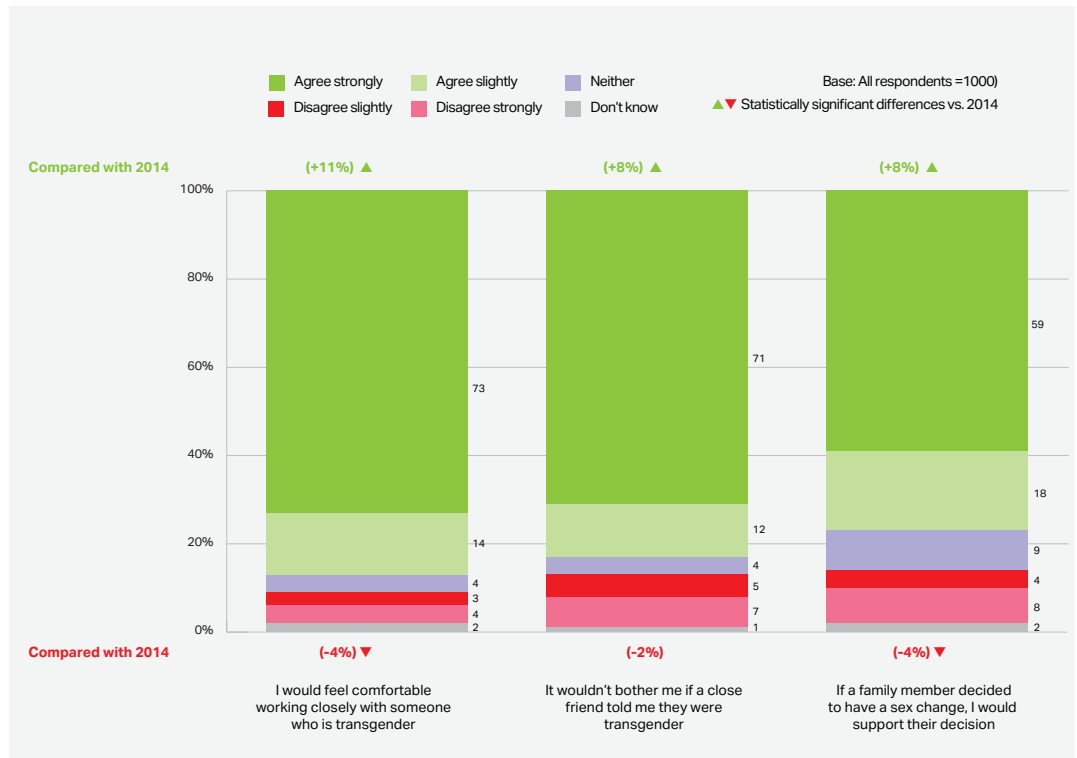


Figure 9.9: Perceptions around transgender identity (a)

Almost 9 in 10 (87%) adults in Ireland believe that “I would feel comfortable working closely with someone who is transgender” and that is significantly higher than the 76% who expressed this view in 2014. The significant increase in support is noted among all demographic groups with the exception of those living in Munster and those in the farming community whose view is stable on 2014 levels at 74% and is the lowest across social grades. Those living in Connacht/Ulster show the highest increase since 2014, up significantly by 18% points to reach the national average of 87%.

Over 4 in 5 (83%) claim that “It wouldn't bother me if a close friend told me they were transgender”, significantly ahead of the 75% who asserted this in 2014. There is stronger support from those living in the Rest of Leinster (excl. Dublin) at 89% and those who are widowed/divorced/separated (88%) in being accepting of a friend if they were transgender than is evident in other demographics. Both of these demographics have increased significantly by double digits since 2014 (by 14% points and 12% points respectively).

Three in four (77%) adults in Ireland believe that “If a family member decided to have a sex change, I would support their decision”, a significant increase of 8% points on the 2014 figure. Females (85%) and 25-34s (82%) are the demographic most likely to endorse this support. By contrast, around 1 in 8 (12%) disagree that they would be supportive of a decision by a family member to have a sex change (to transition), with men (18%), farmers (24%) and those widowed/ divorced/ separated (18%) most likely to disagree with this.

A sizeable majority, significantly more than in 2014, expresses being comfortable with transgender colleagues and friends and expects being supportive if a family member would seek to transition.

Results of another three statements on perceptions of transgender identity are outlined here.



Figure 9.10: Perceptions around transgender identity (b)

There is reasonably strong support (70% agree) that *“Transgender people should be able to change their legal documents (such as their birth certificate) to match their preferred gender”*. This is slightly lower than the 73% who agreed with this statement back in 2014. Females (77%) are most likely to be in agreement.

Around half (53%) of adults in Ireland believe that *“Being transgender is something you are born with”*, a viewpoint that has declined significantly by 9% points from 62% back in 2014. Women (59%), over 65s (67%) and those widowed/divorced/separated (68%) are most likely to agree with this. 18-24s have the most polarised view whereby one third (33%) agree with this belief while just over one third also disagree (37%). This also represents quite a big shift in viewpoint since 2014, where the corresponding figures were 45% agree and 26% disagree – a 23% point swing in favour of disagree.

There is a significant decrease in support for the view that *“It is difficult to accept transgender people as normal”* where 70% of the public in Ireland disagree with this statement, up from 56% in 2014. The levels of disagreement are strongest among women (74%), 18-24s (79%) and ABC1 social grades (76%). There does remain a sizeable minority (19%, significantly down from 27% in 2014) who believe that it’s difficult to accept transgender people as normal. This viewpoint is more strongly held among over 55s (23%) and farmers (25%).

Most people agree that transgender people should be able to change their legal status. A similar majority accepts transgender people as normal (70%), which is significantly more than in 2014 (56%). Nonetheless, opinions differ regarding the question whether a transgender identity is something one is born with. This viewpoint has declined significantly since 2014 (from 62% to 53%).

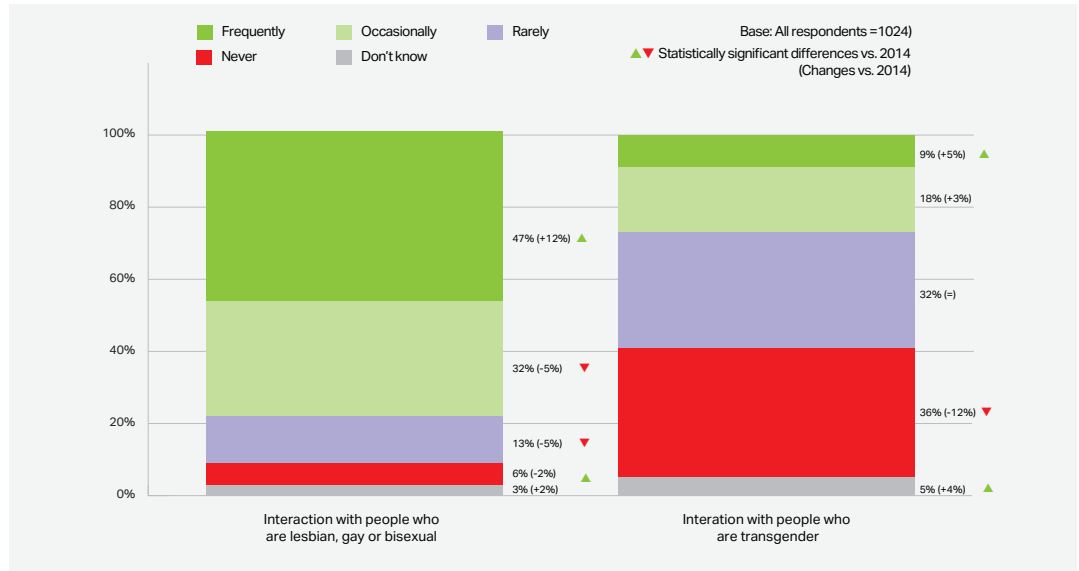


Figure 9.11: Interactions with LGBT people

Extent of interaction with LGBT people

The final section deals with interactions with LGBT people.

Almost half (47%) of respondents claim to have frequent interaction with LGB people, a significant increase compared with 2014. There are increases in frequent interactions noted across all demographic groups since 2014, the most notable of which are for 25-34s (+18% points), 35-44s (+20% points) and 55-64s (+17% points). Interestingly, those aged 18-24 only increased by 3% points, though they were the age group with the most frequent LGB interactions back in 2014. Dublin and Rest of Leinster rise by 14% and 19% respectively, while residents of Munster and Connacht/Ulster have more modest increases (+7% and +4% respectively). Higher (ABC1) social grades also show a significant increase of 18%.

Those aged 25-34 (60%) and ABC1s (56%) see the highest levels of interaction with LGB people though frequent interactions are higher among all those aged under 45 and also females. Those living in Munster (39%), Connacht/Ulster (40%) and those with a lower education level (38%) are less likely to have frequent interaction with someone who is LGB.

Frequent interaction with transgender people has over doubled from 4% in 2014 to 9% in 2023. As with LGB interactions, there are increases in frequent interactions with transgender people noted across all demographic groups since 2014, the most notable of which are for 45-54s (+9% points), 18-24s (+6% points), ABC1s and Dublin residents (both up 6% points).

While around one in four (27%) claim to have either frequent or occasional interaction with transgender people, on average, one third (36%) of adults in Ireland report never having any level of interaction with a transgender person, though this is significantly lower than 2014 where it was almost half (48%). This rises significantly for those aged over 65 (54%) and farmers (51%). Close to half (45%) of those living in Munster have not had any level of interaction with transgender people.

The increased visibility over time of LGBT people in society is reflected in significantly more frequent interactions with LGBT people as reported by the polled participants, in comparison with 2014.

Those who report frequent LGB interactions are significantly more likely to agree with many of the attitudinal statements relating to education; comfort with a child having a lesbian, gay, bisexual or transgender teacher, that LGBT issues should be addressed in Relationships & Sexuality Education and that teachers should give students positive messages about LGBT identities.

Those who report frequent LGB interactions are significantly more likely to disagree with statements regarding it being OK to discriminate against LGBT people and significantly more likely to agree that overcoming one's own prejudices is important. They are significantly more likely to feel comfortable in the company of, or around, LGBT people and significantly less likely to believe that people should keep their sexuality to themselves.

They are also significantly more likely to disagree with the following statements about perceptions of LGB identities:

- Lesbian, gay or bisexual people's sexual orientation is not normal
- Being lesbian, gay or bisexual is just a phase that people can grow out of
- Lesbian, gay or bisexual people can be cured
- Equality has been achieved for gay, lesbian and bisexual people
- Someone can be convinced to be or 'turn' lesbian, gay or bisexual
- Being lesbian, gay or bisexual is a choice
- People who say they are bisexual are just confused about their sexual orientation
- Being lesbian, gay or bisexual is a sin

Those who report frequent LGB interactions are significantly more likely to agree that they would support a family member's sex change (transition), that transgender people should be able to change their legal documents and that they would be comfortable working with a transgender person. They are significantly less likely to believe that it is difficult to accept transgender people as normal.

Those who report frequent transgender interactions are notably more likely than those without to be positively disposed to LGBT issues generally, though owing to the relatively small base size of those with frequent transgender interactions, few of these are statistically significant.

The ones which are statistically significant are:

- More likely to disagree that learning about LGBT issues in school might make a young person think they are LGBT or that they want to experiment
- More likely to agree that teachers should give students positive messages about LGBT identities
- More likely to disagree about feeling uncomfortable in the company of lesbian, gay or bisexual people
- More likely to agree they would feel comfortable if their son / daughter was transgender
- More likely to disagree that being LGB is a choice
- Less likely to agree that you can't possibly know your sexual orientation at a young age like 12
- More likely to disagree that people who say they are bisexual are just confused about their sexual orientation
- More likely to agree that being transgender is something you are born with
- More likely to disagree that it is difficult to accept transgender people as normal
- More likely to agree that they would feel comfortable working closely with someone who is transgender
- More likely to agree that it wouldn't bother them if a close friend told me they were transgender
- More likely to agree that transgender people should be able to change their legal documents (such as their birth certificate) to match their preferred gender.

Summary and discussion of findings from the telephone survey

Overall, the findings of the telephone interviews conducted in 2023 show a statistically significant change in attitudes in comparison with those conducted in 2014, across 30 of the 39 statements measured. The positive changes are in line with the national and international literature (DCEDIY, 2023, Noone et al. 2022, Flores, 2021, Pew Research Centre, 2020, EC 2019, Haynes and Schwepp, 2019).

Statements relating to education saw 6 significant positive shifts out of 7 different attitudes measured, the most notable of which were double digit increases in agreement with being comfortable with children having lesbian, gay,

bisexual or transgender teachers. The only statement which saw no change was *"LGBT issues should be addressed in Relationships & Sexuality Education (RSE) within schools"*, although agreement with this statement was already strong at 76%.

Attitudes to discrimination towards LGBT people saw significant differences in 3 out of 6 statements. Those which were on par with the findings from 2014 were *"Using LGBT slang words isn't really a big deal (gay, fag, dyke etc.)"*, *"I think it is ok if my friends make jokes about LGBT people"* and *"I think it's okay not to employ someone on the basis that they are transgender"*, but agreement with these statements was already at reasonably low levels.

All 10 statements relating to being in the company of or around LGBT people saw positive attitudinal shifts since 2014 with *"I am comfortable with a male couple (two men) kissing in public"* showing the greatest change of all attitudes measured in this study compared to 2014, where it was significantly up by 23% points from only 46% in 2014.

Statements relating to perceptions around transgender identity saw significant attitudinal shifts in 5 out of 6 views measured. One statement, *"Being transgender is something you are born with"* saw its support, surprisingly, reduced significantly since 2014 (from 62% to 53%), while other statements, suggesting a positive attitude towards transgender people, saw increased support. The only statement not showing change from 2014 was *"Transgender people should be able to change their legal documents (such as their birth certificate) to match their preferred gender"*. Agreement with this statement however was already high at 71%.

Statements relating to the belief system around being LGB saw significant shifts in 6 out of 10 viewpoints measured. Significantly more positivity was evident towards LGB people in statements about them being *"confused about their sexual orientation"*, their sexual orientation being *"not normal"*, *"a sin"* and that they could *"be cured"*. It is worth noting that many of the statements that saw no significant change in attitudes could be considered to have no right or wrong answers, but rather that they are reflective of a potential underlying division in people who believe that being LGB is something one is born with (supported by science) and people who consider it a lifestyle choice, learned behaviour and possibly subject to conversion by peers.

In the majority of instances, the changes in attitudes at an overall level are reflected across all socio-demographic sub-groups, though not all of these are deemed to be statistically significant due to the smaller base sizes with these sub-groups. In some instances, where little change is noted it is because the attitudes reflected already strongly held beliefs back in 2014. Despite the overall positive changes there are some areas that require further comment as they are areas that point to the need for ongoing interventions, such as public education.

LGBT identities: A legitimate way of being in the world

Looking at all the survey items together, what becomes evident is that despite the improvement in attitudes over time, there continues to be a small but significant percentage of adults in Ireland that do not see being LGBT+ as a legitimate way of being in the world. Between 10% and 22% of participants continue to agree with views such as being LGB is a phase, a choice, or not normal; that people can be convinced to 'turn' LGB and that accepting transgender people as normal is difficult. These findings are somewhat in line with Noone et al.'s (2022) Irish online public attitudes survey, where 7% did not believe that *'the existence of different sexual orientations is natural'* and 29% disagreed with the statement that *'it is impossible to truly change one's sexual orientation'*.

The statistically significant decline since 2014 in agreement with the view that being transgender is something you are born with (down from 62% to 53%) and the high number who answered neither agree nor disagree (18%) and don't know (8%) to this question, suggests a high degree of uncertainty among the public around their knowledge of transgender issues. Viewed in the context of the mainly improved attitudes to other questions about transgender people the decline in agreement may be linked more to a gap in knowledge as opposed to being associated with negative views about transgender people.

Bullying and name calling

Since 2014, there was an upward trend (+9%) in people agreeing with the statement that *"Bullying is a normal part of growing up and schooling"* (up from 28% to 37%), with a sizeable minority of 8% still believing that *"Making fun of (or 'slagging') a young person in school because they are LGB is not harmful."* These findings are worrying as not only does the literature demonstrate that experiences of bullying can compound minority stress and increase adverse mental health outcomes for LGBTQI+ people (Költő et al. 2021, McDermott et al. 2018, World Health Organization, 2020), but findings from Module One of this study, also found that those who had experienced LGBT bullying in schools had statistically significantly higher symptoms of depression, anxiety, stress, and lower happiness, self-esteem and resilience. In addition, findings in Module One demonstrated that there were statistically significant higher rates of potential eating disorder, self-harm, suicidal thoughts and suicide attempts among those who had experienced homophobic, biphobic or transphobic bullying compared to those who had not.

Age of awareness of LGB sexual orientation

Findings in relation to public knowledge around the age of awareness about LGB orientation show that 36% of participants agreed that LGB people can't possibly know their sexual orientation at the age of 12 years. This view is contrary to the findings in Module One where amongst the youngest age group, the 14–18-year-olds, 12 was identified as the most common age of knowing. This is concerning given the impact that this may have on the social support available

from the community, which has been identified as an important protective factor in adolescents' mental health (McDonald, 2018, Hall, 2018). In addition, non-belief may also increase adolescents' unwillingness to come out, which could be a risk factor for mental health problems (Chang et al. 2021, Hall, 2018).

Equality Agenda

A survey item that saw a small change since 2014 was the statement that *"Equality has been achieved for LGB people"*, with a 4% rise in agreement with this statement since 2014 to 36%. This item had a high percentage of participants that neither agreed nor disagreed (16%), which could suggest that a sizeable level of uncertainty exists among the public on whether equality has been achieved for LGB people. This indicates the need for a greater focus on education in relation to the equality agenda, especially given the various inequality issues that are still outstanding such as the ban on conversion therapy, the outstanding issue of hate crime legislation, and the recognition of LGBTQI+ parents. Achieving Marriage Equality by referendum in Ireland in 2015 may well be an influencing factor behind these views, in the sense that people may perceive Marriage Equality as equating with equality for all sexual and gender minority people.

Legal document change

Although the statement *"transgender people should be able to change their legal documents (such as their birth certificate) to match their preferred gender"* received a high rate of agreement (71%), it is a 3% drop since 2014. This level of agreement is still positive when compared to the 65% agreement reported in the Ireland data in the EC Eurobarometer (2019) to the statement that *"Transgender people should be able to change their civil documents to match their inner gender identity"* and the 59% in agreement reported across the EU (EC, 2019) for the same statement. It is also positive when compared to the British Social Attitudes Survey, where 53% agreed with the view that *"transgender people should be able to have the sex on their birth certificate changed if they wanted to"* (Morgan et al. 2020). However, the 3% drop in agreement from 2014 should not be ignored and serves as a reminder that any gains achieved in positive attitudes towards LGBTQI+ people cannot be taken for granted and that work to retain and build upon positive attitude ratings is continually required (Flores et al. 2021).

Findings from the online survey

This section of the report deals with the findings from the online survey conducted in June 2023 and attitudinal statements that were not included in the telephone survey. Because no online survey was done in 2014, the findings discussed in this section do not include such a comparison. As some attitudinal statements were included in both the telephone and online surveys the findings from these are compared at the end of this section.

This first section deals with education about LGBTI issues within schools. Attitudes to 7 statements are presented here where respondents were asked to select how strongly they agreed or disagreed with each one. The statements around intersex were preceded with an explanatory note that read *“Intersex is an umbrella term used to describe a wide range of natural bodily variations. Intersex people are born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies”*.

The statements around transgender identities were preceded with an explanatory note that read *“Transgender is an umbrella term used to describe someone whose gender identity and/or expression differs from the sex assigned to them at birth”*.

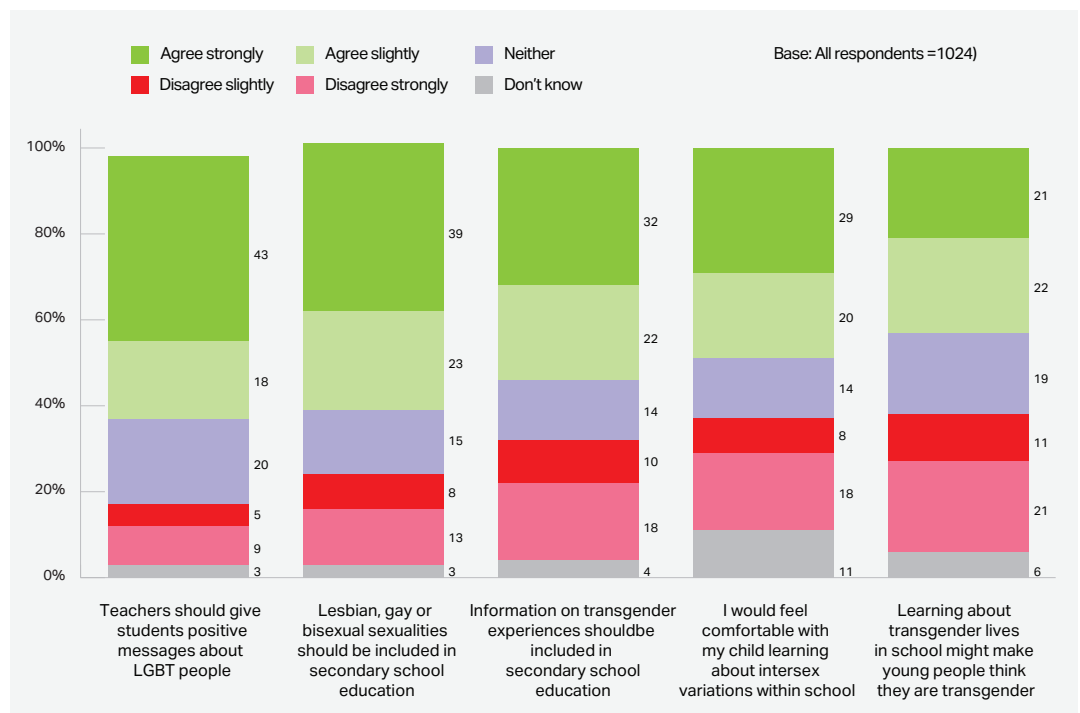


Figure 9.12: Views on education about LGBTI issues within schools

Over 3 in 5 (62%) agree that *“Teachers should give students positive messages about LGBT people”* and this is significantly higher among females, higher (ABC1) social grades, singles and those with higher education. Those living in Connacht/Ulster are least likely to agree that teachers should give students positive messages about LGBT people.

A similar proportion (61%) agree that *“Lesbian, gay or bisexual sexualities should be included in secondary school education”* though there is slightly stronger levels of disagreement coming through on this attitude. Regionally, residents of Dublin are more likely to agree with this than other areas of the country (though this is not statistically significant).

Over half of the respondents (54%) believe that *“Information on transgender experiences should be included in secondary school education”* with females and singles significantly more likely to concur.

Almost half (49%) of adults in Ireland claim they *“would feel comfortable with my child learning about intersex variations within school”* while over one quarter (26%) disagree with this statement. Interestingly, one third (33%) of those with dependent children disagree about feeling comfortable with their child learning about intersex variations within school, significantly higher than those without children.

Just over 2 in 5 (43%) adults in Ireland believe that *“Learning about transgender lives in school might make young people think they are transgender”* and this perception is significantly more likely to be held by males (48%) rather than females (38%) and also among those with dependent children (49%). Conversely, 1 in 3 (32%) disagree with this statement with females showing significantly higher disagreement than males.

A majority agree that positive messages about LGBTI lives need to be given in school and that education on these identities needs to be provided. However, 1 in 4 are uncomfortable about pupils learning about intersex variations. Two in five believe that teaching about transgender identities might make young people believe they are transgender.

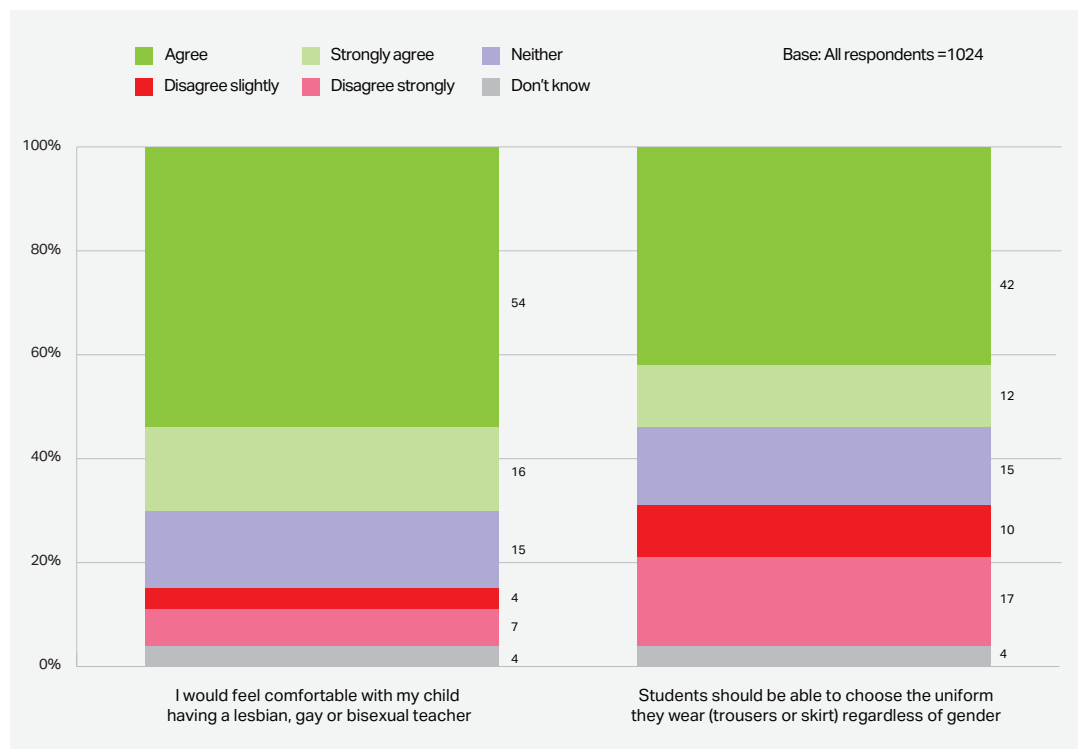


Figure 9.13: *Comfort with LGB teacher and comfort with students choosing their uniform regardless of gender*

Quite a large majority (70%) agree that *"I would feel comfortable with my child having a lesbian, gay or bisexual teacher"*, with those aged 18-24 (76%) and Dubliners (75%) the cohorts notably more likely to agree with this statement. Only 1 in 9 (11%) disagree with the statement, and they are significantly more likely to be male.

Over half (54%) claim that *"Students should be able to choose the uniform they wear (trousers or skirt) regardless of gender"* with females (62%) significantly more in support than their male counterparts (48%). Similarly, the younger cohorts of 18-24 (65%) and 25-34 (62%) are significantly more strongly aligned to this belief than older cohorts.

Most respondents are comfortable with LGB teachers, but only half are happy to allow pupils to choose freely between wearing a skirt or trousers in school.

Acceptance of discrimination

The following statements deal with the acceptance of discrimination among the general public. Attitudes to 7 statements are presented in this section. The results for the first four statements are presented first.

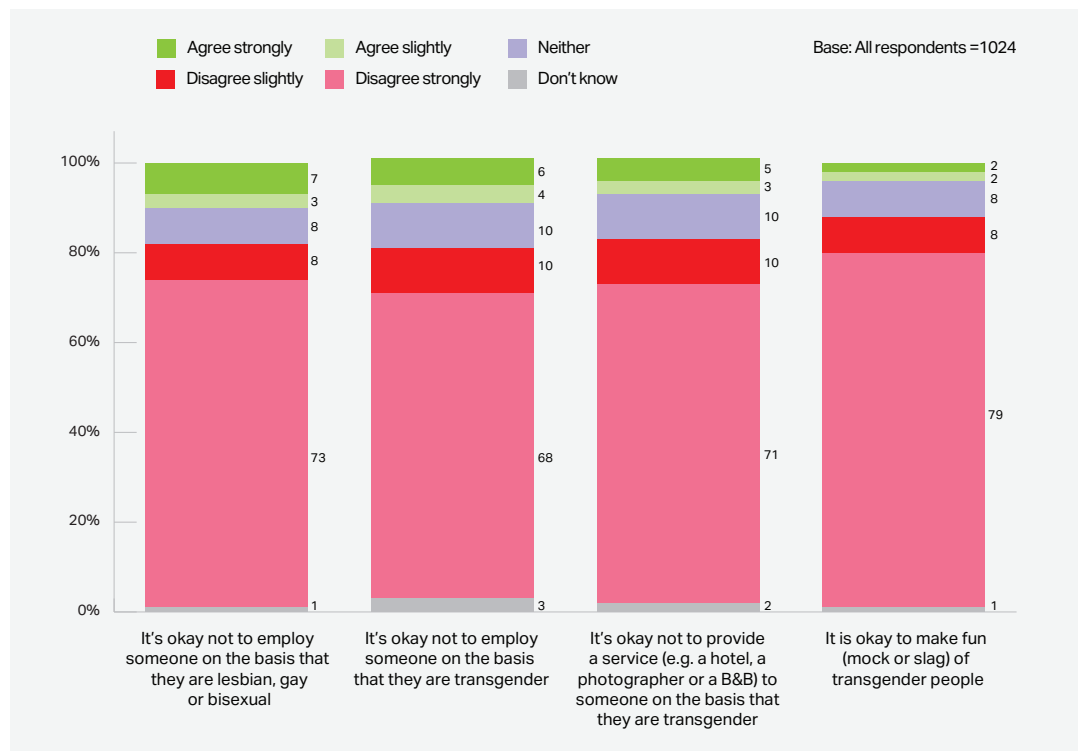


Figure 9.14: Views on acceptance of discrimination against LGBT people

Around 1 in 10 adults in Ireland believe that *"It's okay not to employ someone on the basis that they are lesbian, gay or bisexual"*. There are limited differences evident by demographic groups, though this belief is highest among 45-54s and over 65s (15% and 14% respectively). Four in five disagree with this attitude.

Similarly, 1 in every 10 adults in Ireland believe that *"It's okay not to employ someone on the basis that they are transgender"*. Again, there are limited differences evident by demographic groups, though this belief is least likely to be held by the widowed/divorced/separated group (5%). Four in five however also disagree with this attitude.

The vast majority (81%) do not believe that *"It's okay not to provide a service (e.g. a hotel, a photographer or a B&B) to someone on the basis that they are transgender"*. Only 7% agree that it's ok to do this. Limited differences are evident by demographic groups concerning this statement.

A similarly large majority (87%) do not agree that *"It is okay to make fun (mock or slag) of transgender people"*. Females (91%) and over 65s (92%) and those widowed/divorced/separated (92%) are most likely to disagree with this statement. Conversely, there are 1 in 25 (4%) adults in Ireland who agree that it's ok to make fun of transgender people.

Eighty percent or more express themselves against discrimination and making fun of any of the LGBT groups.

The response to a further three statements addressing discrimination follow here.

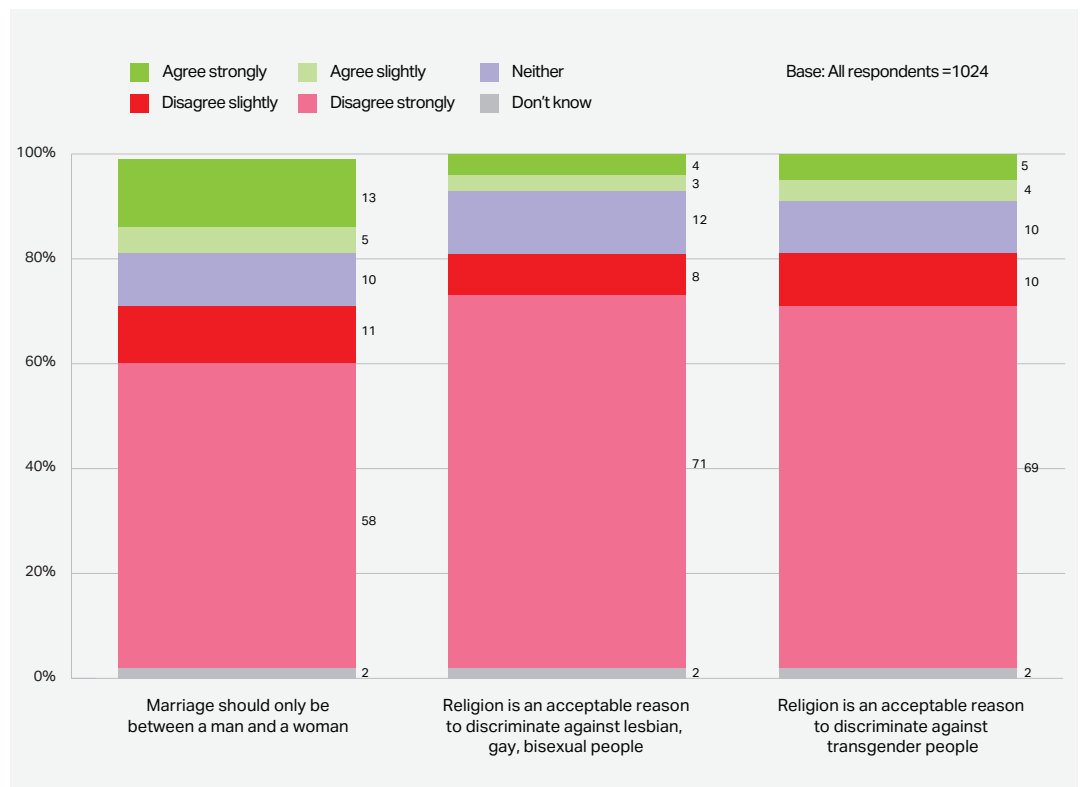


Figure 9.15: Views on marriage and religion as a reason to discriminate against LGBT people

Almost 1 in 5 (18%) adults in Ireland are of the belief that “*Marriage should only be between a man and a woman*”. Men (22%) are significantly more likely than women (15%) to agree with this. Age is also a big discriminator for this belief. While 10% of 18-24s hold this attitude, it increases significantly to 3 in 10 (29%) for those aged 65+. Those in Dublin (15%) are least likely to agree while those residing in Munster (22%) and Connacht / Ulster (21%) are more so in agreement. Marital status also dictates a difference with those married (21%) significantly more likely to be aligned with this position than singles (14%). The majority (69%) of the general public however do not agree that marriage should only be between a man and a woman.

Whilst the vast majority (79% in both cases) disagree that “*Religion is an acceptable reason to discriminate against lesbian, gay, bisexual people*” or that “*Religion is an acceptable reason to discriminate against transgender people*” there remains a sizeable minority who believe it is ok to do so, 9% for discrimination against lesbian, gay or bisexual people, and 7% for discrimination against transgender people. Men (9%) and singles (10%) are significantly more likely to think it’s ok to discriminate against transgender people on the basis of religion than the population at large. Discrimination against LGB people is less likely to differ by demographics.

Religion is not considered a valid reason to discriminate against any of the LGBT groups by 80% of the population. Also, the outcome of the Marriage Referendum is reflected in support expressed for same-sex marriage.

Comfort with contact/proximity, and sexual expression/affection of LGB people

The next section deals with comfort with contact/proximity, and sexual expression/affection of LGB people. These three statements were not all included in the one question, rather came from different groups of statements in the questionnaire, but are presented collectively here as they relate to the topic of comfort.

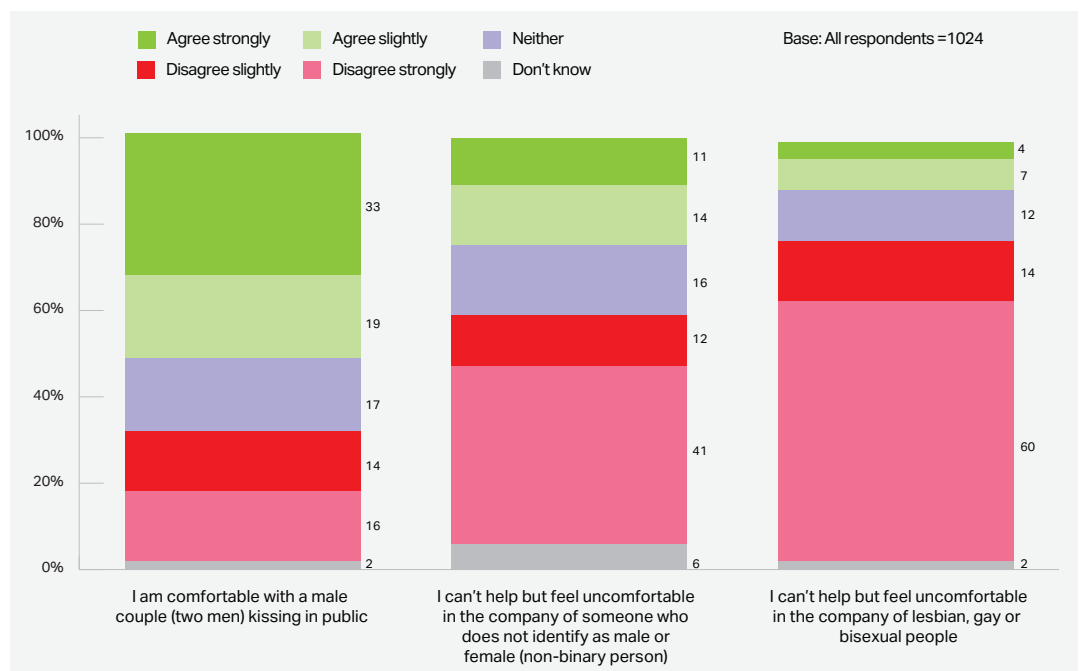


Figure 9.16: Comfort with contact and sexual affection of LGB people

Over half (51%) of adults in Ireland claim that *"I am comfortable with a male couple (two men) kissing in public"*. This view is significantly higher among younger adults (64% for 18-24s, 72% for 25-34s and 58% for 35-44s) and significantly lower among older age cohorts (37% for 55-64s and 33% for 65+). Similarly, those living in Dublin (60%) are significantly more likely to support this than those outside Dublin. Singles (62%) are also significantly more comfortable with two men kissing than those widowed/divorced/separated (37%). The flip side is that 3 in 10 adults in Ireland are not comfortable with two men kissing in public with disagreement biased towards older cohorts and significantly so among the over 65s.

One quarter (25%) claim that *"I can't help but feel uncomfortable in the company of someone who does not identify as male or female (non-binary person)"*. Men (29%) are significantly more likely to believe this than women (21%). Limited other differences are noted by demographics.

While 3 in 4 disagree that *"I can't help but feel uncomfortable in the company of lesbian, gay or bisexual people"* there remains a sizeable minority (11%) who do feel uncomfortable in the company of lesbian, gay or bisexual people. Men (15%) are significantly more likely than women (8%) to say they feel uncomfortable.

A majority expressed being comfortable in the company of LGB people and a non-binary person, although 3 in 10 of the population are uncomfortable with a male couple kissing in public.

Comfort with/support for a family member who identifies as bisexual, transgender or intersex

The following section looks at comfort with/support for a family member who identifies as bisexual, transgender or intersex. These four statements were queried at different points in the questionnaire, but are presented collectively here as they relate to the topic at hand.

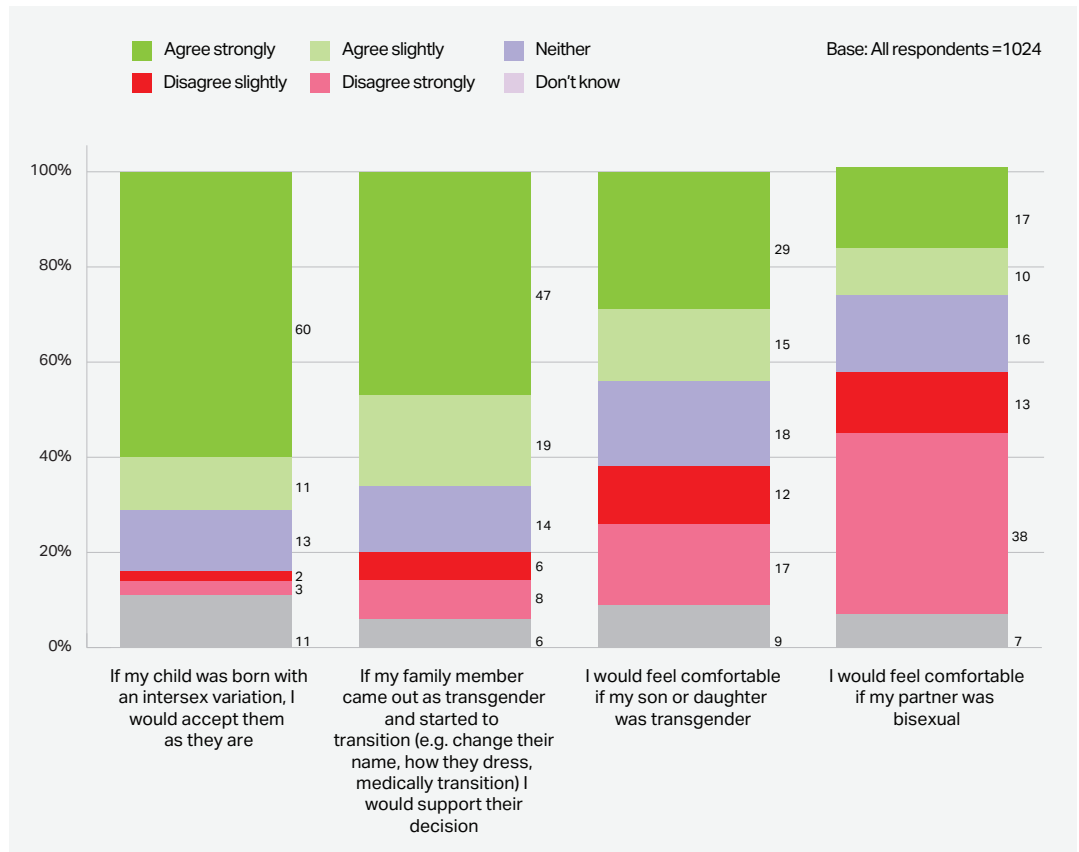


Figure 9.17: Comfort with/support for a family member who identifies as bisexual, transgender or intersex.

A majority (71%) of adults in Ireland claim “If my child was born with an intersex variation, I would accept them as they are”. Only 5% of adults disagree with this statement however, and there are a reasonably high proportion of respondents who replied “don’t know” at 11%.

Almost 2 in 3 (65%) respondents agree that “If my family member came out as transgender and started to transition (e.g. change their name, change how they dress, medically transition) I would support their decision”. Females (70%) are significantly more likely than males (60%) to agree. One in seven (14%) disagree that they would be supportive of a family member coming out as transgender and starting to transition and this is most notable among men at 18% who are significantly more likely to disagree than women.

Less than half say they “would feel comfortable if my son or daughter was transgender”. This view is significantly higher among 18-24s (55%). Those without dependent children (46%) are significantly more supportive than those with dependent children (39%).

Just over 1 in 4 (27%) agree that “I would feel comfortable if my partner was bisexual” while one half (51%) disagree with this statement. Men (33%) are significantly more likely to agree than women (20%) while agreement also declines significantly as age increases, from 45% in agreement among the 18-24s to 14% and 11% among the 55-64 and 65+ age groups respectively. Similarly, those who are single (39%) are significantly more likely to claim to be

comfortable with a bisexual partner than those who are married (22%) and those who are widowed/divorced/separated (13%).

Participants are accepting of a child born with an intersex variation (71%) and supportive if a family member were to transition (66%). However, fewer would feel comfortable if their own child was transgender (44%) or if their partner was bisexual (27%).

Attitudes towards transgender people's rights

This part of the report deals with attitudes towards transgender people's rights. Attitudes to 7 statements are presented here where respondents were asked to select how strongly they agreed or disagreed with each one.

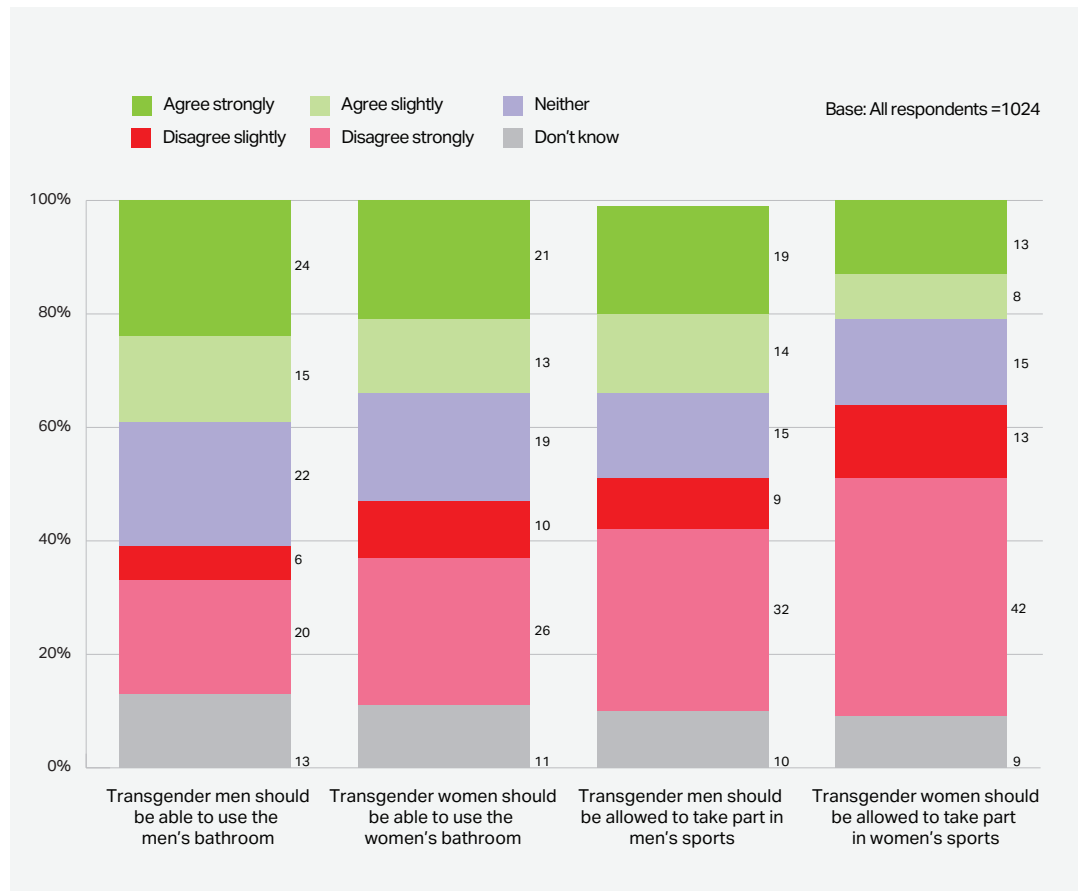


Figure 9.18: Attitudes towards transgender people's rights (a)

While 2 in 5 (39%) agree that "Transgender men should be able to use the men's bathroom" there is a relatively high degree of variation evident with over one quarter (27%) who disagree and 35% undecided or not knowing. Agreement is significantly higher among younger adults (54% for 18-24s) and significantly lower among older age cohorts (35% for 55-64s and 32% for 65+). Singles (46%) are significantly more likely to agree than those who are married (36%) and those without dependent children (42%) are significantly more supportive than those with dependent children (35%).

Just over one third (34%) agree that *“Transgender women should be able to use the women’s bathroom”* but again, there is a relatively high degree of polarisation evident with over one third (36%) disagreeing and 30% undecided or not knowing. Differences in agreement are similar to those about trans men and men’s bathrooms where there is significantly higher agreement among younger adults (46% for 18-24s) than there is evident among older age cohorts (31% for both 55-64s and 65+). It is least supported by those living in Connacht/ Ulster (27%) who are significantly lower in agreement than those living outside those provinces.

One third agree that *“Transgender men should be allowed to take part in men’s sports”* while there is substantially less agreement that *“Transgender women should be allowed to take part in women’s sports”*, at only one in five (21%). Support for both of these statements is significantly stronger for younger cohorts. Women are significantly more supportive on trans women’s inclusion in women’s sports than men (25% vs 16%) while there is no difference in agreement between men and women on trans men’s inclusion in men’s sports (both at 33% agreement). Singles and those without dependent children are also significantly more supportive of both trans men and trans women in sports in their respective gender group.

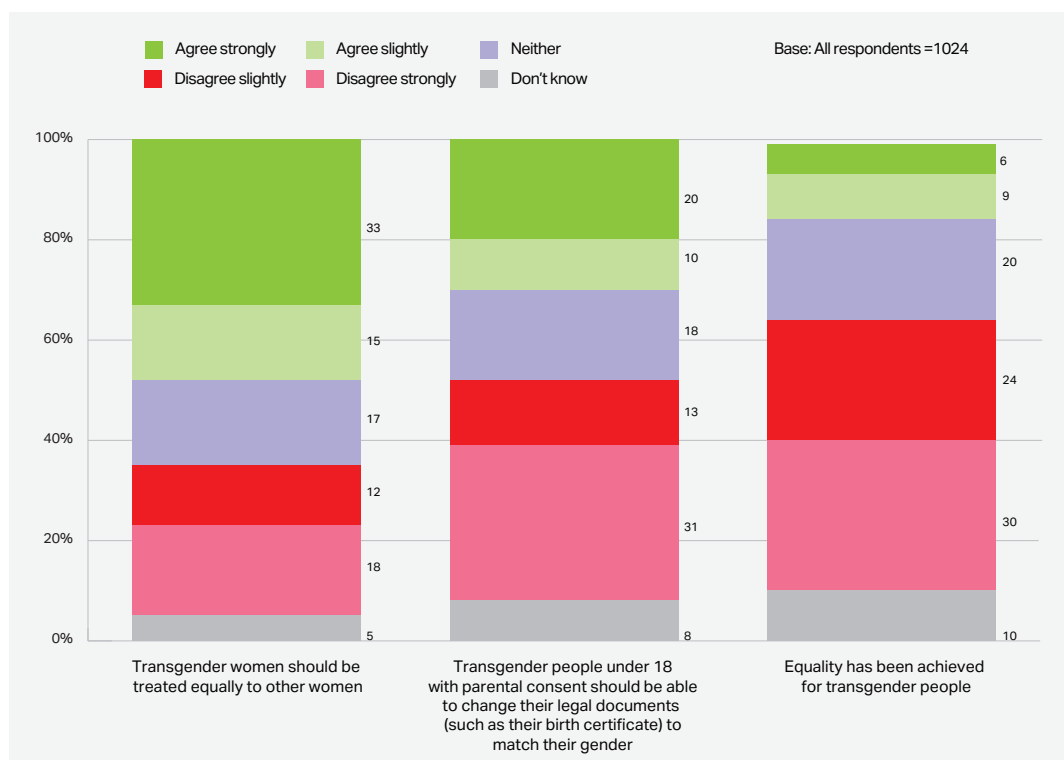


Figure 9.19: Attitudes towards transgender people’s rights (b)

Almost half of the respondents (48%) believe that *“Transgender women should be treated equally to other women”* and this is significantly more endorsed by females (52%) than males (44%). 18-24s are most in agreement (57%) as are higher ABC1 social grades (53%). Dubliners are also significantly more likely to agree (56%) while it is significantly least supported by those living in Connacht/ Ulster (41%). 3 in 10 (30%) however disagree that *“Transgender women should*

be treated equally to other women” and those aged 35-54 show the highest disagreement at 35%.

Just under 3 in 10 (29%) agree that “Transgender people under 18 with parental consent should be able to change their legal documents (such as their birth certificate) to match their gender” while over 2 in 5 (44%) disagree that this should be possible. Support for the ability to change legal documents comes most significantly from younger cohorts (34% among 18-34s) and singles (35%). Disagreement is significantly higher among those with dependent children (51%).

Only 15% of the adult public believe that “Equality has been achieved for transgender people” with that belief held significantly more strongly among the 65+ age cohort at 21% with few other demographic differences evident. Over half (54%) disagree that equality has been achieved. Disagreement comes significantly more strongly from younger cohorts (66% among 18-24s). Higher ABC1 social grades (61%) are also significantly more likely to disagree as are singles (60%) and those without dependent children (58%).

Over half of the sample disagrees that transgender equality has been achieved. However, there is variation in opinions on legal gender changes and whether transgender people should use male or female bathrooms. Notably, over half (55%) of respondents are opposed to transgender women participating in women’s sports. Overall, perspectives vary on whether transgender women should be treated equally to other women.

Belief system about being transgender

This section deals with the belief system about being transgender. Attitudes to 4 statements are presented here.

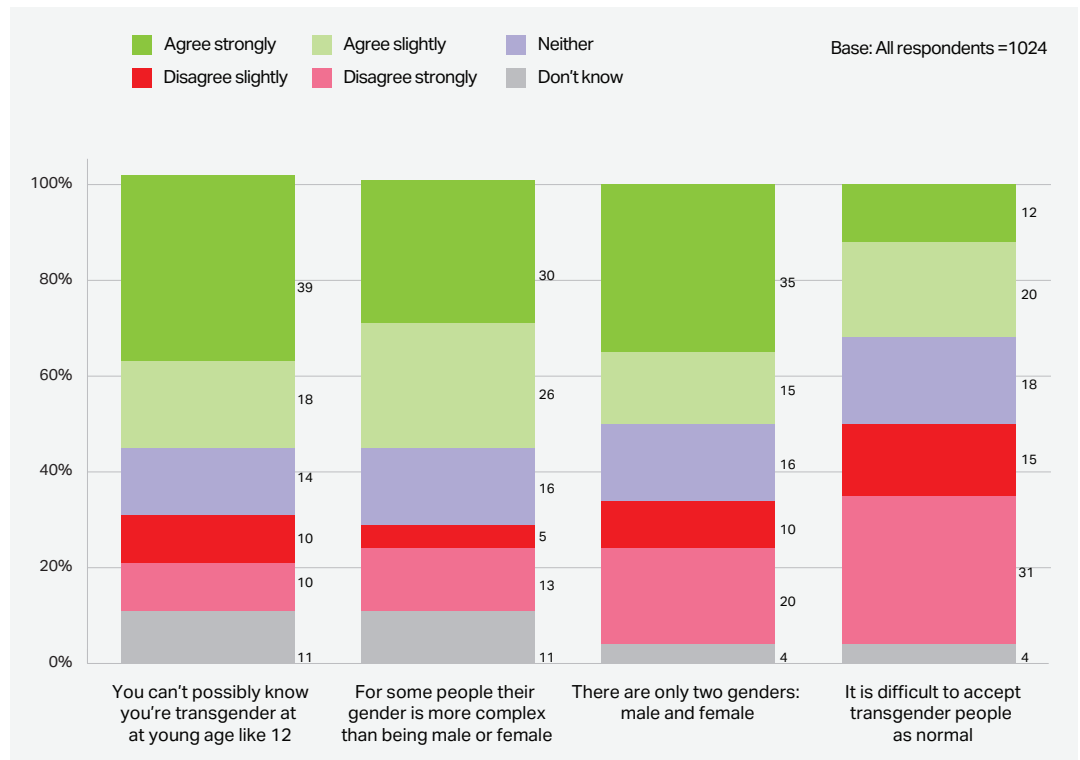


Figure 9.20: Beliefs systems about being transgender

Over half (56%) agree that *"You can't possibly know you're transgender at a young age like 12"* and this is significantly more strongly endorsed by males (61%) than females (52%). Those without dependent children (53%) are significantly less likely to agree than those with dependent children (62%). Older cohorts are also more likely to affirm this belief, significantly so among 55-64s (67%).

A similar proportion (56%) agree that *"For some people their gender is more complex than being male or female"* and this is significantly more likely endorsed by those with higher education (61%) than those with lower education (51%). Those without dependent children (60%) are significantly more likely to agree than those with dependent children (49%).

Exactly half (50%) of adults in Ireland believe that *"There are only two genders: male and female"*. This is significantly more likely for males (54%) rather than females (46%). Those married are significantly more likely to agree (54%) than singles (42%). Those with dependent children (59%) are significantly more likely to agree than those without dependent children (45%).

One third (32%) believe *"It is difficult to accept transgender people as normal"*, with males (37%) significantly more likely to affirm this belief. Almost half (46%) of adults in Ireland disagree with this statement and this is significantly higher among females (52%), 25-34s (54%) and singles (52%).

A majority (56%) believe that a 12-year-old could not know whether they are transgender. That gender identity is complex for some people is acknowledged by a similar majority. Nonetheless, half of respondents believe gender is binary, and 46% don't find it difficult to accept being transgender as 'normal'.

Politics of being LGBT and equality agenda

This next section focuses on the politics of being LGBT and the equality agenda. These five statements were not all included in the one question, rather came from different groups of statements in the questionnaire. They are presented collectively here as they relate to the topic at hand.



Figure 9.21: Views on equality, and social and political issues affecting LGBT people

Over 3 in 4 (77%) agree that “Same-sex parents should be treated equally to opposite sex parents” and the vast majority of those agree strongly with this viewpoint. It’s a view significantly more likely to be held by females (81%) over males (73%) and by 18-34s (82%). Limited other differences are evident. However, there remains a minority (10%) who disagree that this should be the case. Disagreement that same-sex parents should be treated equally to opposite sex parents is significantly more likely to be voiced by those aged 65+ (16%).

Three quarters (73%) of adults in Ireland hold the belief that “The government should ensure that hate speech and hate crimes against LGBT people are adequately addressed in our laws” driven significantly more by older age cohorts (83% of those aged 55 and above). Those without dependent children (78%) are significantly more likely to agree than those with dependent children (65%). Limited other notable differences are evident.

Half (50%) believe that “LGBT people should be granted asylum if they are persecuted because of their sexual orientation or gender identity in their country of origin” while one in five (21%) disagree that this should be the case. Singles, those with higher education and those without dependent children are significantly more likely to agree with this statement (all at 56%). Those who disagree with granting asylum are significantly higher among males (25%) and those with dependent children (29%).

One third (32%) agree that “There are comments in the media (social media, news media, web media, etc.) that call for violence against lesbian, gay, bisexual, and transgender persons” while an almost identical proportion (29%) do not believe this to be the case. Over 1 in 5 (22%) do not know if this is true or not. Younger cohorts are significantly more likely to believe there are media comments calling for violence (47% of 18-24s and 46% of 25-34s agree with this), while singles (40%) and those in higher education (40%) are also significantly more likely to agree.

Only 3 in 10 (29%) adults in Ireland believe that “Ireland is a safe place to be transgender” with males (34%) significantly more likely to assert this than females (24%). The statement about Ireland’s safety is quite polarising though as an almost equal proportion (30%) don’t find Ireland a safe place to be transgender. It’s especially polarising among the 18-24s age group (where 37% disagree) – this was the group who were most likely to also think Ireland was in fact safe.

A large majority of adults believe in equal treatment of same-sex parents and the need for legislation to reduce hate speech and hate crimes. Half of the sample support asylum in Ireland for LGBT people persecuted elsewhere. Perspectives on incitement against LGBT people in the media and safety for these communities vary. Opinions are divided on whether Ireland is a safe place to be transgender.

Extent of interactions with LGBTI people

The following section deals with interactions with LGBTI people. Respondents were asked how frequently do they interact with people who they have known to be lesbian or gay, bisexual, transgender or intersex.

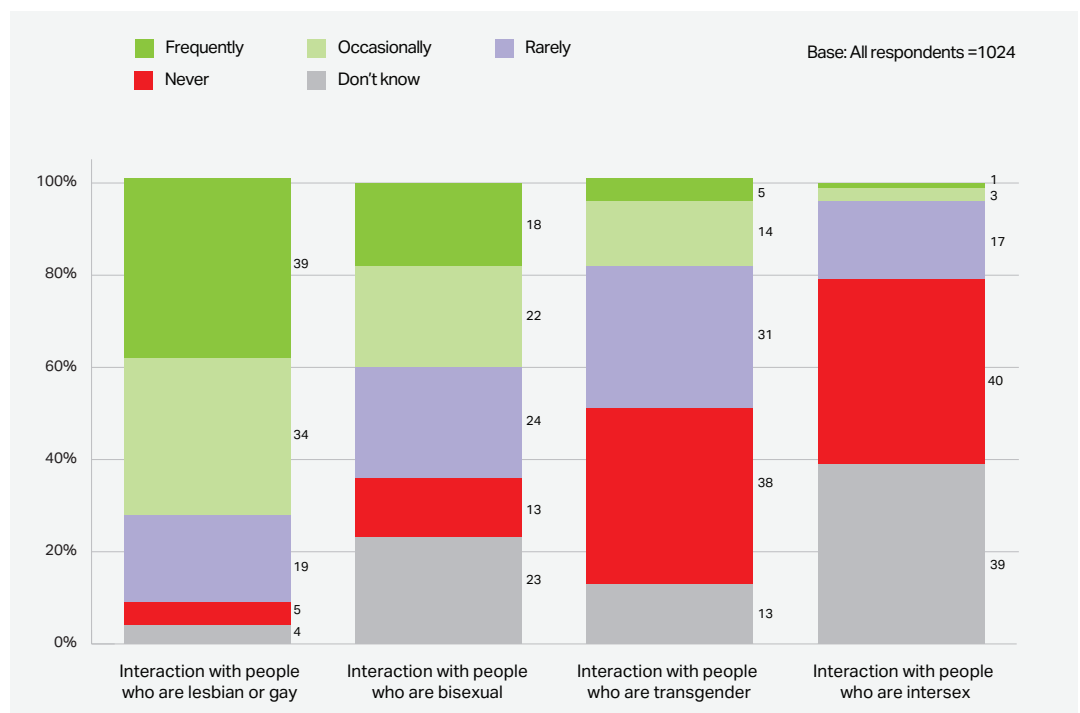


Figure 9.22: Extent of interactions with LGBTI people

Almost 2 in 5 (39%) of the adult public in Ireland claim to have frequent interaction with lesbian or gay people. Those aged 25-34 (46%) and females (43%) see significantly higher levels of interaction with lesbian or gay people than the total population. Those living in Dublin (45%) and singles (45%) also show significantly higher interactions. Connacht/Ulster residents (31%) are significantly less likely to have frequent interaction with someone who is lesbian or gay.

Only around 1 in 5 (18%) report having frequent interaction with bisexual people, with a further 1 in 5 (22%) claiming to have occasional interaction. Almost 1 in 4 claim not to know, while around 1 in 8 claim never to have any interactions with bisexual people. Under 35s are significantly more likely to have frequent interactions than older cohorts.

Around 2 in 5 (38%) never have any interactions with transgender people, while 1 in 20 (5%) adults in Ireland have frequent interactions, and this is significantly higher among 18-24s (14% of who have frequent interactions). Singles also show significantly higher levels of interaction.

There are very low reported levels of interaction with intersex people in Ireland. Almost 2 in 5 (39%) selected the "don't know" option while a further 2 in 5 claim to never have interactions with intersex people. The majority of the remainder claim to rarely have interactions with intersex people.

Those who report frequent interactions with lesbian or gay, bisexual or transgender people are significantly more likely to be positively disposed to the LGBTQI+ issues contained in the survey (note, the base size of those who have frequent interactions with intersex people is too low, at n=10, to analyse their responses with any degree of robustness).

Those who report frequent interactions with lesbian or gay, bisexual or transgender people are significantly more likely to agree with statements which support the LGBTQI+ community, such as being comfortable in the company of LGBTQI+ people, with education issues and supporting LGBTQI+ people in their everyday lives.

They are also significantly more likely to disagree with attitudinal statements which suggest it's ok to make fun of or discriminate against LGBTQI+ people. Indeed, this is the case for all 37 attitudinal statements contained in the survey. Those who report frequent interactions are also significantly more likely to assert that they are knowledgeable about LGBTI experiences.

Most people report frequent or occasional interactions with people who are gay or lesbian. Fewer report interactions with bisexual people and still fewer with transgender people. Those who report frequent interactions with lesbian or gay, bisexual or transgender people are significantly more likely to be positively disposed to the LGBTQI+ issues contained in the survey. Reported interactions with intersex people are too few to be included in further analysis.

Knowledge of LGBTI experiences

This final section deals with people's knowledge of LGBTI experiences. Respondents were asked to agree or disagree that they were "very knowledgeable" about the experiences of lesbian or gay, bisexual, transgender or intersex people.

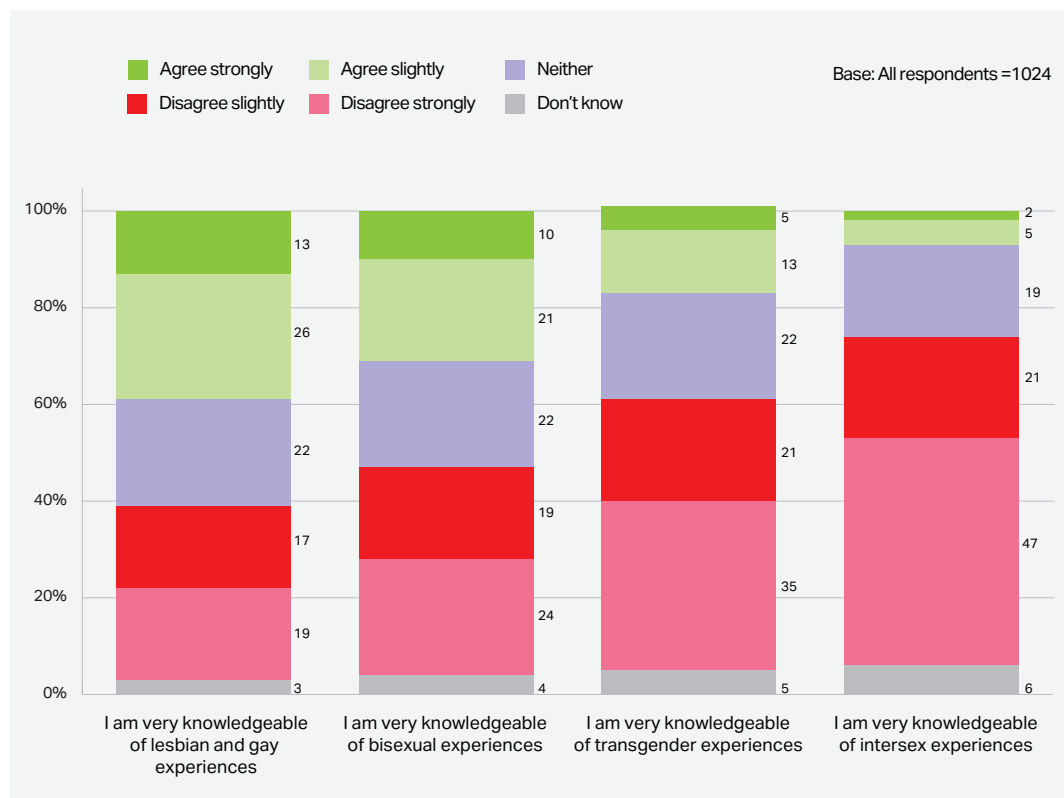


Figure 9.23: Knowledge of LGBTI experiences

Almost 2 in 5 agree (strongly or slightly) that they are "very knowledgeable of lesbian and gay experiences". Just over 3 in 10 agree for "bisexual experiences", less than 1 in 5 for "transgender experiences" and only a small minority (7%) for "intersex experiences".

Those aged under 35 are significantly more likely to agree with each of the four statements while those aged 55+ are significantly more likely to disagree. Singles are also significantly more likely to agree about all statements with the exception of intersex.

Those who agree that they are very knowledgeable of lesbian or gay, bisexual or transgender experiences, are significantly more likely to be positively disposed to the LGBTIQ+ issues contained in the survey and express support for the LGBTIQ+ community. This knowledgeable group is also significantly more likely to assert that they have frequent interactions with lesbian or gay, bisexual, transgender and intersex people and are comfortable in their company. They are also significantly more likely to disagree with attitudinal statements which suggest it's ok to make fun of or discriminate against LGBTIQ+ people.

Knowledge of LGBTI experiences decreases along a sliding scale from lesbian and gay, to bisexual, transgender and finally intersex. Knowledge correlates with reported frequency of interaction and being more positively disposed towards LGBTQI+ issues.

Summary and discussion of the findings of the online survey

The main focus of the online survey was on attitudes towards, and knowledge of, transgender and intersex identities. In addition, some questions were included that were also asked in the telephone survey. This was done to allow a comparison to be made between the outcomes of the online survey and telephone survey in order to develop some insights into how the method used might affect the outcomes. The overall outcomes of the online survey will be discussed first followed by the methodological comparison.

Overall, high numbers expressed positive attitudes towards issues such as same-sex marriage and same-sex parents' right to equal treatment. Also, participants agreed that the government needs to address hate crimes and hate speech legislation. While older people were more likely to express disagreement in terms of the former two equality issues, they were also more likely to agree that hate crime/speech should be adequately addressed in our laws. There were also very positive attitudes towards people with transgender and intersex identities. It was not considered acceptable by most participants to refuse to provide a service to transgender people, to mock transgender people, or use religion as a reason for discrimination against LGBT people. Also positive was the high percentage who indicated that they would be accepting of an intersex child. Beyond these overall positive responses, some key themes emerged that warrant further discussion.

Inclusive education

As discussed in Module One, the inclusion of education on LGBTQI+ identities in the school curriculum not only enhances knowledge and visibility but it is an important strategy for increasing LGBTQI+ students' sense of inclusion and belonging. Noone et al. (2022), in their online survey, identified high levels of agreement with statements that the government should include LGBTI+ matters in the Relationship and Sexualities Education curriculum (82%) and include LGBTI+ lives in the teaching curriculum in primary and senior levels (73%). However, in our study with the different identities separated out support for this was reduced. For example, while about 3 in 5 participants (62%) agreed that information about LGB sexualities should be included in the secondary school curriculum, this fell to 54% when questions were asked about the inclusion of information on transgender experiences. This may be related to erroneous beliefs that people can be 'converted' to a gender or sexual orientation, as over 2 in 5 (43%) believe that "*Learning about transgender lives in school might make young people think they are transgender*".

Similar to beliefs around the inclusion of transgender identities within the curriculum, 49% reported being comfortable with their child learning about intersex variations. This result is much lower than the results of the European Commission Eurobarometer, Ireland-country data (2019), which showed 70% agreement with the similar statement *“school lessons and material should include information about being intersex.”* It is also lower than the 65% of participants across the EU that agreed with the statement (EC, 2019), despite the latter figure being made up of responses from EU countries with very varying perspectives about LGBTQI+ issues. This comparatively low level of agreement, coupled with the fact that a quarter of participants were undecided/unsure about this statement, and only 7% reported being knowledgeable of intersex experiences clearly suggests a knowledge gap affecting opinions.

In relation to students being allowed to choose between wearing trousers or a skirt as part of a uniform, just over half of participants agreed (54%) that students should be able to choose, with the remainder disagreeing or being undecided. In Module One of this study, 42% of TGNC participants reported being able to wear clothing that aligned with their gender, which is higher than the 16% reported in an earlier Irish study (TENI, 2015), suggesting that attitudes are changing within schools. This is positive as no doubt being required to wear a uniform that does not align with one’s gender heightens levels of anxiety for transgender students (TENI, 2015).

Legal documents for under 18’s

In relation to legal documents, there was a low rate of agreement (30%) towards transgender people under 18 being able to change their legal documents to match their gender, even with parental consent. Noone et al.’s (2022) study contained a somewhat similar statement, that *“government should introduce a system of gender recognition for children of any age on the basis of parental consent for those under 16 and self-declaration for those over 16”*, which received a higher response of 55% agreement based on their 7-point scale. In both Noone et al.’s (2022) and this study older people had lower rates of agreement with these statements. Women were more supportive in Noone et al.’s (2022) study than men, while in the present study those without dependent children and single people were most supportive. It is interesting that a similar statement in the telephone survey inquiring whether *“transgender people should be able to change their legal documents to match their preferred gender”* but without a mention of age, was supported by 71%. Notwithstanding the different methodological approaches used between the telephone and online approaches, when inquiring about under 18’s, agreement rates are substantially lower. This raises a possible question about the public’s trust in the decision making of parents with transgender children, parents whose consent is required for under 18’s (i.e. 16 and 17-year-olds) to be able to change their legal documents, and a process that is already written into Irish law. The low levels of support, coupled with the 26% who were undecided/unsure may also be an indicator of a lack of knowledge about 16 and 17-year-olds existing legal right to change their legal documents with parental consent. The absence of

distinction in terms of age in the question may have informed this finding or it may also be reflective of the lack of knowledge reported by participants about transgender experiences more generally. Participants may not have considered that having discordant documents is a real issue with significant implications for transgender people. These include challenges for instance in seeking housing, accessing health services, legal services, training/employment, and travel (James et al. 2023, Malta et al. 2020). The added pressure and stress may also impact mental health (Malta et al. 2020, Scheim, 2020, Tan et al. 2022). It is also puzzling that the public in our study expressed clear opposition to the idea of discrimination against transgender people, however, were reluctant to agree with the legal supports to prevent this. This kind of ambiguity has also been found in other studies (Lewis et al. 2022, Pew Research Centre, 2022, Morgan et al. 2020). For instance, the Pew Research Centre (2022) concluded that although the US public seemed generally in favour of protecting transgender people from discrimination, they expressed uneasiness with the pace of change on transgender issues.

Age of awareness

One fifth of participants did not believe that a person might know they were transgender at the age of 12 years, with one quarter of participants being undecided/uncertain. The older cohorts and those with dependent children were more likely to agree that you can't know you are transgender at a young age like 12. In Module One of this study, 13 was the average age of transgender and gender non-conforming people knowing their LGBTQI+ identity. Similarly, in Goldberg et al.'s (2023) US study, 12.5 years was the average age that transgender and gender-expansive youth realized they were something other than cisgender, with 58.6% realising at the age of 13 or younger (Goldberg et al. 2023). This finding may also be an indicator of a lack of knowledge of transgender lives, although it is possible that answers would have differed if another age, for instance 14, had been queried.

Comfort around/support for transgender, non-binary and bisexual people

A majority of participants (65%) expressed that they would support a family member to transition (socially and medically). Nonetheless, when asked about comfort in relation to a son or daughter being transgender, agreement was lower (44%). Females were more likely to agree and males more likely to disagree with the former statement, and the youngest cohort, and those without dependent children were more supportive of the latter. Proximity seemed to play a role in lower ratings in other Irish based research, specifically when statements involved dependent children (DECDIY 2023, EC, 2019).

When considered in comparison to LGB people in this study, levels of discomfort regarding being in the company of a non-binary person (25%) were far higher than discomfort regarding being in the company of LGB people (11%). Substantial gaps in positive attitude ratings between non-binary people and LGB were also found in other Irish studies (DCEDIY, 2023, Noone et al. 2022). In the recent DCEDIY (2023) study of attitudes towards diversity in

Ireland, the comfort rating regarding living next door to a person who does not identify as male or female was high (80%) but was between 8 and 9 percentage points lower than the ratings given to living next door to gay men or lesbians respectively. In this study, men and the youngest cohort (18-24s) were more likely to express discomfort regarding non-binary people. In other studies, right wing authoritarianism, traditional masculinity and anti-egalitarianism predicted negative attitudes towards non-binary people, and conversely traditional femininity predicted positive attitudes towards this group (Perez-Arche and Miller, 2021). Religion has also been found to be associated with increased prejudice towards gender non-conforming people (Campbell et al. 2019).

Positive attitudes to bisexuality remain challenging. Approximately a quarter of participants expressed that they would feel comfortable if their partner was bisexual, while half disagreed. Male, younger and single participants were more likely to agree with the statement. Others have reported factors such as higher social dominance orientation, political conservatism, and essentialist beliefs about the discreteness of homosexuality (Feinstein et al. 2016), as well as concerns about the stability of a bisexual sexual orientation (Armstrong and Reissing, 2014) as influencing attitudes.

Participation in sport

While not a new topic of discussion, more recently there is greater attention on the issue of transgender people's participation in sport, with debates endeavouring to navigate the tensions between issues of discrimination and fairness of competition (Flores et al. 2020). Positive attitudes about transgender people's participation in sport were low in this study. Just one third (33%) of participants agreed that *"transgender men should be allowed to take part in men's sports"*, and just one fifth (21%) agreed with *"transgender women taking part in women's sports"*. The younger cohort were more favourable towards both transgender women and men's inclusion, while women were more supportive of transgender women's participation in women's sport than men. These findings are more or less in line with Flores et al.'s (2020) US based study, where 31% agreed with *"allowing students who have had a 'sex change' to play college sports as a member of their current gender"*. However, the 21% reported in this online survey is lower than the 44% agreement that sports needs to be more inclusive of trans women as found by Cleland et al. (2022) in an Australian study. Notably in Flores et al. (2020) study rates of undecidedness/uncertainty were 35%, while in our study they were 25% and 24% regarding transgender men and transgender women, respectively. In the same American study it was also found that people who have higher interaction levels with transgender people and who have strong egalitarian attitudes were more favourable towards transgender people's participation in sport (Flores et al. 2020). Conversely, people with high gender identity conformity, high moral traditionalism and those with traditional gender role beliefs were more opposed to transgender people's participation in sport that aligned with their gender identity (Flores et al. 2020).

Access to public toilets is essential for every human being who wishes to participate in life beyond the home (Slater and Jones, 2018). The critical literature, on public toilet use, highlights how toilets are a key site through which transgender people are 'othered', mainly through debates about safety, rights and gender essentialism (Jones and Slater, 2020, Colliver et al. 2018). In this study there was polarisation evident around bathroom use. While 39% of participants agreed that transgender men should be able to use the men's bathroom, fewer were in agreement with transgender women being able to use the women's bathroom (34%), with over one third agreeing or being undecided/not knowing. These rates are low when compared to other more recent studies (Morgan et al. 2020, Neil and McAlister 2019, Luhur et al. 2019). For example, in Neil and McAlister's (2019) Northern Ireland study and Morgan et al.'s (2020) UK based study, 55% and 58% of men indicated that they were comfortable/approving of transgender men using a male toilet, and 59% and 66% of women were comfortable/approving of a transgender woman using a female toilet. In line with other studies (Morgan et al. 2020, Crissmann et al. 2020) age was an influencing factor, with more positive attitudes held by younger age groups. The high level of undecidedness/uncertainty emphasises the need for more public discussion, and awareness raising on transgender people's lives, and just like with the legal aspects, the practical and psychological implications of this form of exclusion (Bagagli et al. 2021).

Safety and asylum seeking

Findings in Module One of this study (Chapter 7) demonstrated that sizeable percentages of LGBTQI+ people have experienced or witnessed anti-LGBTQI+ hate speech in the media, with a greater proportion of transgender and gender non-conforming people experiencing this in comparison to their cisgender counterparts. Yet, the general public appear to be divided in relation to their perception of the level of anti-LGBTQI+ hate people are exposed to. While about a third agreed that *"there are comments in the media that call for violence against lesbian, gay, bisexual and transgender persons"* and that *"Ireland is a safe place to be transgender"*, an equal proportion disagreed and about a third were undecided/unsure about this issue. Younger people were more likely to believe there were media comments calling for violence, and that Ireland is a safe place for transgender people, and males were more likely than females to think Ireland is a safe place for transgender people. What is perhaps most concerning is the high numbers of people being undecided. This leaves them exposed to trends in the media and social media, which is how hate campaigns gain their support (Köhler and Ebner, 2019).

More were supportive than were not of LGBT people being granted asylum if being persecuted because of their gender identity or sexual orientation in their country of origin, however, while not the exact same measure, the 50% agreement to the granting of asylum to people experiencing persecution is lower than the 64% reported in Noone et al.'s (2022) study who were in

agreement with offering additional supports to asylum seekers who are LGBTQI+ people. In both Noone et al. (2022) and in this study, agreement with the statements about LGBTQI+ asylum seekers was lower among males. In this study, the youngest and oldest cohorts were more in agreement with granting asylum to people experiencing persecution in their own country as were single people, those with higher education and those without dependent children.

Comparison of findings between telephone survey and online survey

This final section compares the results of attitudes to various statements which were included in both the Computer Assisted Telephone Interviewing (CATI) and the Online approach. Where the wording of the attitudinal statements is identical in each methodology, it is included just once, printed above the graphics with the results of both Telephone and Online methodologies.

Where the wording differs, even slightly, the exact wording is included above each methodology. For example, the graphic about “positive messages” has different wording for the Telephone and Online surveys, whereby the word “identities” was used in the Telephone approach (to remain consistent with the wording used in 2014), while the wording used in the 2023 Online survey was updated to use the word “people” instead of “identities”. In presenting the results of the same or similar questions in the Telephone and Online surveys, this section sets out to compare results and consider issues in relation to methodology.

Education: Results show agreement with the statements in both data collection methods, but agreement is significantly stronger in the interviewer administered (Telephone) scenario.

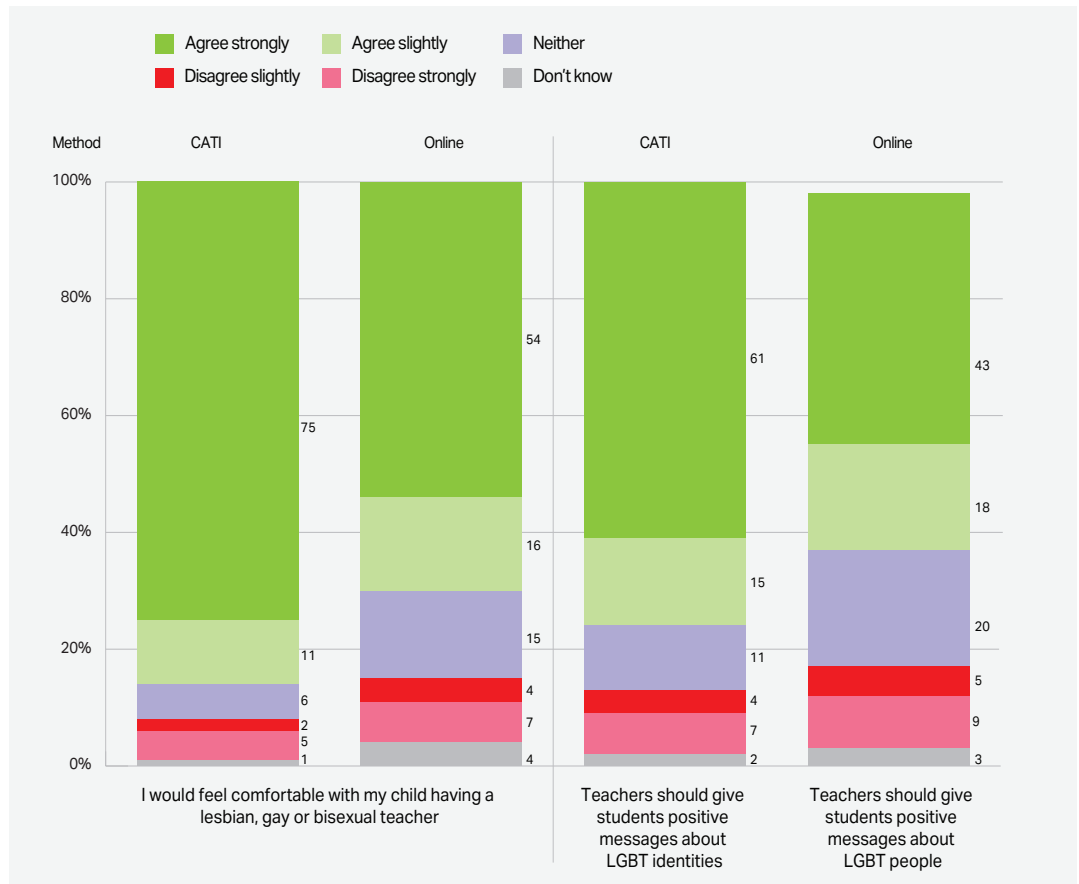


Figure 9.24: Comfort with LGB teacher and education on LGBT people

Discrimination

Lesbian, Gay or Bisexual: Results show primarily disagreement in both data collection methods, but disagreement is significantly stronger in the interviewer administered (Telephone) scenario.

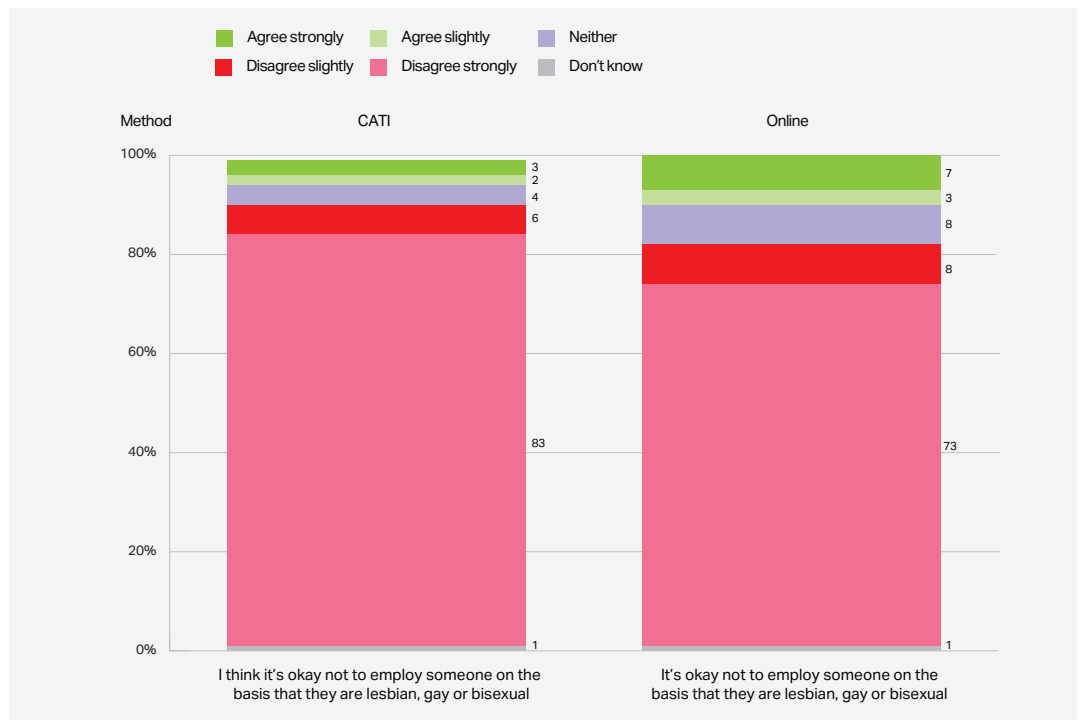


Figure 9.25: Acceptance of discrimination against LGB people

Transgender: Results show primarily disagreement in both data collection methods, but disagreement is significantly stronger in the interviewer administered (Telephone) scenario.

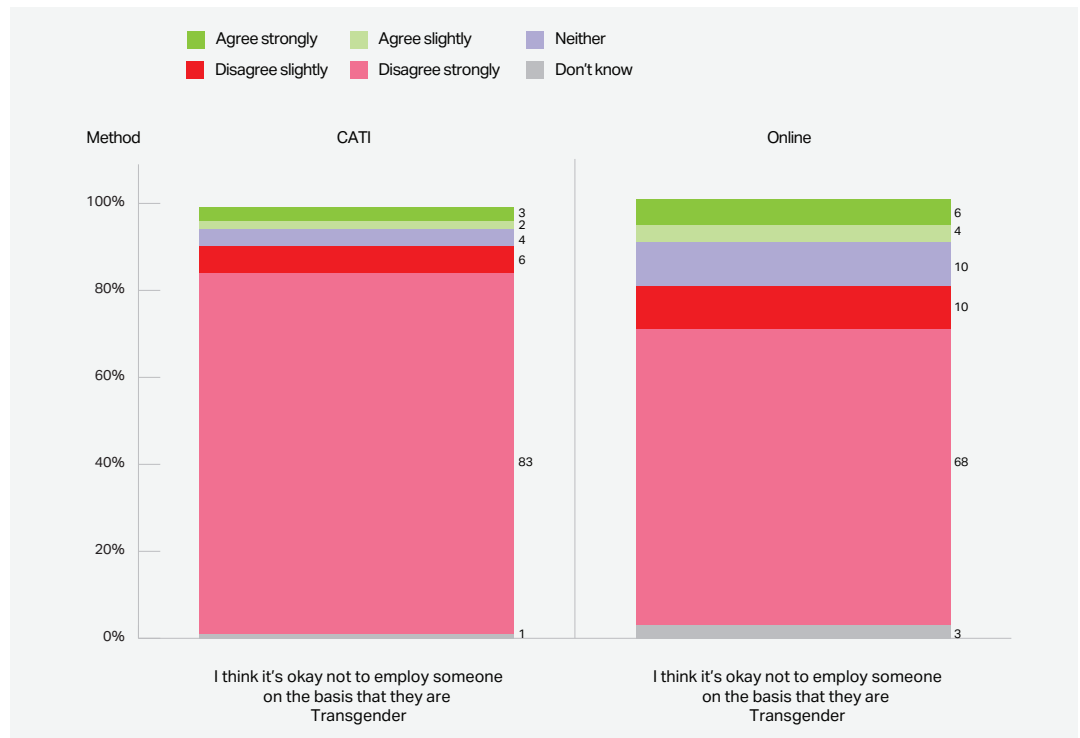


Figure 9.26: Acceptance of discrimination against transgender people

Being in the company of or around LGB people: Results show significantly stronger positive attitudes in an interviewer administered scenario rather than in the self completion data collection method.

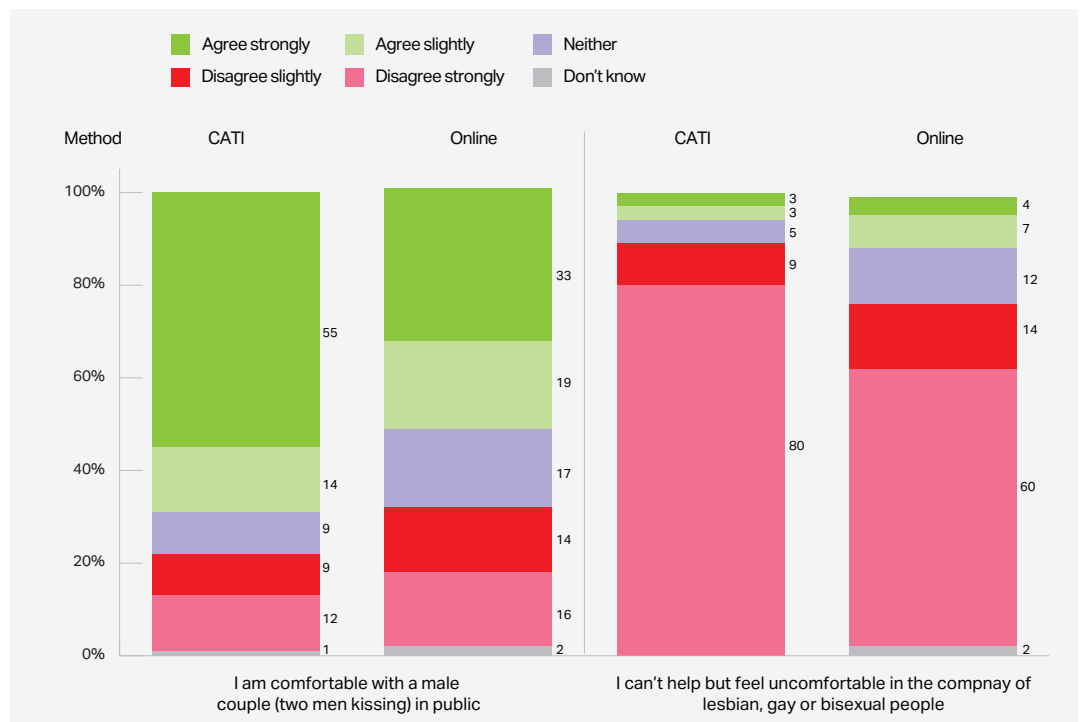


Figure 9.27: Comfort with male couple kissing and being around LGB people

Transgender belief system: Disagreement is higher than agreement in both data collection methods, but disagreement is significantly stronger in the interviewer administered scenario.

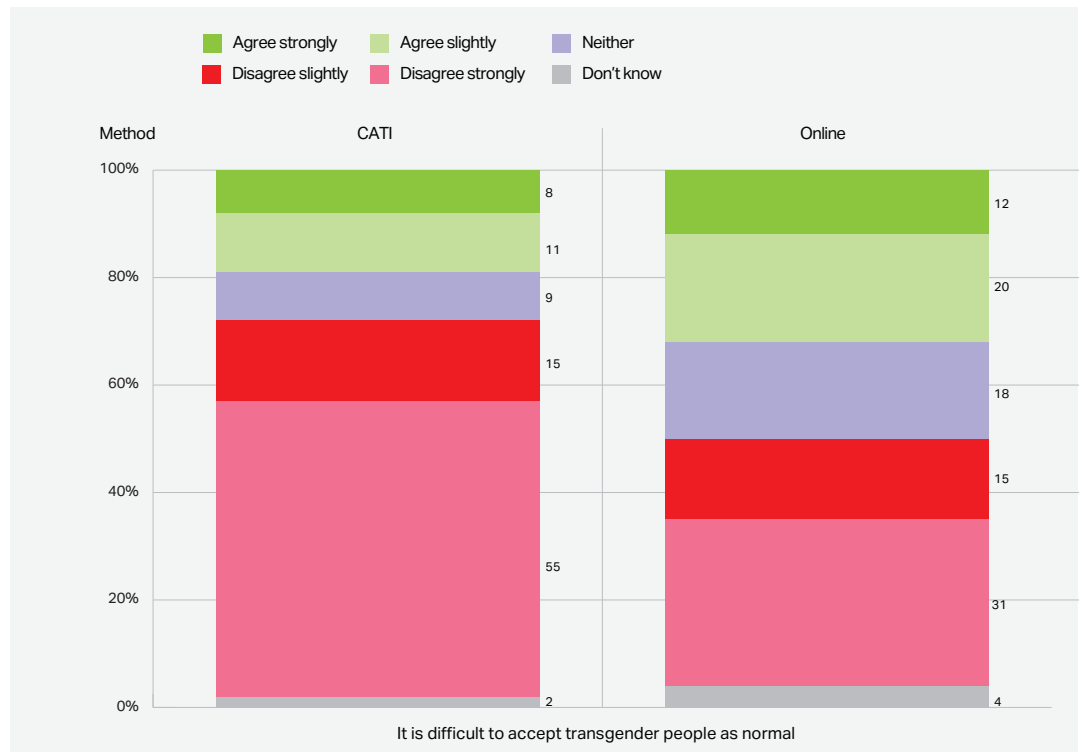


Figure 9.28: Acceptance of transgender people as normal

Comfort with and support for transgender family member: Similarly, while levels of agreement are strong in both data collection methods, they are significantly stronger in the interviewer administered study.

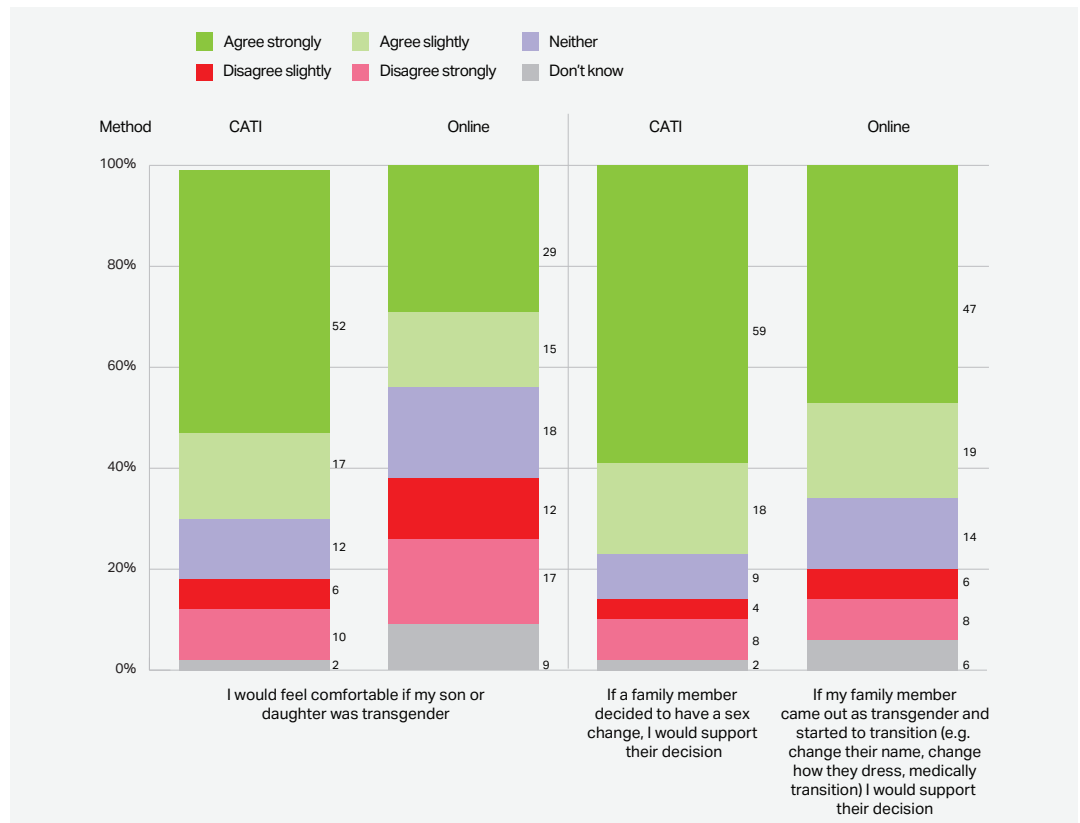


Figure 9.29: Comfort with and support for transgender family member

Discussion of comparison findings

The inclusion of the same or similar questions in both the telephone and online surveys allowed a comparison between the two methodologies. While the overall outcomes were the same, the telephone survey had significantly higher degrees of agreement with positive statements about LGBT issues and more disagreement with statements reflecting common bias against LGBT people. In terms of methodological approach, interaction bias is a key issue for consideration when comparing results across the two different approaches. Interaction bias refers to the effect that interaction can have in how a question is communicated, and the context of its communication, on the responses that are received. This can relate to different types of interaction across methods, or as in the case of this study, interaction with a trained interviewer in the CATI method, and no interaction with another person in the online survey. In addition, social desirability bias can play a role, meaning that respondents provide answers on the basis that they will be viewed favourably by others, rather than providing their true opinions (Jann et al. 2019). In this study participants in the telephone interviews may have been more intent on projecting a socially desirable image than participants in the online survey. It is also possible that selection bias may have occurred in so far as people who volunteer to be interviewed by telephone could conceivably have slightly different perspectives on human factors than people who engage with an online survey. In addition, the online survey was part of an omnibus survey which included a variety of other topics, placed before this survey. The topics ranged from the mundane, such as grocery shopping, to more serious social issues, such as assisted dying. Therefore, there is no way of knowing whether this impacted people's responses to this survey; whether people paid the same amount of attention, or took or more or less time to complete the survey. Also, there is no way of knowing if the respondent to the online survey discussed the responses with others, prior to completion. In short, with such a myriad of possible reasons for the difference in responses, it is important not to jump to conclusions regarding the reasons for what are otherwise rather consistent differences.

Chapter 10: Key Findings From Across Both Modules, Including Recommendations

Key Findings Module One

Participant profile

The final sample comprised 2,806 LGBTQI+ participants between the ages of 14 and 84, with an average age of 31. In total, 28% of the sample indicated that they had a gender identity that was different from the sex they were assigned at birth. 718 participants identified as transgender and 31 participants identified as intersex or as having an intersex variation. Half of the sample identified as either gay or lesbian, while approximately one fifth identified as bisexual. The remainder comprised those identifying as queer, pansexual, asexual, questioning, other and heterosexual. The majority of the sample had completed third level education and were working for payment or profit. The average age of awareness of one's LGBTQI+ identity was 14 years old while the average age of disclosure was 19 years. A small proportion (3%) of the sample had not come out to anybody, most of whom were cisgender, bisexual and aged under 25. Four in five participants reported that their immediate family and people they socialised with were aware of their LGBTQI+ identity. Participants were most open about their LGBTQI+ identity with people they socialised with and least open with strangers. Approximately one fifth of transgender participants did not live openly as their gender.

The profile of the study participants in 2016 and 2024 differed significantly with respect to sexual orientation, gender identity, age, ethnicity, education level and employment status.

LGBTQI+ wellbeing

The average happiness score was 6.13 roughly one point above the midpoint of 5, with approximately half of participants rating themselves 7 or higher on a 0-10 scale. The average score for self-esteem was 26.77, which is on the low end of the normal range. Levels of happiness and self-esteem within this LGBTQI+ sample were lower than those found in the general population, both nationally and internationally. A comparison with *LGBTIreland* (2016) indicated a decrease in the prevalence of being happy and of high self-esteem which were highly statistically significant and remained statistically significant after taking into account differences in the sexual orientation, gender identity and sociodemographic profile of the participants from the two studies. In terms of resilience, the average score was just below the midpoint of 3 on a scale of 1 to 5, just within the low resilience category. Positively, comfort with gender and sexual identities was high with scores of approximately 8 on a 0-10 scale, with higher scores signalling greater comfort.

The highest level of support for LGBTQI+ identity came from participants' social networks, but high levels of support from immediate family (75%), and work/school acquaintances (63%) were also found. These are positive findings in that social support plays a buffering role between levels of minority stress and mental health and wellbeing for LGBTQI+ people. For participants who practiced a religion, 30% felt that their congregation were unsupportive of their LGBTQI+ identity.

Two-thirds felt welcome and advocated for in the LGBTQI+ community. Notwithstanding these positive results, 31% felt their identity wasn't given equal recognition, 27% felt isolated and separate from other people who share their identity, and 22% felt excluded from the community. These responses came from both longer 'established' groups such as participants who identified as bisexual, lesbian, and transgender and gender non-conforming, as well as more recently documented/emerging identities, such as asexual or aroace people. Barriers to community connection/belonging were also experienced for reasons other than sexual or gender identity, with participants identifying experiences of racism, ageism, ableism, and sexism. These findings remind us of the intersectional nature of LGBTQI+ people's lives and the need for an intersectional underpinning in any inclusion related work.

Personal lived experiences as LGBTQI+ people, such as the personal growth and development that comes with understanding and accepting oneself, the sense of freedom from norms that this can offer, along with an alternative perspective of the world and how marginalisation and inequality occur, as well as resulting involvement in socio-political activities were key among the strengths that participants identified within themselves.

Mental health and distress

Between approximately two-fifths and one half of participants fell within the moderate/severe/extremely severe categories for depression, anxiety, and stress (47%, 50% & 39%) respectively. Lifetime prevalence of self-harm, suicidal thoughts and suicide attempt was high at 52%, 65% and 26% respectively. 14 and 15 years were the most common ages of first self-harm and first suicide attempt respectively. Over 50% reported that their self-harm, suicidal thoughts and suicide attempt was in some way related to being LGBTQI+.

The rates of self-harm and suicidality found were comparatively higher than those found in the general population of Ireland while the rates of symptoms of severe/extremely severe depression and anxiety as well as self-harm and suicidality among the younger cohorts of LGBTQI+ participants were much higher compared to the rates among young people in *My World Survey 2* (Dooley et al. 2019).

Two-fifths of participants reached the threshold for having a possible eating disorder, while one third had scores indicative of a moderate level of alcohol consumption and one tenth had scores indicative of a high/very high level of alcohol consumption. Lifetime prevalence of drug use was 54% (non-medical

use), with over half of those (57%) taking drugs within the last year. Of these, just under one third (30%) fell into the moderate level category, and 9% were in the substantial or severe category, suggesting that further investigation/intensive assessment are required. Far more participants felt that their mental health had worsened since the start of the COVID-19 pandemic (48%) than those for whom it had improved (18%).

TGNC participants reported higher symptoms of depression, anxiety and stress; higher rates of potential eating disorder and suicidality; and lower levels of happiness, self-esteem and resilience compared to their cisgender counterparts. Only on harmful or hazardous drinking did TGNC participants have lower (better) scores than cisgender participants. There was a clear trend between age and wellbeing and mental health, with levels of happiness, self-esteem and resilience increasing, and symptoms of depression, anxiety and stress, and rates of suicidality decreasing with increasing age cohort. In general, lesbian and gay participants fared better on wellbeing and mental health measures compared to participants identifying as bisexual, pansexual, asexual and queer, with the exception of alcohol use where gay participants scored highest. These findings highlight the need for developing targeted and generalised interventions for LGBTQI+ people.

Comparative results to the *LGBTIreland* cohort show that on some indicators of mental health there has been a deterioration. There was a significantly higher level of reported symptoms of severe or extremely severe depression (+17% relative increase), anxiety (+30% relative increase) and stress (+33% relative increase), which could not be accounted for by any of the key demographic differences between the cohorts. Although the lifetime prevalence of self-harm, suicidal thoughts and suicide attempt were slightly higher in this study (+9%, +3% & +8% relative increases respectively), these differences were not statistically significant once differences in the sexual orientation, gender identity and sociodemographic profile of the participants from the two studies were accounted for.

The findings also highlighted some of the positive factors for mental health wellbeing among LGBTQI+ people, with recent legislative changes, namely the Marriage Equality Act and the Gender Recognition Act, being identified as having an overwhelming positive impact on participants' mental health, along with connection to the LGBTQI+ communities in terms of making friends, joining groups, visiting spaces and engaging with LGBTQI+ media. Media representation of LGBTQI+ identities was also rated highly positive for one's mental health. In line with the literature, for trans and non-binary participants, transitioning socially, legally or medically was identified by the majority of participants as having a positive impact on their mental health. The qualitative findings on factors that positively impacted mental health echo some of the quantitative findings, with feeling supported, self-acceptance, acceptance from others, and having a role and place in one's community where one was able to be out contributing to mental wellbeing.

School continues to be a challenge for many LGBTQI+ students, as identified by 40% of the study sample who were either currently enrolled in school or had attended within the last 5 years, in the Republic of Ireland. The mean rating for LGBTQI+ school friendliness (M=4.79) was below the midpoint (5) of the scale used, with about a third of participants (31%) reporting 'not belonging at all' in school. Participants' sense of school LGBTQI+ friendliness and belonging was not statistically significantly different from *LGBTIreland*, suggesting that little has changed in participants' perceptions of school. Nearly half (49%), reported experiencing homophobic, biphobic or transphobic bullying in school while one quarter (26%) reported that they had missed or skipped school to avoid such bullying. Significantly more participants reported witnessing LGBT bullying in 2024 compared to 2016 (79% vs. 67%) and thought of leaving, or did leave school early due to negative treatment (41% vs. 28%). The negative impact of bullying was clear where those who had experienced LGBT bullying had statistically significant higher reported symptoms of depression (M=21.88 vs. M=17.84), anxiety (M=21.02 vs. M=16.04) and stress (M=23.22 vs. M=19.18), and lower happiness (M=4.83 vs. M=5.60), self-esteem (M=22.4 vs. M=24.20), resilience (M=2.46 vs. M=2.72) and gender identity comfort (M=6.87 vs. M=7.68) compared to those who had not experienced bullying. There were also statistically significant higher rates of potential eating disorder, self-harm, suicidal thoughts and suicide attempts among those who had experienced LGBT bullying compared to those who had not.

The school environment, in terms of inclusion, visibility, safety, and support fell short with 44% reporting that gender and sexual diversity wasn't addressed in SPHE, and 41% disagreeing with the view that positive statements and representations of LGBTQI+ people are included in the curriculum. Few schools appeared to have LGBTQI+ groups/champions (15%) supportive spaces for LGBTQI+ people (28%), or openly LGBTQI+ identifying teachers (23%). Nearly half of participants (48%) reported avoiding certain spaces in school due to feeling unsafe. For transgender and non-binary participants, the school environment was especially challenging in terms of expressing one's gender identity, with 57% not being addressed by the correct name and pronoun(s) and 46% not being free to wear a uniform which aligned with their gender identity. Participant suggestions for improving the school environment were attention to safety and support, equality for LGBTQI+ students, education of staff and students, raising LGBTQI+ visibility and the removal of religious influence.

As the findings show, the teenage years are the years during which some of the most key formative events occur in terms of realising and disclosing one's LGBTQI+ identity, and entering secondary school where the need to feel that one's sexual orientation and gender identity is visible and accepted and one belongs within the school community. It is also a time of encountering many challenges within the school, such as bullying, which may impact students' mental health and academic performance, as well as the onset of self-harm behaviour and suicidality for some young people. The role the school has to play in supporting students in all aspects of these challenges is vital.

Sexual and gender minority people continue to face high levels of LGBTQI+ related harassment and violence, evident in the reported rates of verbal harassment (72%), being threatened with being outed (33%), non-consensual touching (30%), physical attack (24%) and sexual assault (16.5%). In terms of a personal sense of safety, the majority of participants would feel unsafe showing affection with a same sex partner in public (53%) and holding hands with a same sex partner in public (45%), while among transgender and non-binary participants, 54% reported feeling unsafe expressing their gender identity in public. Approximately one third of participants reported either feeling unsafe or would not, use public transport, be seen going to or leaving an LGBTQI+ club or venue, or be seen checking an LGBTQI+ website on a public computer. Approximately 23% of participants had experienced anti-LGBTQI+ hate speech either online or in public media in the last year, and TGNC and young people aged 14-18 were more likely to have experienced this. Participants viewed anti-LGBTQI+ hate speech in the media as not only having negative impacts and consequences for LGBTQI+ individuals and the LGBTQI+ community, but felt that it fosters the expansion of hate through the wider society. These issues need to be addressed to prevent the negative psychological impact of feeling unsafe, and also to avoid contexts where LGBTQI+ people reduce their visibility for safety reasons. Reduced visibility can result in less contact between LGBTQI+ and non-LGBTQI+ people, contact that is not only important for one's mental health but can improve societal attitudes through positive day-to-day interactions. Importantly, the media was also seen as having a positive impact in terms of LGBTQI+ representation and visibility and being a source of education and information both for LGBTQI+ people and wider society, as well as the potential it offers LGBTQI+ people and allies for the creation of a space for belonging, inclusion and solidarity. Legal and policing protections against, as well as consequences for, discriminatory acts, and media management and accountability in relation to the reporting and representation of LGBTQI+ lives and related issues were key topics identified for keeping LGBTQI+ people safe.

Healthcare utilisation experiences

While the findings revealed that most participants never experienced healthcare practitioners discriminating against them in healthcare (83%), telling them that their LGBTQI+ identity could be changed (91%), or asking unnecessary/ invasive questions about their identity unrelated to their reason for visiting (79%), a lack of education on LGBTQI+ people's identities and healthcare needs, practising with a cis-hetero normative lens, and a lack of visibility of LGBTQI+ healthcare information were some of the issues participants encountered with healthcare services. Approximately one quarter (27%) never felt comfortable to disclose their LGBTQI+ identity to their healthcare practitioner; for transgender participants, there were particular fears around disclosure, such as being pathologized and not getting the care that they required. Similarly, participants recounted both positive and negative encounters with mental health care practitioners, with the former comprising interactions with supportive,

respectful, knowledgeable practitioners and the latter involving interactions with practitioners who lacked competency in LGBTQI+ issues. Barriers to accessing mental health care identified by participants included waiting times, cost, stigma and fear of being pathologized due to one's LGBTQI+ identity. These deficits may have implications for LGBTQI+ people's willingness to access services and must be addressed in order to ensure timely, inclusive and affirmative access to healthcare.

The findings also illuminated the many issues that transgender and non-binary people face when using healthcare services to medically transition; the first being the accessibility and availability of services, in so far as for most of those who had or were in the process of medically transitioning, the majority (69%) relied on healthcare services outside of Ireland to support them and a significant proportion (30%) had self-medicated using hormones as part of their transition. For these cohorts, these pathways, which were necessitated by the length of waiting times within the National Gender Service and the lack of 'affirmative' care within Ireland, imposed huge financial burden as well as risks to health from DIY HRT and not receiving good quality aftercare in Ireland post-transition. Other issues identified with the service in Ireland included not getting referral due to 'blocking and 'gatekeeping' by GPs and other healthcare professionals, an inappropriate psychological assessment process and the lack of communication around wait times. The mental health toll of all these challenges were underlined by participants, highlighting the need for an urgent reform of the existing service.

The findings in relation to the healthcare experiences of people who identify as intersex or have an intersex variation(s) echoes international literature on this population, with non-consensual medical interventions performed as an infant or child, and hormonal treatment commencing in adolescence.

Key Findings Module Two

Module Two utilised a telephone survey and an online survey to measure public attitudes among a representative sample of the adult population of Ireland. The telephone survey replicated the 2014 public attitudes survey contained in the *LGBTIreland* report. A statistically significant positive change in attitudes since 2014 across 30 of the 39 measures examined was found, under the themes of education, discrimination, being in the company of LGBT people, transgender identity, and LGB related belief systems. In the main, positive changes were found across all socio-demographic sub-groups explored. Smaller change effects were often due to already high rates of positive attitudes in 2014.

Notwithstanding these positive findings some areas for consideration were evident. Between 10% and 22% of adults continue to agree with views such as being LGB is a phase, a choice, or not normal, that people can be convinced to 'turn' LGB and that accepting transgender people as normal is difficult. Also, there was a statistically significant decline since 2014 (62% to 53%) in agreement with the view that being transgender is something you are born with,

but the high rate of uncertainty also expressed in relation to this measure may suggest a gap in knowledge being the key driver here.

Since 2014, a worrying upward trend (+9%) in the view that bullying is a normal part of growing up and schooling was found, and a sizeable minority (8%) still believed that making fun of young people in school because of being LGB is not harmful. Over a third of adults believed that LGB people can't know their sexual orientation at 12; worrying in instances where this translates to less supportive environments for young people, or making them unwilling to come out, both possible risk factors for mental ill health. Also found was a small 4% rise (albeit not significant) since 2014 in the belief that equality has been achieved for LGB people to 36%, with 18% expressing uncertainty about this issue, notable in light of the outstanding equality issues such as the need for a ban on conversion therapy, hate crime legislation, and recognition of all LGBTQI+ parents. A small 3% reduction (albeit not significant) was found, from a high base of 71% agreement in 2014, regarding transgender people being able to change their legal documents, a reduction that should be monitored in light of lower ratings to similar measures found in other national and international studies.

The main focus of the online study was on attitudes to and knowledge of transgender and intersex identities. Generally positive attitudes to these two groups were found specifically in terms of the non-acceptance of the refusal to provide a service to transgender people, non-acceptance of mocking of transgender people, or using religion as a reason for discrimination against LGBT people. Other findings suggested less favourable attitudes to transgender people, for example, when ascertaining attitudes to the inclusion of information on LGB sexualities in the secondary school curriculum, 62% expressed positive attitudes about the former while less (54%) did so regarding the inclusion of education on transgender people. There was a high rate in the belief (43%) that learning about transgender lives in school might make young people think they are transgender. Less than half also reported being comfortable with their child learning about intersex variations in school, however the findings also suggest low levels of knowledge about being intersex. Just over a half of adults agree that students should be allowed to choose between trousers or a skirt as part of their uniform, a finding that could be improved, as dressing in a way that does not align with a students' gender identity has been found to heighten students' levels of anxiety.

There was a low rate of agreement (30%) to transgender people under 18 years being able to change their legal documents to match their gender, even with parental consent. Under current legislation in Ireland, children aged 16 and 17 can apply to the courts to have their gender changed with parental consent and medical approval. This finding could suggest that there could be low public support for extending this right to all children under 18, which raises some questions around trust in parents and knowledge of 16 and 17-year-olds existing legal right to change their legal documents with parental consent. The absence of distinction in terms of age in the statement may have informed this finding or it may also be reflective of the more general lack of knowledge about

transgender experiences that was reported by participants. In addition, over half of participants believed that a person cannot know they are transgender at the age of 12, and one quarter were undecided/uncertain, a finding that is contrary to many transgender people's own experiences. Again, the need to improve on this perception is important if we want to create a more supportive context within which young transgender people can live their day-to-day lives and indeed come out.

Levels of comfort in terms of being around/supporting transgender and non-binary people were lower than levels pertaining to LGB people. In terms of transgender people, comfort about a son or daughter being transgender (44%) was substantially lower than comfort with supporting a family member to transition (socially and medically) (65%). Rates of discomfort about being in the company of non-binary people were higher (25%) than rates regarding being in the company of LGB people (11%), and views on bisexuality remain challenging where half expressed discomfort with the idea of their partner being bisexual, signalling the need for targeted initiatives to continue the work of improving public attitudes about established identities/orientations as well as focusing on the emerging identities.

Positive attitudes about transgender people's participation in sport were low where just one third (33%) agreed that transgender men should be allowed take part in men's sports, and just one fifth agreed with transgender women taking part in women's sports. In a similar vein, the findings showed that fewer adults were in agreement with transgender women being able to use the women's bathroom (34%) than participants that agreed (39%) that transgender men should be able to use the men's bathroom. High levels of undecidedness/uncertainty were found about both issues pointing to a need for more informed discussion on these topics.

One third of the public were in disagreement with the fact that there are comments in the media calling for violence against LGBT people. In addition, one third were also undecided/unsure about this fact. Just half of adults were supportive of LGBT people being granted asylum if being persecuted because of their sexual orientation or gender identity, with younger, older and single people being more in favour of this.

Limitations and strengths of the study

Module One

The findings for Module One need to be read in the context of the following limitations. The sample is non-randomised and not representative of the general population, overrepresenting young people and students, and those living in Leinster and underrepresenting older people and those in retirement, as well as those living in Munster. The slightly higher proportion of ethnic minorities in the general population compared to the study sample resulted in relatively low numbers within ethnic minority groups which precluded a more in-depth analysis of the Traveller and Roma groups within this study. There

was also an overrepresentation of participants that had completed third level education. The self-selection of participants to the study may have resulted in an oversubscription by people who are particularly interested in LGBTQI+ issues, which may have biased the results. There was a notable increase in the proportion of people who identified as TGNC in this survey compared to 2016 and a corresponding decrease in the proportion identifying as gay or lesbian. While from a statistical point of view this has been accounted for, and while every effort was made to represent all voices in the qualitative commentary, there is a possibility that it may be more reflective of issues and experiences of TGNC participants. In relation to the question around school experience, while the impression was given that most responses related to experiences in secondary school, retrospective reflection on primary school experiences may also be included in the qualitative comments. In line with the 2016 data only a minority of participants were not 'out'; this group's outcomes may well be different to the majority who are 'out' to someone. Additionally, only a small number of participants identified as intersex. While efforts have been made to make intersex people's experiences visible throughout the study, the small numbers and varying identities among this group may have resulted in their voice being less visible. The survey was self-completed and hosted online and this may have precluded participation by people with literacy challenges and those without access to, or familiarity with, technology, especially older people. The survey itself was very lengthy which impacted the overall completion rate. However, the final sample that was analysed only included those who completed the survey up to a certain point to ensure that those included had completed a good proportion of the survey.

Based on LGBTI identity, the total sample in Module One was 2,360, an increase of 238 participants compared to 2016. According to Census 2022, the population of Ireland is 5,149,139. Based on an estimated 10% of the population identifying as LGBTI¹⁴ the target population is 514,913. The minimum sample size to achieve a confidence level of 95% (+/-3%) is 1,065 meaning that the sample obtained in this study is over twice this number, adding to the robustness of this module. In addition, this is the largest sample studied on LGBTQI+ mental health and wellbeing in Ireland inclusive of both LGBTQI+ young people and adults, as well as being the first follow-up study of this scale on this issue.

Module Two

The following study limitations, many of which were set out at the end of Chapter 9 in the 'Comparison between methodologies section', require consideration when interpreting the findings.

14 In the *My World Survey 2* on the mental health of young people in Ireland, 9% identified as LGBQ+ and 2% preferred not to say (87% identified as heterosexual). In the online component of Module Two of this study, where no interviewer interaction occurred, and this study's questions were placed among a wider set of different topics, 9% identified as LGB and a further 3% identified as 'prefer not to say' (89% identified as heterosexual). The DCEDIY (2023) public attitudes towards diversity profile comprised of 4% GLB identified people, and a further 4% identified as not sure/other/refused to answer (92% identified as heterosexual). Interviewer interaction occurred in both the CATI and CAPI methods used in that study.

The repeat survey of the Module Two study was originally developed by the research team in 2014. The new questions for the online survey were also developed by the research team in consultation with the research advisory group. Neither sets of questions contained any previously developed or validated instruments. In addition, there is an underrepresentation of people with lower levels of education in both the telephone and online samples. Social desirability bias may have played a role in the responses received, particularly in the telephone interviews, which involved interaction with an interviewer.

The online survey was part of an omnibus survey, which means the questions in the online survey were accompanied by other non-LGBTQI+ related attitudes questions, which were about a range of topics from everyday living type questions, for example, grocery shopping across to attitudes about what may be completely new ideas for interviewees, such as assisted dying. Therefore, the nature of the non-LGBTQI+ questions asked in conjunction with the LGBTQI+ related questions may have had an impact on individuals' responses to this survey, as may the duration of the survey, and the location of the questions in the series sequence. Also, there is no way to know if participants gave more or less time to the online survey or if they consulted with others before answering the questions. Equally, there is no way of knowing how questions, in both surveys, were interpreted by participants or if their interpretations were the same as the researchers intended. In terms of its strengths, the samples in both the telephone and online surveys are representative of the adult population of Ireland across gender, age, region and social class.

Recommendations

The *Being LGBTQI+ in Ireland* study indicates that many LGBTQI+ people in Ireland continue to face challenges in relation to their mental health and wellbeing, with LGBTQI+ young people and trans and gender non-conforming people at increased risk and vulnerability. Based on the study's findings, the following recommendations are made to government departments, bodies under their aegis, and state agencies with a view to advancing LGBTQI+ people's mental health and wellbeing, rights and social inclusion in Ireland:

Supporting mental health and reducing risks among LGBTQI+ people

- In line with *Sharing the Vision: A mental health policy for everybody* (Government of Ireland, 2020), where the LGBTQI+ population is recognised as a priority group, the HSE should invest in and test specific interventions and initiatives targeting depression, anxiety, substance misuse, eating disorders, self-harm and suicide among LGBTQI+ people. The needs of transgender and gender non-conforming youth, queer, pansexual and asexual individuals need to be prioritised in such interventions. The successor strategy to *Sharing the Vision: A mental health policy for everybody* (Government of Ireland, 2020) should include specific actions addressing the lives and needs of LGBTQI+ people that are actionable, achievable, concrete, measurable and time-bound.

- The next iteration of *Connecting for Life, Ireland's National Strategy to Reduce Suicide* (Department of Health, 2015) and *Sharing the Vision: A mental health policy for everybody* (Government of Ireland, 2020) should include explicit and specific actions to address the lives and mental health needs of the LGBTQI+ community, in particular transgender people. These actions need to have clear KPIs and milestones and be measurable and time-bound.
- To ensure the quality of and access to mental healthcare for the LGBTQI+ community, significant investment is needed in accessible, safe, high-quality, regulated mental health services with improved access which include tailored and specific supports for LGBTQI+ people.

Building LGBTQI+ inclusive and affirmative health care

- The HSE must reduce barriers, including stigma, cost and waiting times, faced by LGBTQI+ people when accessing general health services by identifying specific actionable, achievable, concrete, measurable and time-bound strategies or interventions to overcome these challenges. An exploration of these barriers and their impact needs to be taken into account in the evaluation of all health services, including the evaluation of healthcare-related actions detailed under the *National LGBTI+ Inclusion Strategy 2019–2021*. In addition, specialised LGBTQI+ services need sustained investment paired with a commitment to broadening the availability of LGBTQI+ social services regionally.
- Through a community partnership approach, the HSE needs to develop, fund and implement a new model of gender-affirming care for young people and adults that complies with national and international human rights and medical standards of care and is based on the principles of self-determination and informed consent. This new model should be decentralised, free at the point of use, delivered locally, holistic, person-centred and responsive to emergent community needs through an integrated multidisciplinary network of outpatient services.
- Extensive waiting times and the inaccessibility of prescribed hormonal care has resulted in transgender, non-binary and gender non-conforming people self-medicating. Prior to the establishment of a functioning model of gender-affirming care, this situation must be addressed through interim actions delivered in primary care and take a harm-reduction approach.
- Crucially, the provisions of healthcare needs to be cognisant of the needs of individuals with intersex variations. Thus, the delivery of LGBTQI+ inclusive and affirmative healthcare needs to ensure that the rights of individuals with intersex variations are respected and upheld when receiving care.
- Professional associations and regulatory bodies with the responsibility for the approval of health education curricula should identify and include standards for LGBTQI+ awareness as a requirement for accreditation. In addition, health education institutions and their educators should conduct

a review of current curricula to ensure that they are not reinforcing heteronormative and cisgender biases.

- The HSE and other healthcare providers should build capacity amongst all healthcare and support staff through training and ongoing continuing professional development in the area of LGBTQI+ inclusive and affirmative approaches to the provision of care. The fostering of LGBTQI+ inclusive and affirmative healthcare through all healthcare and support staff training needs to be integrated using a whole service approach which addresses the inclusivity of LGBTQI+ people in relation to policy, governance, education, intervention programmes, participation, and partnership.

Strengthening LGBTQI+ people's rights

- Given the explicit challenges facing transgender individuals due to the misalignment in their legal documentation, the Department of Social Protection should implement the recommendations from the Review of the Gender Recognition Act 2015 and provide legal gender recognition for non-binary people and reform the legal gender recognition system for trans young people.
- The Department of Children, Equality, Disability, Integration and Youth should enhance the *Equal Status Acts 2000-2018* and the *Employment Equality Acts 1998-2015* to provide explicit protections for all LGBTQI+ people.
- The Department of Justice should work to enact new hate crime and hate speech legislation accompanied by a holistic action plan against hate crimes that includes a reformed Garda response and wrap-around supports for victims.
- In view of the findings in relation to attitudes to transgender people using public toilets that aligned with their gender, the Department of Health and the Office of Public Works should undertake to ensure that public toilets are universally accessible.

Creating a supportive school culture for LGBTQI+ people

- The Department of Education should work with Belong To – LGBTQ+ Youth Ireland to arrange for the *LGBTQ+ Quality Mark* to be available and promoted to schools nationally, including the allocation of funding to support this roll-out.
- The Department of Education should continue to prioritise the timely implementation of *Cineáltas: Action Plan on Bullying Implementation Plan 2023-2027*, with a focus on initial teacher education and continuous professional development for new and existing post-primary school staff.

Support LGBTQI+ people to live in safe communities

- The successor strategy to the LGBTI+ *National Inclusion Strategy* and LGBTI+ *National Youth Strategy* should be grounded in a whole-life approach and have actionable, achievable, concrete, measurable and time-bound

actions to support LGBTQI+ people. Actions within the strategy should have clear key performance indicators and milestones that are mapped to delivery timelines, and the responsibility and collaborative work of each action needs to be explicit with the provision of funding where necessary.

- To strengthen the LGBTQI+ community as a source of protection, the Department of Rural and Community Development and the Department of Children, Equality, Disability, Integration and Youth should fund and support regional LGBTQI+ resource centres, community groups, organisations and social spaces to provide access to LGBTQI+ youth work services, supports for parents and family members, the provision of alcohol-free spaces and facilities for LGBTQI+ people.
- The survey of attitudes of the general public showed that the knowledge base of the general public around LGBTQI+ identities include many uncertainties. Moreover, as a result, the population is vulnerable to misinformation aimed at discrediting the LGBTQI+ community, in particular transgender, intersex and non-binary groups. While progress has been made since 2014 in terms of inclusivity and reduction in prejudice, to sustain this progress well targeted educational initiatives based on evidence-based research are needed. Therefore through a community partnership approach the Department of Children, Equality, Disability, Integration and Youth should implement specific actionable, achievable, concrete, measurable and time-bound interventions to increase the knowledge and understanding of LGBTQI+ lives among the general public with targeted consideration regarding transgender, non-binary, intersex and bisexual experiences and needs.
- Coimisúin na Meán (commission for regulating broadcasters and online media). and the Department of Children, Equality, Disability, Integration and Youth should take actions to enhance public awareness of LGBTQI+ related equality issues, including the safety challenges and discrimination experienced by LGBTQI+ people in-person and online. These actions should be complemented by actions set out and led by the Department of Education for educational environments.
- The Department of Justice should implement a campaign informing the general public that LGBTQI+ people have the right to apply for international protection on the basis of being persecuted for their gender identity or sexual orientation in their country of origin.
- The Department of Tourism, Culture, Arts, Gaeltacht, Sport and Media, in partnership with Coimisiún na Meán, should provide training and facilitate consciousness-raising among the media professionals regarding the lives and needs of the LGBTQI+ community and encourage LGBTQI+ visibility within public service broadcasting requirements and make funding available for LGBTQI+ programming.

- LGBTQI+ organisations, through an integrated whole-organisation approach, should review policies, practices, strategies, systems, infrastructure and processes to ensure that their advocacy work and services meet the needs of all LGBTQI+ individuals, and that they provide inclusive and culturally safe environments, services and supports for all.

Advancing the evidence base and evaluating progress

- The *Being LGBTQI+ in Ireland* study should be repeated in five years to assess progress, in the areas of mental health, school experiences, gender-affirming health care, and the impact of social media and public attitudes, especially towards transgender, intersex, and gender non-conforming people, as well as people with emerging sexual identities. Initiatives and interventions arising from this report and the sub-reports should be evaluated to assess their impact.
- In Ireland, sexual orientation, gender identity and intersex status are routinely omitted from key population-level data collection approaches. As such, in order to paint a more complete picture of gaps in policy and service provision, as well as demonstrate the benefits of investing in supports and services:
 - The Central Statistics Office (CSO) in conjunction with the Department of Children, Education, Disability, Integration and Youth should work to capture the size, composition and diversity of LGBTQI+ communities in Ireland.
 - Government-funded organisations and services should develop and implement standardised data collection protocols that include questions on sexual orientation, gender identity and intersex status beyond the binary approach, ensuring privacy and confidentiality, across all relevant data systems and stakeholders, including HSE and other healthcare providers, Tusla and social services, educational institutions, homelessness services, Approved Housing Bodies and other government agencies.
- Given the dearth of research on emerging sexual identities, specifically, pansexual and asexual individuals, there is a need to expand understanding of the risks and protective factors which impact the mental health of these and other emerging groups in future research endeavours, particularly research undertaken by the Health Service Executive and the Health Research Board.
- Currently, comparisons between LGBTQI+ groups and the population in general are limited by the fact that such research is rarely conducted in Ireland. Funding needs to be made available to conduct such research.
- Given the dearth of information on people with intersex variations, in particular, the HSE should undertake or commission a review of the needs of the intersex community. Specific attention needs to be given to mental

health, reproductive and gynaecological care, bone health, cancer care and gender-affirming healthcare.

- In line with emerging discourses on the importance of participatory methodologies, all future research conducted by government departments, third-level institutions and research bodies should be co-designed with LGBTQI+ communities, with a greater focus on intersectionality issues and inclusion of all minority communities. This research needs to be appropriately funded to ensure that methodologies are not only participatory, but also accessible to people irrespective of disability, socio-economic status and rurality.

Prioritise LGBTQI+ experience and expertise

- Actions, strategies, policies, and interventions to improve the lives and meet the needs of the LGBTQI+ community need to be developed and implemented through a community partnership approach. This approach needs to be grounded in consultation, inclusion and participation, facilitating decision-making at all levels in order to form a meaningful foundation for collective approaches to local and national issues of importance to the LGBTQI+ community.

Appendix 1:

Participant Information Leaflet

Name of Study: *Being LGBTQI+ in Ireland:* The national study of the mental health and wellbeing of lesbian, gay, bisexual, trans, queer and intersex people in Ireland.

Principal Investigator: Professor Agnes Higgins (PI), School of Nursing and Midwifery, Trinity College Dublin.

Research team: Dr. Jan de Vries, Dr. Louise Doyle, Dr. Mark Monahan, Ms. Thelma Begley, Dr. Brian Keogh, Dr. Karin O'Sullivan, Ms. Renee Molloy, Ms. Carmel Downes, Trinity College Dublin.

Thank you for taking time to read this. You are being invited to participate in a survey for a research study. One of the aims of this study is to examine the mental health of Lesbian, Gay, Bisexual and Transgender, Queer and Intersex (LGBTQI+) people in Ireland by collecting information in a survey. We are contacting as many LGBTQI+ people across the Republic of Ireland as possible in the hopes of gathering as much information as possible.

Before you decide whether to participate, you need to understand why the research is being done and what it will involve. Please take the time to read the following information carefully. If there is anything that is not clear, or you would like more information about the study, please contact Prof Agnes Higgins via phone at XXX or email at ahiggins@tcd.ie/BeingLGBTQI@tcd.ie.

Part 1 – The Study

Why is this study being done?

It is five years since we conducted the first national survey on the mental health and wellbeing of lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI+) people in Ireland. This study will repeat this survey to assess changes that have happened in the last 5 years as well as ask new questions which we hope will inform policy, service provision, and legislation going forward.

Why have I been invited to take part?

You have been invited to take part as you clicked on a link on a website or email that directed you here. Your participation in this study is entirely voluntary so you do not have to participate if you do not wish. Once you submit your response, because the survey is anonymous, we will not be able to identify your response and remove it.

How will the study be carried out?

This study will use an online anonymous survey to ask you questions about your mental health and experiences as a LGBTQI+ person. The survey will take about 30-40 minutes to complete, depending on how much time you give to writing on the free text questions.

What will happen to the results of this study?

After completing the study, the researchers may decide to present the findings to forums such as practitioners and LGBTQI+ groups, or publish in peer-reviewed journals. The results will also be published as a report and key findings document.

Are there any benefits to taking part in this research?

There are no direct benefits to you from participating in this study. We hope that information gained from you will help to inform policy, service provision, and legislation going forward.

Are there any risks to me or others if I take part?

The survey contains sensitive questions about your experiences of mental health, including questions about depression, anxiety, stress, eating disorders, self-harm, suicidal thoughts and suicide attempts. These questions have the potential to provoke difficult emotions and memories. To minimise this potential, the survey will include warnings on the focus of the questions so as to provide you with an opportunity to skip sections that you may find upsetting. We also put a list of support services on our study website [<http://www.beinglgbtqi.ie>] so that you can seek out support should you need it.

Part 2 - Confidentiality

Your survey response is completely anonymous, and will be combined with everyone else's, so there is no way anyone will know how you responded. We also ask that you do not write your name or anything that might identify you in any of the free text questions asked within the survey.

What are my rights?

- Your participation in this study is entirely voluntary. If you decide not to take part, your decision will not have any adverse consequences.
- You have a right to have all of your questions answered before deciding whether to take part in the study.

Part 3 – Costs, Funding and Approval

Has this study been approved by a research ethics committee?

This study has received ethical approval from the Faculty of Health Sciences Research Ethics Committee, Trinity College Dublin on 11-07-2022. Reports on this project will be submitted to the Research Ethics Committee on an annual basis until the project is completed.

Who is organising and funding this study?

This study is being conducted by Professor Agnes Higgins with a research team. The study is funded by the National Office for Suicide Prevention (NOSP) & Social Inclusion, Health Service Executive (HSE) and the What Works and Dormant Accounts Fund, Department of Children, Equality, Disability, Integration and Youth through Belong To.

Is there any payment for taking part?

No, you will not receive payment for taking part in this study.

Part 4 – Further Information

Who should I contact for information or complaints?

If you have any concerns or questions, you can contact:

- 1. Principal Investigator: Prof Agnes Higgins, School of Nursing and Midwifery, TCD, 24 D'Olier St., Dublin 2. Email: ahiggins@tcd.ie
- 2. Data Protection Officer, Secretary's Office, Trinity College Dublin, Dublin 2, Ireland. Email: dataprotection@tcd.ie. Website: www.tcd.ie/privacy.

Will I be contacted again?

You will not be contacted directly by the research team at any point during this research study or after it.

Appendix 2: Telephone survey demographic profile of LGBTIreland participants

Gender identity		Work status		Dependent children	
Male	49%	Working full time (30 hours or more)	43%	Any	45%
Female	51%	Working part time	15%	None	51%
		Unemployed	11%	Refused	4%
		Home maker, housekeeper	7%		
		Full time student	4%		
		Retired	16%		
		Refused	4%		
Age		Marital status			
18-24	11%				
25-34	21%	Married/civil partnership	48%		
35-44	21%	Living as married/co-habiting	9%		
45-54	17%	Single	28%		
55-64	14%	Widowed/divorced/seperated	12%		
65+	16%	Refused	4%		
Social class		When finished education			
AB	14%	Some primary education or less	1%	Note: #% = <0.5%	
C1	28%	Completed primary education	4%		
C2	21%	Completed lower secondary level	16%		
DE	31%	Completed upper secondary level	32%		
F	6%	Completed third level education	45%		
		Refused	2%		
Region					
Dublin	28%				
Leinster	26%				
Munster	28%				
Connacht/ Ulster	18%				

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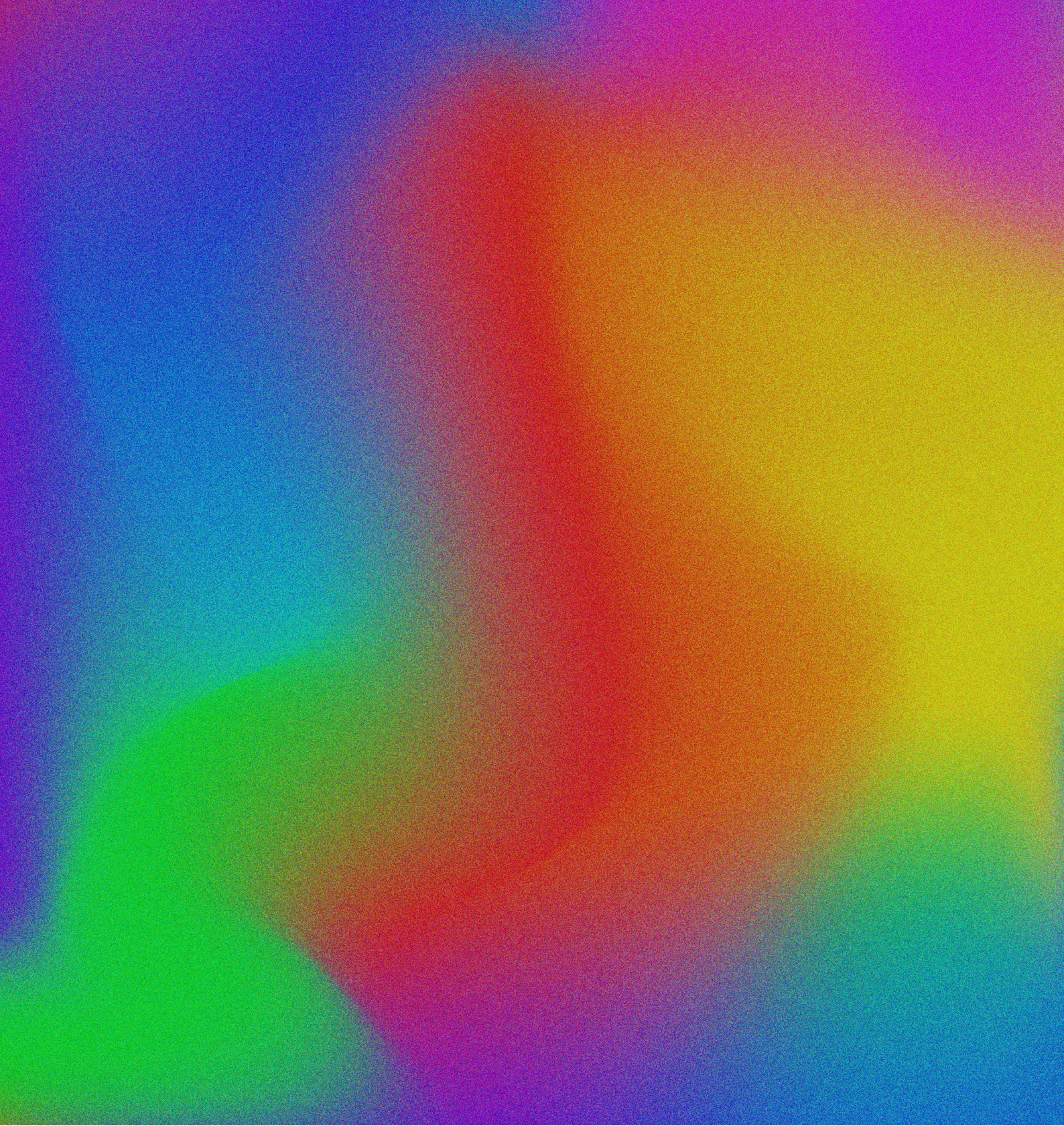
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