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Belong To LGBTQ+
Youth Ireland

Mental Health in the Irish LGBTQI+ Population with Disabilities

Findings from the Being LGBTQI+ in Ireland Study

January 2025

An Roinn Leanaí, Comhionannais,
Míchumais, Lánpháirtíochta agus Óige
Department of Children, Equality,
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Being
LGBTQI+
in Ireland

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Note

Throughout this report, particular terms have been adopted for ease of understanding and to reflect the language/terms used within research being cited. However, there are many phrases and terms used interchangeably within the literature.

For further information on disability-related language and terminology, please refer to the NDA's Advice Paper on Disability Language and Terminology.

Available here: https://nda.ie/publications/nda-advice-paper-on-disability-language-and-terminology

Glossary

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

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

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.

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

Disability is defined in different ways depending on the context, with some definitions rooted in the medical model of disability and others rooted in the social model of disability. It is the latter model upon which the following definition arises from the UN Convention on the Rights of Persons with Disabilities (UNCRPD) which defines '**persons with disabilities'** as "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others."

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.

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'.

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

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.

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

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+.

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'.

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

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.

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.

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.

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.

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.

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.

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 men, women or both sexes. It includes a wide range of attractions and terms, the most common being gay, lesbian, bisexual and heterosexual.

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.

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.

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.

Executive Summary

This report addresses the relationship between self-reported disabilities and mental distress within the LGBTQI+ population in Ireland. It draws on data from the 2022 national online survey '*Being LGBTQI+ in Ireland*' (n= 2,806) which comprehensively focuses on well-being and mental health in these communities. The overall findings of this study are reported elsewhere (Higgins et al., 2024). This specific report concentrates exclusively on disabilities within the LGBTQI+ communities. Its objectives are: (1) to outline the prevalence of disabilities within the LGBTQI+ communities; (2) to examine the relationship between reported disabilities and mental distress indicators in these groups, and; (3) to present some of the commentary people made in the survey related to disabilities and LGBTQI+ identities.

The study made use of questions on disability from the Census of the Population of Ireland (CSO, 2022) to determine the prevalence of seven disabilities: impairments to vision, hearing or basic physical activities, intellectual disability, difficulties learning/remembering or concentrating, mental health issues, and chronic illness/pain. Three response categories were provided: 'no', 'yes, to some extent' and 'yes, to a great extent'. In addition, eight validated measures were used as indicators of mental distress: self-harm, suicidal ideation, suicide attempts, depression, anxiety, stress, low self-esteem, and alcohol use. A large segment of participants (n=2,596) responded to these questions. The statistical association of the mental health outcomes with the reported disabilities was established to determine the relationship between disabilities and mental distress among the LGBTQI+ population. Experiences of disability were further explored based on participants' comments to several open-ended survey questions. While these questions were not focused on disabilities, participants with disabilities used them to comment on their experiences.

The results showed that the *prevalence of disabilities is high* within this cohort, with nearly 70% (n=1,810) reporting that they had at least one disability either to some or to a great extent. Over half (53%, n=1,373) reported an emotional/psychological/mental health issue to any extent, which was the most prevalent type of disability reported. This was followed by a difficulty with learning/remembering or concentrating to any extent, with just over a third of the sample (34%, n=881) reporting this type of disability. In response to all of the seven disabilities included in the census question, the LGBTQI+ population had higher prevalence rates compared to those reported in the general population of Ireland from the 2022 Census. The

prevalence of a psychological or mental health difficulty was ten times higher while a difficulty with learning, remembering or concentrating was seven times greater. Of LGBTQI+ participants who reported a disability, higher levels of disability were reported by younger, single, gender non-conforming, non- gay/lesbian participants while lower levels of disability were reported among those who were White Irish, had the highest level of education, and were in paid employment.

The results also showed a higher prevalence of mental health distress, including suicidal thoughts, self-harm, suicide attempts, symptoms of severe or extremely severe depression, anxiety and stress, and low self-esteem, among those with a disability compared to those without a disability on all of the seven disabilities. However, when sociodemographic factors (gender identity, sexual orientation, age group, ethnicity, level of education and employment status) were taken into account in conjunction with the disabilities (emotional/psychological/mental health difficulty excluded from analysis), there were no significant differences in mental health outcomes based on whether or not one had a blindness or visual impairment, deafness or hearing impairment or difficulties with basic physical activities. Having a learning/remembering/concentration difficulty and a pain/breathing/chronic illness difficulty were both independently associated with increased risk of the mental health issues measured, with the exception of alcohol problems. Having an intellectual disability to a great extent was associated with increased risk of symptoms of severe or extremely severe depression. A pattern of increasing number of disabilities being associated with increasing risk of poor mental health-related outcomes, with the exception of problematic alcohol use, was observed, also highlighting the adverse cumulative effect of disabilities.

The responses to various open-ended questions provided added insights into how disabilities are perceived to affect LGBTQI+ people. *Disabilities were described as an obstacle to belonging to support groups and communities*, resulting in isolation, invisibility, and lack of recognition. Specifically, the inaccessibility of queer spaces and the lack of inclusivity/accessibility around queer events for people with a disability was highlighted. Difficulties around dating and forming relationships due to the nature of one’s disability were also mentioned. Moreover, participants reported *discrimination* experienced within familial and romantic relationships, in work, education and healthcare as a result of their difficulties.

Overall, the findings were in line with what emerged in the limited international research which suggest that in comparison to general population data, the prevalence of disabilities are higher among sexual and gender minorities.

In interpreting the findings several *limitations* need to be considered. While the large number of participants is a strength of the study, it cannot be ascertained whether the sample is representative of the population. There are indications that younger participants and those with a transgender identity are overrepresented. In addition, given that the data in this study were collected through an online survey, there is a risk that people with severe disabilities (i.e. visual, intellectual and memory) would have been unable to participate.

Considering these limitations, the following *recommendations* are provided with caution.

Recommendations for policy

While people with disabilities and LGBTQI+ people are mentioned separately as priority groups within health and social care policies, LGBTQI+ people with disability are rarely explicitly referenced. Therefore, it is recommended that:

- LGBTQI+ people with disability be given greater visibility and should be explicitly referenced in future health and wellbeing policies and regulatory standards, including mental health and disability policies.
- In line with principles of coproduction, every opportunity should be taken to ensure that the voices of LGBTQI+ people with disability are represented at the policy table.
- Funding needs to be increased to LGBTQI+ services to develop specific supports and resources for LGBTQI+ people with disability that are co-designed with LGBTQI+ people with disability.

Recommendations for Research

Having accurate data on the prevalence of disability among sexual and gender minorities is important if policy makers and service providers are to meet people's needs equitably and effectively. Therefore, it is recommended that:

- Data on people's sexual, gender and disability status should be collected in all future disability studies. This needs to include people with an intersex variation. In designing the questions consideration should be given to the various terms people use to describe sexual orientation and gender identity and include options to capture those who are questioning or are unsure of their sexual attraction/identity or do not experience sexual attraction.

- Given the significant gap in research on LGBTQI+ people with disability in Ireland, additional research, both quantitative and qualitative, is needed to deepen our knowledge of their experiences.
- In light of the findings from this and other studies indicating that in the prevalence of disabilities is higher in comparison to general population data among sexual and gender minorities and in the absence of an explanation or reason there is a need for further research to explore why this may be the case.
- In line with emerging discourses on the importance of participatory methodologies future research needs to be co-designed with LGBTQI+ communities, with a greater focus on minority communities not represented in this study. This research needs to be appropriately funded to ensure that methodologies are not only participatory but accessible to people with all forms and degrees of disability.

Recommendations for service provision

People with a disability may have specific needs based on their personal circumstances and intersecting identities, which has implications for access to and provision of health and social care services. Therefore, it is recommended that:

- Health, social care and disability services review policies, strategies, systems, infrastructure and processes to ensure they are providing inclusive and culturally safe environments for LGBTQI+ people with disability.
- Professionals working in health, social care and disability organisations need to be educated on LGBTQI+ issues that address the intersection of disability, gender, and sexual orientation and is co-designed with LGBTQI+ people with disability.

Recommendations for the LGBTQI+ community

There is a need for the LGBTQI+ community and support organisations to better understand and represent the needs of people with a disability and LGBTQI+ identity. Therefore, it is recommended that:

- Education is provided to staff within LGBTQI+ organisations that addresses the intersection of disability, gender, and sexual orientation.

LGBTQI+ organisations review policies, strategies, systems, infrastructure and processes to ensure they are representing the voice of LGBTQI+ people with disability, advocating for their needs and providing inclusive and culturally safe environments, services and supports.

Chapter 1 : Introduction and background to report

Report in context of the study objectives

The most recent demographic statistics available on people living with a disability in Ireland indicate that over a million people (n=1,109,557) or 22% of the population experience at least one long-lasting condition or difficulty to any extent. Of these, 407,342 (8% of the population) reported experiencing such a condition to a great extent or a lot and 702,215 (14% of the population) reported a long-lasting condition or difficulty to some extent or a little (Central Statistics Office, 2022).

There are no official figures on the prevalence of disabilities within the LGBTQI+[1] population in Ireland (Oireachtas, 2019), but based on estimates in comparable countries, a range of 1.2 to 3.8% of the population (45,000-142,700) has been suggested. Based on this estimated range and the Census data of disabilities in the general population (22%), between 9,900 and 31,394 people within the LGBTQI+ communities would have at least one long-term disability. Considering the increase in current estimates of the LGBTQI+ population globally (Boyon, 2021) and also in Ireland (Ceatha et al., 2023), this number may be significantly higher.

The reason for the lack of precise information on disabilities among the LGBTQI+ communities is that questions on disability are often not included in LGBTQI+ focused research (Argenyi et al., 2023). Likewise, disability research does not take into consideration sexual and gender minority identities of people with a disability. This narrow lens limits space for consideration of the potential interaction and interplay between these combined identities. The motivation for this report is to address this gap in the RoI and focus on the combined impact of a disability and being part of the LGBTQI+ minority on people’s mental health. The intersectional approach taken as part of this study will provide a more precise perspective on this combined impact (Crenshaw, 2017; Murphy and Higgins, 2022). The theoretical mechanisms at the basis of this are encapsulated in ‘minority stress theory’ and ‘Intersectionality theory’ (see below).

In short, the core focus of this report is on this intersection of disability and gender identity/sexual orientation and its impact on mental health. Drawing on data from *the Being LGBTQI+ in Ireland* study, the three main objectives are:

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

1. To present an overview of the prevalence of disabilities within the LGBTQI+ communities,
2. To examine the relationship between reported disabilities and mental distress indicators for LGBTQI+ people, and
3. To present commentary people made in the survey related to disabilities and LGBTQI+ identities.

Theoretical background: Minority stress and Intersectionality

Meyer's **minority stress** model (Meyer and Frost, 2013) is an explanatory framework which postulates that people in sexual and gender minorities experience disparities in negative mental health outcomes due to excessive social stresses resulting from stigmatisation and prejudice (Frost and Meyer, 2023). These distal or external stressors are additive to the general stress of everyday life and include direct acts of discrimination, verbal and physical harassment and may occur in public, within schools, work, and health care. In addition to overt acts and expressions, distal stressors include more subtle acts such as microaggressions and non-affirmation of identity (Murphy and Higgins, 2022). Furthermore, proximal or internal stressors experienced by minorities include internalisation of negative societal attitudes and beliefs, which can lead to identity concealment and anticipation of rejection, also called anticipatory discrimination (Meyer and Frost, 2013, Frost and Meyer, 2023). It is worth noting the similarities in terms of the discrimination and stigma faced by both LGBTQ+ people and people with disabilities.

The concept of **Intersectionality** (Crenshaw, 2017) was introduced to provide a framework to understand how privilege and discrimination in society are based on multiple factors of social identity which generate advantage or disadvantage. This principle is of particular relevance to the study of disability within gender and sexual minorities. Belonging to more than one stigmatised minority group is bound to increase the risk of discrimination and harassment and hence the impact of minority stress. This suggests added pressure on mental health for intersecting minority groups based on disability, but also race, ethnicity, etc. within the wider LGBTQI+ communities.

Overall prevalence of disability within the LGBTQI+ communities

The majority of studies that explore disability within the LGBTQI+[2] communities use census data or data collected from national or regional surveys and reports, mainly in the USA (Argenyi et al., 2023; Surfus 2023; Cochran et al., 2017; Fredriksen-Goldsen et al., 2012), Australia (Bollier et al., 2020; Hill et al., 2022) and the UK (Browne and Lime, 2008; Booker et al., 2017). Thus, while the number of available studies is low, some of those that are available have large sample sizes and are often nationally representative. What is problematic however, is the use of differing definitions and classifications of disabilities, as well as differences in the demographic profile of those included within studies (sexual orientation, gender, age), which makes cross-study comparisons difficult. (See table 1.1 for a description of the disabilities include in the prevalence studies cited)

The findings from the literature suggest that the prevalence of disabilities within the LGBTQI+ communities is high. More specifically, findings from a recent study in the USA, using data from the United States Census Bureau, indicate that disabilities, including sensory disabilities, remembering disabilities (which may include mental health conditions that affect memory) and mobility disabilities, were 156% more prevalent in the LGBT community than in the general population (Surfus, 2023). The prevalence of disabilities in the non-LGBT population was 13%, compared to 21% in the LGBT community.[3] This prevalence of disability is slightly lower than the 18.3% reported in a secondary analysis of a cross sectional survey of LGBTQ youth (n=9,418) aged 13-17 in the US (Argenyi et al., 2023) and much lower than the 39% reported by Hill et al., (2022) following their secondary analysis of two national surveys, *Private Lives 3*[4] and *Writing Themselves In 4*,[5] of LGBTQA+ young people and adults in Australia (Hill et al., 2022). While both studies included physical, mental health and intellectual disabilities within their definition (Argenyi et al., 2023; Hill et al., 2022), Hill et al. (2022) also included sensory disabilities, neurodiversity, acquired brain injury and unnamed disabilities, which may account for the differing prevalence rate. In addition to having a higher prevalence of disabilities than heterosexual adults, Fredriksen-Goldsen et al. (2012) suggest that sexual minorities (LGB) are also more likely to have disabilities from a younger age. Using data from the Washington State

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[2] In some parts of this report the terms used change from LGBTQI+ to terms such as LGB, LGBT, LGBTQ or LGBTQA+. This change is to reflect the terms used within the papers being cited.

[3] Queer, intersex and questioning identities were not included in the census survey.

[4] *Private Lives 3* involved adults aged 18+.

[5] *Writing Themselves In 4* involved young people aged 14-21 years.

Behavioral Risk Factor Surveillance System (n=82,531), they reported that lesbian, gay and bisexual adults were more likely to have a disability when aged 18-30 in comparison to their heterosexual counterparts.

Disability prevalence also varies within sexual and gender minority groups. People who identify as transgender tend to have the highest rates of disability, ranging from 53% in young adults aged 13-17 years to 38% in the adult population (Surfus, 2023), and rising to 62% in people 50 years and over (Fredriksen-Goldsen et al., 2014). Following transgender people, the sexual minority with the second highest rate of disabilities appears to be bisexual men, 40% of whom report having a disability, followed by bisexual women with a reported rate of 36% (Fredriksen-Goldsen et al., 2012). In Argenyi et al.'s (2023) Australian study 31% of bisexual youth (aged 13-17) reported having a disability, which is much higher than the 15% reported among bisexual adults in the United Kingdom (Booker et al., 2017) and the 4% of bisexual men aged 18-55 reported by Bollier et al. (2020) in their Australian study.

In terms of people who identify as lesbian or gay, Booker et al. (2017) reported that 14% of LG adults had one or more disability, whereas Argenyi et al. (2023) reported that 28% of LG youth (aged 13-17) had a disability, with Bollier et al. (2020) reporting 3% of gay men having a disability. As previously stated, the difference may be due to differences in age profiles as well as differences in the classification and definition of disability.

Prevalence of sensory disability among LGBTQI+ people

While there is limited research on the prevalence of sensory disabilities in sexual minorities, analysis of US census data indicates that 4% of LGBT people have a visual disability compared to 2% of heterosexual people (Surfus, 2023). Rates of reported hearing disabilities vary within the literature, with Surfus (2023) reporting that LGBT and heterosexual people have the same rate of hearing disabilities at 2% (Surfus, 2023), whereas a higher rate of 4% was found in a much smaller study of a sample of LGBT people (n=819) in the UK (Browne and Lime, 2008). The highest rate of either a hearing or visual disability was found among young LGBTQA+ people aged 14-21 in Australia, 17% of whom reported having a sensory disability (Hill et al., 2022).

Prevalence of physical disability among LGBTQI+ people

Using data from the 2013–2014 National Health Interview Survey, Cochran et al. (2017) reported a 42% prevalence of physical disabilities and/or functional limitations among LGB adults, in comparison to 36% among heterosexual adults, with the largest difference found between sexual minority women (43%) and heterosexual women (36%) (Cochran et al., 2017). A lower prevalence of 15% for long term health impairment or physical disability was reported among 819 LGBT people in the UK (Browne and Lime, 2008), with 25.9% of LGBTQ+ youth aged 13-17 years reporting a physical disability in Argenyi et al.'s (2023) study.

Within group analysis of over 40,000 participants involved in the UK Household Longitudinal Study indicates slightly higher rates of 'limiting long standing illness' among bisexual men and women (25%), compared to gay and lesbian participants (22%) and heterosexual participants (21%) (Booker et al., 2017). Surfus (2023), using data from the US Census Bureau, reported a 4.5% prevalence of mobility disability among LGBT adults while the transgender population had more than double this (11%) (Surfus, 2023). Among LGBTQ+ youth aged 13-17 years in the US, rates of physical disability were 53% for transgender people, 31.8% for bisexual people, 29.4% for gay/lesbian people, 16.4% for pansexual, 7.2% for asexual, 6.7% for queer people, and 2.9% for questioning people (Argenyi et al., 2023).

Intellectual and cognitive disability among LGBTQI+ people

Prior to 2022 no studies were found on the prevalence of intellectual and cognitive disability among sexual and gender minorities (Smith et al., 2022). Since Smiths review three studies have explored the broader category of cognitive disabilities which can include intellectual disabilities (Surfus, 2023; Argenyi et al., 2023; Hill et al., 2022). In LGBT adults in the US, 4.5% reported a cognitive disability, while 19.5 % of transgender adults report a cognitive disability (Surfus, 2023). Among LGBTQ people aged 13-17 in Argenyi et al.'s (2023) study 32.4% reported a cognitive disability,[6] with the highest rates found in transgender youths (56%, compared to 44% for cisgender), followed by bisexual (31.6%), and gay/lesbian youths (29.8%). Lower rates of cognitive disability were found among people who identified as pansexual (17.4%), asexual (9.2%), queer (3.9%) and questioning youths (2.9%) (Argenyi et al., 2023). In Hill et al.'s (2022) study 34.6% (n=866) of participants reported neurodiversity/autism, while 13.9% (n=347) reported an intellectual disability, and 0.4% (n=10) an acquired brain injury.

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[6] Participants were asked 'which of the following bests describes the disability you have? Physical, developmental or learning, psychiatric/mental health, or another type please describe. Written in responses were recategorized and attention deficient/hyperactive disorder (ADHD), autism spectrum, and learning disorders were coded as cognitive disabilities.

Mental health and LGBTQI+ people

The general mental health literature increasingly points to the fact that people with physical, sensory and intellectual disabilities are at increased risk of psychological distress and mental health problems (Sareen et al., 2007; Buckley et al., 2020; Cree et al., 2020) in comparison to the general population. High rates of mental health and psychosocial issues, including depression, anxiety, self-harm, suicidal behaviours, posttraumatic stress disorder, eating disorders and substance use disorders are recorded in studies involving sexual and gender minority groups (Mongellii et al., 2019; King et al., 2008; Higgins et al., 2016).

In many studies on disabilities, mental health difficulties are included as a specific form of disability. If framed as such, it is generally identified as the most prevalent type of disability among people who identify as a sexual minority with prevalence rates ranging from 78% in those aged 13-17 (Argenyi et al., 2023) to 88% in those aged 14-21 (Hill et al., 2022). Mental distress is frequently higher in LGB people than heterosexuals (Cochran et al., 2017; Fredriksen-Goldsen et al., 2012; Booker et al., 2017), with the highest levels seen in bisexual people (Fredriksen-Goldsen et al., 2012; Booker et al., 2017).

Table 1.1: Disabilities included in the prevalence studies cited

Study	Participants included	Disability included	Question asked (rating scale)
Argenyi et al., 2023	LGBTQ aged 13-17 from the LGBTQ National Teen Survey (USA)	Physical, developmental/ learning, psychiatric/mental health	Participants were asked 'which of the following bests describes the disability you have? Physical, developmental or learning, psychiatric/mental health, or another type please describe.' Written in responses were recategorized and attention deficient/hyperactive disorder (ADHD), autism spectrum, and learning disorders were coded as cognitive disabilities
Bollier et al., 2020	Gay and bisexual men, aged 18-55 from the first wave of the Australian Ten to Men study, a national survey on male health.	Unnamed disability	Respondents were not asked directly if they had a disability; rather, they were asked if they had difficulty in six core activity domains: Seeing, even if wearing glasses; Hearing, even if using a hearing aid; Walking or climbing steps; Remembering or concentrating; Self-care such as washing all over or dressing; and Understanding or being understood while using your usual (customary) language.

Study	Participants included	Disability included	Question asked (rating scale)
Booker et al., 2017	LGB (other) aged 18+ from the UK Longitudinal Household Study	Physical (non-limiting long-standing illness (NLLSI) and limiting long-standing illness (LLSI)), psychological distress	Disability status was determined by two questions. The first asked about disability and the second about specific types of disability. Three categories were calculated to indicate illness status: No illness, non-limiting long-standing illness (NLLSI) and limiting long-standing illness (LLSI). The General Health Questionnaire (GHQ-12) was used to measure psychological distress.
Browne and Lime, 2008	LGBT aged under 26 and 26-55+ from the Count Me In survey (United Kingdom)	Physical (long-term health impairment), hearing disability	Questions asked: are you or do you identify as having a long-term health impairment or a physical disability? Are you or do you identify as being deaf, hard of hearing, deafened or deaf-blind?
Cochran et al., 2017	LBG (other) aged 18+ from the 2013–2014 National Health Interview Survey in USA	Physical (functional limitations), mental distress	Questions asked: Do you experience difficulties, due to a health problem, in performing 12 activities. Activities were drawn from two domains: 1) mobility deficits and 2) participating in common life activities. The K-6 Distress Scale was used to measure mental distress (Kessler et al., 2002).
Fredriksen-Goldsen et al., 2012	LGB aged 18+ from the Washington State Behavioral Risk Factor Surveillance System in USA	Physical, mental distress	Disability was measured by asking respondents if they were limited in any way in any activities because of physical, mental, or emotional problems. Second, they were asked if they had any health problem that required them to use special equipment, such as a cane, a wheelchair, a special bed, or a special telephone. They were asked if they had ever been told by a health professional that they had asthma or arthritis, measured by whether respondents had ever been told by a health professional that they had some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia. Mental distress was measured by asking participants: For how many days during the past 30 days was your mental health, including stress, depression, and problems with emotion, not good?

Study	Participants included	Disability included	Question asked (rating scale)
Hill et al., 2022	LGBTQA+ People with wisabilities report data from 2 national surveys: *Private Lives 3* involved adults aged 18+ *Writing Themselves In 4* involved young people aged 14-21 years in Australia	Physical, neurodiversity/autism, acquired brain injury, sensory, intellectual, psychiatric/mental health, unnamed disabilities	In *Private Lives 3*, disabilities were categorised according to the classifications provided by the Australian Institute of Health and Welfare's *Standardised Disability Flag Module*. The Disability Flag consists of eight questions concerning activity participation and need for assistance on a 4-point scale, ranging from 'have no difficulty' to 'always/sometimes need help or supervision'. In *Writing Themselves in 4*, disability was categorised by asking participants: Do you identify as having a disability, experiencing neurodiversity/autism, or having a long-term physical or mental health condition? Long-term health conditions could include things like epilepsy, mental health conditions, speech or sensory impairments. A disability could include things like the loss of – or difficulty using – a body part, or difficulty managing everyday activities.
Surfus, 2023	LGBT aged 18+ from United States Census Bureau	Hearing, seeing, remembering/cognitive, mobility	Disability data in relation to seeing, hearing, remembering, and mobility from the Census Household Pulse Survey was used.

Experiences of LGBTQI+ people with disability

Problematic for people with disabilities is that they still live within an ableist world and consequently continue to experience discrimination in the workplace, especially when looking for work. They also experience challenges in accessing services: including health services and services such as financial institutions, shops, bars and restaurants. They are also more likely to report their experiences of discrimination as serious or very serious compared to people with no disability (Banks et al., 2018). People with disabilities in Ireland also report more social isolation, less participation in social activities and a lower level of satisfaction with life compared to people without disabilities (National Disability Authority, 2017). In a recent qualitative study on social engagement of disabled undergraduate students in higher education in Ireland, the authors reported that in order to engage in 'educationally beneficial' activities, students with a disability must expend disproportionate amounts of time and personal effort to overcome a range of systemic barriers (Rath, 2022).

People in LGBTQI+ communities and people with a disability broadly experience similar categories of distal stressors such as structural discrimination and harassment and proximal stressors such as internalised stigma, identity concealment, and expectations of rejection (Lund, 2021). In addition, people who identify as LGBTQI+ negotiate 'heteronormativity' and aversity to 'gender diversity'. The negative impact this has on the mental health of many people who identify as LGBTQI+ in the RoI has been documented (Higgins et al., 2016, 2024). It would appear that the issues arising from an ableist culture within the general population have similar implications for the mental health and wellbeing of people with a disability within the LGBTQI+ community (Einfeld et al., 2011; Tough et al., 2017).

While there are a range of qualitative studies exploring various aspects of the lives of LGBTQI+ people there is a scarcity of literature that specifically explores the lived experiences of LGBTQI+ people with disability. In a recent qualitative study involving 29 LGBTIQA+ people with a range of disabilities participants expressed fears and concerns about not having their identities understood or respected when engaging with services and described the stress of trying to ascertain whether it was safe to disclose their multiple identities (O'Shea, 2020). For many this meant constantly having to strategically decide what aspects of their identities to prioritise and share, which added another layer of distress and burden on the person. O'Shea's (2020) study also problematised the coming out process in that the need to repeatedly 'come out' in different support contexts was challenging and made expressing the full range of needs and experiences to services a difficult process for LGBTIQA+ people with a disability.

Studies that focus on LGBTQ+ people with a learning/intellectual disability demonstrate that they face particular challenges within disability services. Smith et al.'s (2021) systematic review on LGBT people's experiences of social inclusion/exclusion in the context of disability services highlights how ill-equipped support staff are in relation to responding to the needs of this population with many viewing the provision of support for sexual expression as outside of the scope of their role. They also noted how little guidance was provided to staff about sexuality or what was 'appropriate' to discuss regarding sex and sexuality.

Several studies also describe how people with disabilities experience mistreatment not only within health and disability services but also in the form of exclusion from both LGBTQI+ communities and disability communities as each failed to recognise LGBTQI+ people with disability (O'Shea, 2020; Smith et al., 2021; Dinwoodie et al., 2020). Dinwoodie et al. (2020) describe this in terms of partial support offered in

LGBTQ support services as well as intellectual disability services, in that services either cater for the person's disability or their LGBTQ identity. It is little wonder therefore, that LGBTQ+ people with a learning/intellectual disability express a need for all services, organisations and communities to be inclusive of their disability, sexual orientation and gender identity rather than supporting one or the other (Dinwoodie et al., 2020; Smith et al., 2021). In terms of disability services more generally, the need for an understanding of the complexity of people's disabilities was highlighted, and that a 'one size fits all approach' to inclusion did not really address the systemic issues that hamper access. Online communities were seen as particularly important for LGBTIQ+ people with disabilities, especially people who may not be able to connect in physical spaces (O'Shea, 2020).

For LGBTQI+ people with learning or intellectual disability the challenges they experience can be magnified. People with a learning /intellectual disability are either desexualised or have their sexuality problematized by others, because of a belief that they are incapable of knowing 'their own minds' (Dinwoodie et al., 2020, p7). Participants in Toft et al.'s (2019) study of young disabled LGBT+ people also described a 'process of infantilisation' due to a perception that people's LGBT+ identities was a phase that they would grow out of, accompanied by the perception that because they were disabled, they were incapable of understanding LGBT+ sexuality and gender.

Studies suggest that family carers and support staff find it challenging to balance their paternalism with the autonomy and rights of the person (Robinson et al., 2020) making the 'coming out' process to family, support workers and informal carers a challenge, either due to fears around stigma and discrimination or the absence of the necessary skill, with Dinwoodie et al. (2020) questioning the relevance of mainstream role models of 'coming out' to people with a learning/intellectual disability.

While LGBTQI+ people with learning /intellectual disabilities experience bullying and hostility within the wider community because of their disability and sexuality, they can also experience bullying and discrimination within the LGBTQI+ community because of their disability (Dinwoodie et al., 2020). Smith et al.'s (2021) systematic review highlighted how contact with other LGBTQ people in LGBTQ-specific groups for people with intellectual disability or simply meeting other LGBTQ people supported the creation of positive self-identity and reduced feelings of isolation. The need for an emphasis on disability inclusive LGBTQI+ communities and services is clear.

Attitudes towards people with a disability who identify as LGBTQI+ in Ireland

Surveys of public attitudes by the National Disability Authority (2001, 2006, 2011, 2017) have shown a positive trend in attitudes towards disabled people over time and a decrease in the perception that disabled people are treated fairly (NDA, 2017). A 2021 online survey of public attitudes towards disability in Ireland found that a significant proportion (approx. one third) disagreed that people with disabilities have equal rights in Ireland, around two fifths of people disagreed that those with disabilities (physical or intellectual) are supported adequately to make their own decisions while three quarters agreed that stronger laws are required in Ireland to safeguard people with disabilities from all forms of abuse (Safeguarding Ireland, 2021). More recently, an experimental study into public attitudes towards persons with disability conducted by the ESRI found that support for policies that favour disabled people is generally high in Ireland particularly so among those closer to someone with a disability (Timmons et al., 2023).

Public support for people with disability appears to be greater in comparison to other minority groups. Research carried out the University of Limerick found that people's willingness to intervene on behalf of a person subjected to a physical attack would be greater for persons with a disability compared to LGBT persons, and greater for LGBT persons compared to persons belonging to an ethnic minority group, indicating the existence of a hierarchy of victimhood (Haynes and Schweppe, 2019). Research has also shown a reduction in the extent of discrimination experienced by people with disabilities between 2004 to 2014 (Banks et al., 2018). More recently, a higher level of acceptance toward LGBTQI+ identities, can also be related to the referendum and subsequent legalisation of same sex marriage in Ireland in 2015 (Wilson, 2020). Studies on attitudes toward minority genders and sexuality in Ireland found a broad acceptance for LGBTQI+ people, with most support for identities that are seen as more normative and less support for identities seen as more transgressive of gender and sexuality norms, such as bisexual and trans people, with the least amount of support for non-binary and intersex people (Noone et al., 2022, Higgins et al., 2024). Notably, people who responded to the public attitudes survey in Higgins et al.'s (2024) research, reported less knowledge about, and interaction with people who identify as bisexual, transgender and intersex when compared to knowledge and interaction with lesbian and gay people, highlighting the need for greater effort by government and LGBTQI+ organisations to bridge these gaps.

Chapter 2 : Methodology

Objectives

The three objectives of this report are:

- To outline the prevalence of disabilities among the LGBTQI+ community;
- To ascertain the influence of disability status on mental health outcomes; and
- To provide commentary on peoples' experiences with disabilities.

Research Design and Participants

This report is based on data from *the Being LGBTQI+ in Ireland* study (n=2,806). The *Being LGBTQI+ in Ireland* study as a whole examines the mental health and well-being of the LGBTQI+ community in Ireland. It collected data using an anonymous online survey from individuals who identified as LGBTQI+, were 14 years of age or over and living in the Republic of Ireland. This study received ethical approval from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin. A more detailed methodology of this study is published in a full report (Higgins et al., 2024). Here only details relevant to the disability aspect are outlined.

Disability questions/measures

In the study, seven types of disabilities were measured using the same questions as used in the most recent census in the Republic of Ireland (CSO, 2022). The following disabilities were included (Table 2.1).

Table 2.1: Disabilities addressed in the Being LGBTQI+ in Ireland study

1)	Blindness or a vision impairment
2)	Deafness or a hearing impairment
3)	A difficulty with basic physical activities such as walking, climbing stairs, reaching, lifting or carrying
4)	An intellectual disability
5)	A difficulty with learning, remembering, or concentrating
6)	A psychological or emotional condition or a mental health issue
7)	A difficulty with pain, breathing or any chronic illness or condition

Participants were asked to indicate the presence of any of the above long-lasting conditions or difficulties and the extent of a difficulty by choosing from three response categories: ‘no’, ‘yes, to some extent’ or ‘yes, to a great extent’.

While no open questions were devoted specifically to disabilities in the survey, participants used the opportunity when completing open-ended questions on other topics to provide qualitative comments in which they related their perspectives on and experiences of living with disability.

Socio-demographic questions

Participants were asked a number of socio-demographic questions, including their age, employment status, ethnicity, highest level of education, gender identity and sexual orientation.

Mental distress indicators

It needs to be noted that while the disability questions included an item in which participants could indicate whether they experienced a mental health disability, the survey contained several validated tools which specifically measured mental health and related aspects. The following measures have been included in the analysis.

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. Participants were asked a series of 21 questions as part of the Depression, Anxiety, and Stress Scale (DASS-21) (Lovibond and Lovibond, 1995). The scale has three sub-scales comprised of seven items for each dimension: depression, anxiety, and stress. Responses for each item were scored from zero to three and ranged from ‘did not apply to me at all’ to ‘applied to me very much, or most of the time’. The items for each sub-scale were added and participants were given a total score. Because the DASS 21 is a short form version of the DASS (the Long Form has 42 items), the final score of each item (Depression, Anxiety and Stress) was multiplied by two (x2) in line with Lovibond and Lovibond’s (1995) recommendation to allow comparisons to be made with the DASS 42. Scores on each of the sub-scales range from a minimum of 0 to a maximum of 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. (Table 2.2 for cut-off points).

Table 2.2: Scoring of the DASS-42

	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely Severe	28+	20+	34+

Self-harm and Suicidality

Self-harm and suicidality questions were derived from the Lifestyle and Coping Survey (Madge et al., 2008). For self-harm, participants were asked whether they had ever deliberately harmed themselves in a way that was not intended as a means to take their own life. For suicidal thoughts, participants were asked whether they had ever seriously thought about taking their own life? For suicide attempt, participants were asked if they had ever made an attempt to take their own life.

Alcohol Use

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 categorised as follows: no alcohol problems (7 or lower), medium level of alcohol problems (8-15), high level of alcohol problems (16-19), and very high level of alcohol problems (20+).

Self-esteem

Rosenberg's Self-Esteem Scale was used 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 (Rosenberg, 1965). Responses were scored from one to four, with higher scores indicating greater self-esteem. Participants were then given a total score based on their responses. Although there is no standard cut-off point for low self-esteem, many studies have used a cut-off point of 25 to classify low self-esteem and have demonstrated that there is satisfactory discrimination to be able to do so (Yu et al., 2022).

Data analysis

The quantitative data were analysed in SPSS Statistics Version 27 (IBM Corporation, 2020) and Stata 18.0 (StataCorp, 2023). Data analysis includes descriptive (frequencies, percentages, means and standard deviations), bivariate and inferential statistics. The valid percentage is reported for each question i.e., the percent when missing data are excluded from the calculations. Internal reliability analysis was conducted to assess the reliability of scales used in the survey. All scale measures achieved high Cronbach's Alpha values (between 0.83-0.93) indicating that they are reliable.

Objective 1: Prevalence of disabilities

The prevalence of each of the seven long-standing conditions or difficulties is reported and compared with the CSO 2022 data.

Objective 2: Association of disabilities with mental distress indicators

In exploring any associations between disability and mental distress, the mental health disability variable was excluded to avoid conflation between this aspect and the other mental health outcomes, as inevitably strong associations would occur and invalidate the findings.

The remaining six two-category disability variables were entered together into eight multivariable Poisson regression models (one for each mental distress related outcome). These models also included socio-demographic variables, namely, participants' gender identity, sexual orientation, age group, ethnicity, level of education and employment status. Disability variables were considered as showing some evidence of being independently associated with an outcome if its corresponding p-value was less than 0.2. Poisson regression models were then estimated containing only these, potentially influential, disability variables and the sociodemographic variables in order to confirm that their p-value remained less than 0.2. Poisson regression models were then estimated containing the original, three-category version of these disability variables (comparing those reporting no disability, some extent of it or a great extent of it) and the sociodemographic variables. Likelihood ratio tests, using a p-value threshold of 0.05, were used to determine whether disability variables should remain in the Poisson regression models and whether they should best be considered as comparing those with and without the disability or as other comparisons, such as those with a great extent of the disability versus those with some extent or no disability.

Finally, an assessment was made of the influence of the number of the six disabilities experienced (still excluding the psychological/emotional condition or mental health issue) on the prevalence of the mental distress-related outcomes. For participants reporting none, one through to six disabilities, the prevalence of each outcome was tabulated and illustrated graphically.

Objective 3: Analysis of commentary on disability experiences in survey

While undertaking the qualitative analysis of all free text questions, responses that made reference to the topic of disability (that being disability / disorder / neurodivergence) were coded within the context of the question and also coded separately under a disability code, so that all responses in relation to disability could be examined. In two questions in particular, the topic of disability received a high number of mentions; namely the question asking participants if there were reasons, they experienced violence and harassment other than because of their LGBTQI+ identity (n=139) and the question if there are challenges participants face as an LGBTQI+ person because of other circumstances in their lives? (n= 97). Issues around disability also featured in other questions, such as in the questions on (i) sense of connection or belonging to the LGBTQI+ communities; (ii) what you find hardest about being LGBTQI+; (iii) improving healthcare services for people who identify as transgender. The ten themes that emerged from the data and participant quotes, accompanied by their gender identity, sexual orientation and id number, are presented to illustrate the themes.

Chapter 3 : Results

Findings Objective 1: Prevalence of disabilities

In line with the CSO question on disability, participants were asked if they had any of seven long-standing conditions or difficulties. Nearly 70% of the sample reported having at least one of the seven disabilities either to 'some' or 'a great extent', meaning that 30% of the sample had none of the seven disabilities listed (30.6%). The socio-demographic profile of participants with and without at least one of the seven disabilities differed with respect to age, ethnicity, education level, employment status, gender identity and sexual orientation (p-value<0.001 for all) (Table 3.1). The prevalence of disability generally increased with younger age so that there was a 20%-35% higher prevalence among those aged under 25 compared to the older age groups. Gender non-conforming participants had higher prevalence rates compared to cis male and female participants while those who were single as opposed to married or divorced/separated/widowed, and those with sexual orientations other than lesbian or gay registered higher prevalence rates also. The lowest prevalence of disability was among those who were White Irish, had the highest level of education, and were in paid employment.

Table 3.1: Socio-demographic characteristics of the study participants with and without a disability

Characteristic	Category	No Disability		Disability	
		n	%	n	%
Age	14-18 years	80	14.1%	487	85.9%
	19-25 years	83	15.8%	441	84.2%
	26-35 years	238	34.8%	445	65.2%
	36-45 years	187	46.8%	213	53.3%
	46+ years	201	48.9%	210	51.1%
Highest Education	Completed lower secondary level or less	73	13.5%	469	86.5%
	Completed upper secondary level	116	20.1%	462	79.9%
	Completed third level education	606	41.3%	862	58.7%
Ethnicity	White Irish	704	32.5%	1461	67.5%
	White Non-Irish	70	23.0%	234	77.0%
	Black, Asian, Mixed or Other	24	17.3%	115	82.7%

Characteristic	Category	No Disability		Disability	
		n	%	n	%
Employment Status	Working for payment or profit	591	42.2%	810	57.8%
	CE Scheme; JobBridge; Back to Work; Internship	4	13.3%	26	86.7%
	Unemployed/Looking for 1st regular job	26	14.5%	153	85.5%
	Student or pupil	136	17.4%	646	82.6%
	Other (including looking after home/family and retired)	42	38.5%	67	61.5%
	Unable to work due to permanent sickness or disability	0	0.0%	107	100.0%
Gender ID	Cis male	401	47.6%	442	52.4%
	Cis female	307	31.2%	676	68.8%
	Trans and gender non-conforming	86	11.4%	670	88.6%
Sexual Orientation	Lesbian	167	35.0%	310	65.0%
	Gay	397	47.2%	444	52.8%
	Bisexual	116	20.7%	445	79.3%
	Asexual/Pansexual/Queer	88	15.8%	469	84.2%
	Other (including heterosexual and questioning)	31	18.0%	141	82.0%
Marital Status	Single	533	26.6%	1470	73.4%
	Married/In a same-sex civil partnership	206	46.3%	239	53.7%
	Separated/Divorced/Widowed	53	43.1%	70	56.9%

NB: The Gender Non-Conforming group comprised Trans Man (No disability 15.1%; Disability 22.5%), Trans Woman (No disability 34.9%; Disability 16.7%), Non-Binary (No disability 47.8%; Disability 57.6%) and 'Other' (No disability 2.3%; Disability 2.9%) categories.

In relation to the prevalence of each of the seven disabilities it is notable that over one fifth of the sample (21.9%) reported that they had a psychological or emotional condition or a mental health issue 'to a great extent' and nearly one third (31.4%) reported this same difficulty 'to some extent', meaning that over half of the sample had an emotional/psychological/mental health issue to any extent. Over one third (34.1%) reported a difficulty with 'learning, remembering or concentrating' to 'some/great extent' and approximately one quarter (25.4%) reported 'some/great' difficulty with pain, breathing or any chronic illness or condition. Further breakdowns can be seen in Table 3.2.

Table 3.2: Disability among survey participants

Do you have any of the following long-lasting conditions or disabilities?	Yes, to a great extent		Yes, to some extent		No		Total
	n	%	n	%	n	%	n
Blindness or a vision impairment	25	1.0	487	18.8	2080	80.2	2592
Deafness or a hearing impairment	13	0.5	208	8.1	2362	91.4	2583
A difficulty with basic physical activities such as walking, climbing stairs, reaching, lifting or carrying	56	2.2	294	11.4	2239	86.5	2589
An intellectual disability	66	2.6	222	8.6	2290	88.8	2578
A difficulty with learning, remembering or concentrating	237	9.2	644	24.9	1701	65.9	2582
A psychological or emotional condition or a mental health issue	564	21.9	809	31.4	1204	46.7	2577
A difficulty with pain, breathing or any chronic illness or condition	199	7.7	459	17.7	1938	74.7	2596

NB: In the current study, like in the CSO 2022, the response categories were 'no', 'yes to some extent' and 'yes to a great extent'.

Number of disabilities

On average participants reported between 1 and 2 disabilities (Mean=1.6, SD=1.6, N=2609). Figure 3.1 below shows the number of disabilities amongst the participants. 25% had one disability out of seven, approximately 19% had two of the seven disabilities, approximately 12% had three disabilities and lower proportions had four or more.

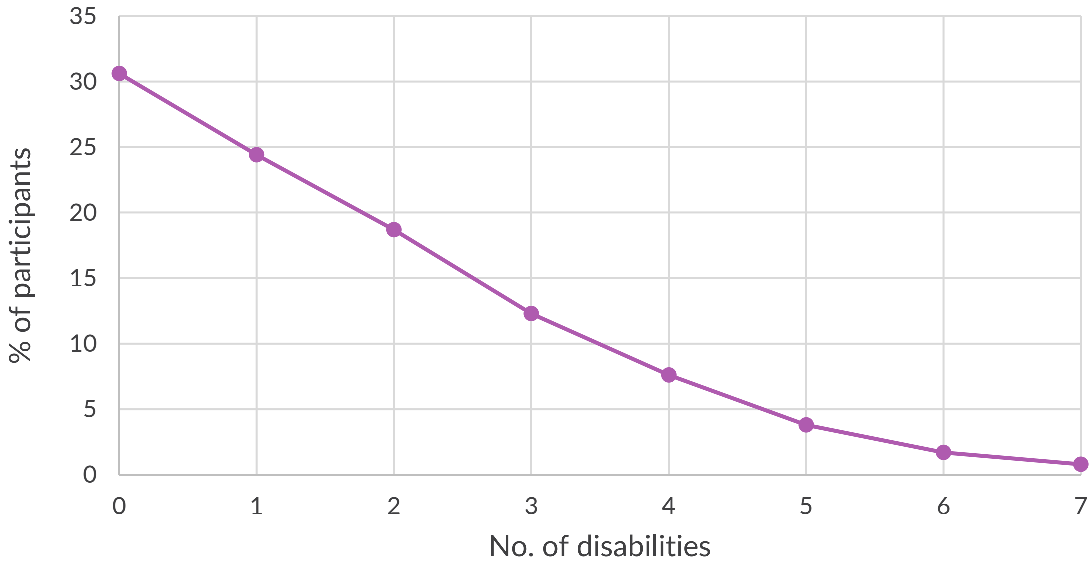

Figure 3.1: Number of disabilities amongst participants

Prevalence comparison to census of population data

In total, 69.4% of participants in the *Being LGBTQI+ in Ireland* study reported experiencing at least one long-lasting condition or difficulty to any extent. When taking ‘yes, to a great extent’ and ‘yes, to some extent’ together the prevalence of all forms of long-lasting conditions or difficulties was greater in the LGBTQI+ cohort compared to the prevalence in the general population of Ireland in 2022. A psychological or mental health difficulty was reported 10.3 times more frequently in the *Being LGBTQI+ in Ireland* sample compared to the general population. A vision impairment was reported approximately 3.4 times more frequently while an intellectual disability and a difficulty with learning/remembering concentrating difficulties were each reported 5.3 and 6.8 times more frequently. In relation to hearing impairment, difficulties with physical activities and pain/chronic illness the rates of reporting were 1.9, 2 and 3 times higher respectively (Table 3.3).

If, the comparison with the general population is limited to only participants in the *Being LGBTQI+ in Ireland* study who answered ‘yes, to a great extent’, the differences with the general population are smaller. But even then, the percentage of LGBTQI+ people reporting an intellectual disability to a great extent was almost three times as common, while a difficulty with learning, remembering and concentrating to a great extent was 6.6 times higher, and a mental health difficulty was 13.6 times more common. In contrast, challenges with basic physical activity and a hearing impairment were both slightly less common.

Table 3.3: Prevalence of disability among Being LGBTQI+ in Ireland sample and the general population

Disability question	Being LGBTQI+ in Ireland Sample		Census 2022 population	
Do you have any of the following long-lasting conditions or difficulties?	Yes to any extent	Yes to a great extent only	Yes to any extent	Yes to a great extent only
	%, (N)	%, (N)	%, (N)	%, (N)
Blindness or a vision impairment	19.8%, (512)	1.0, (25)	5.8%, (296,601)	0.6%, (30,965)
Deafness or a hearing impairment	8.6%, (221)	0.5, (13)	4.5%, (233,420)	0.9%, (44,998)
A difficulty with basic physical activities such as walking, climbing stairs, reaching, lifting or carrying	13.5%, (350)	2.2, (56)	6.8%, (349,155)	2.3%, (118,433)
An intellectual disability	11.2%, (288)	2.6, (66)	2.1%, (109,288)	0.9%, (47,665)
A difficulty with learning, remembering, or concentrating	34.1%, (881)	9.2, (237)	5.0%, (259,050)	1.4%, (71,887)
A psychological or emotional condition or a mental health issue	53.3%, (1,373)	21.9, (564)	5.2%, (269,789)	1.6%, (83,273)

Disability question	Being LGBTQI+ in Ireland Sample		Census 2022 population	
A difficulty with pain, breathing or any chronic illness or condition	25.3%, (658)	7.7, (199)	8.5%, (440,090)	2.8%, (144,671)

Note: Any extent is to 'some extent' and to a 'great extent' combined

Findings Objective 2: Association of disabilities with mental distress indicators

There were marked differences in the prevalence of the mental health outcomes on all validated measures between participants who reported experience of a disability and those who reported no experience of a disability (Table 3.4). Those with a specific disability had a higher lifetime prevalence of suicidal thoughts, and a higher point prevalence of self-harm and suicide attempt, as well as symptoms of severe or extremely severe depression, anxiety and stress, and low self-esteem. Unsurprisingly, having a psychological or emotional condition or a mental health issue was associated with the largest increases in the prevalence of these seven mental health outcomes. Intellectual disability and learning, remembering or concentration difficulties appeared to be associated with the next largest increases in the mental health outcomes. Difficulties with basic physical activities and pain, breathing or chronic illness difficulties were associated with somewhat lower increases in risk of the mental health outcomes. Vision and hearing impairment were the disabilities associated with the least increased risk of the mental health outcomes. The differences were smaller and in the opposite direction with respect to alcohol problems where participants reporting experience of a disability were somewhat less at risk.

Table 3.4: Lifetime prevalence of suicidal behaviours, point prevalence of symptoms of severe/extremely severe depression, anxiety and stress and point prevalence of low self-esteem and alcohol problems for those with and without seven long-standing conditions

Type of disability	Groups	Suicidal thoughts	Self-harm	Suicide attempt	Severe/extremely severe depression	Severe/extremely severe anxiety	Severe/extremely severe stress	Low self-esteem	Alcohol problems
Blindness or a vision impairment	Yes/No	77%/61%	66%/48%	37%/23%	40%/24%	51%/30%	33%/20%	60%/39%	39%/42%
Deafness or a hearing impairment	Yes/No	78%/63%	62%/50%	42%/24%	36%/26%	50%/32%	33%/22%	53%/42%	41%/42%
Difficulty with basic physical activities	Yes/No	84%/61%	73%/48%	45%/23%	41%/25%	59%/30%	36%/21%	64%/40%	36%/42%
Intellectual disability	Yes/No	88%/61%	81%/47%	50%/23%	55%/23%	72%/29%	44%/20%	74%/40%	32%/43%
Learning/remembering/ concentration difficulty	Yes/No	83%/54%	75%/39%	41%/18%	47%/16%	59%/21%	39%/15%	69%/30%	38%/44%
Psychological/emotional/ mental health condition	Yes/No	81%/44%	70%/29%	37%/12%	42%/10%	53%/12%	35%/9%	62%/21%	41%/43%
Pain/breathing/chronic illness difficulty	Yes/No	80%/59%	67%/46%	40%/21%	38%/23%	52%/28%	34%/19%	56%/39%	35%/44%

Blindness or visual impairment, deafness or hearing impairment and difficulties with basic physical activities were not associated with any of the mental health-related outcomes after considering the other disabilities and the influence of sociodemographic variables describing participants' gender identity, sexual orientation, age group, ethnicity, level of education and employment status (Table 3.5).

Most importantly, a learning/remembering/concentration difficulty and a pain/breathing/chronic illness difficulty were both independently associated with increased risk. For example, in the case of self-harm, there is a 30% increase in risk if one has a learning/remembering/concentration difficulty (Risk Ratio 1.30). Having this disability confers even greater risk of suicidal attempts and having symptoms of severe/extremely severe depression, with approximately a 70% increase in risk (Risk Ratio 1.67, Risk Ratio 1.68 respectively). For suicide attempts, experience of an intellectual disability added further risk and for symptoms of severe or extremely severe depression, experience of an intellectual disability to a great extent added extra risk. While alcohol problems were not associated significantly with any of the disabilities, it is interesting that those with a pain/breathing/chronic illness difficulty to a great extent were at reduced risk of alcohol use, a finding that is hard to explain.

Table 3.5: Association between six long-standing conditions or difficulties and lifetime prevalence of suicidal behaviours, point prevalence of severe/extremely severe depression, anxiety and stress and point prevalence of low self-esteem and alcohol problems

Type of disability	Groups	Suicidal thoughts	Self-harm	Suicide attempt	Severe/extremely severe depression	Severe/extremely severe anxiety	Severe/extremely severe stress	Low self-esteem	Alcohol problems
Blindness or a vision impairment	Yes/No	None	None	None	None	None	None	None	None
Deafness or a hearing impairment	Yes/No	None	None	None	None	None	None	None	None
Difficulty with basic physical activities	Yes/No	None	None	None	None	None	None	None	None
Intellectual disability	Yes/No	None	None	1.30 (1.04-1.64)	---	None	None	None	None
Intellectual disability to a great extent	Yes/No	None	None	---	1.35 (0.97-1.88)	None	None	None	None
Learning/remembering/ concentration difficulty	Yes/No	1.28 (1.13-1.44)	1.30 (1.14-1.48)	1.67 (1.36-2.05)	1.69 (1.41-2.04)	1.59 (1.36-1.87)	1.62 (1.33-1.98)	1.50 (1.30-1.72)	None
Pain/breathing/chronic illness difficulty	Yes/No	1.19 (1.06-1.33)	1.20 (1.06-1.36)	1.39 (1.16-1.67)	1.21 (1.01-1.44)	1.43 (1.23-1.67)	1.40 (1.16-1.69)	1.14 (1.00-1.31)	---
Pain/breathing/chronic illness to a great extent	Yes/No	---	---	---	---	---	---	---	0.69 (0.49-0.97)

Note: The questions on the long-standing conditions or difficulties were unanswered by 7.6-8.1% of participants and the questions on suicidal thoughts, self-harm, attempted suicide, depression, anxiety, stress, self-esteem and alcohol problems were unanswered by 1.6-23.1% of participants; Associations are described by prevalence ratios (and their 95% confidence intervals) comparing the prevalence in a group with a disability to those without the disability and with adjustment for the sexual orientaion, gender identity and sociodemographic profile of the study participants as well as the other disabilities. Like a traffic light signal the colours indicates odds from high, to medium to low.

There was a clear graded association between the number of disabilities experienced by participants and the prevalence of mental health-related difficulties (Table 3.6; Figure 3.2). In general, the greater the number of disabilities reported, the higher the prevalence of mental health-related difficulties. The highest prevalence of low self-esteem and symptoms of severe/extremely severe stress was reported by participants with six disabilities. Participants with five disabilities reported the highest prevalence of suicidal thoughts, self-harm and attempted suicide and of symptoms of severe/extremely severe anxiety and depression. A different pattern was evident for alcohol problems whereby the prevalence was highest for those reporting no disability and, in general, risk of alcohol problems was less common among those with an increasing number of disabilities.

Of the participants who had none of the six disabilities, almost half had experience of serious suicidal thoughts but this was the case for two thirds of participants with one disability and at least 80% of those with two or more disabilities. While small in number, almost all those reporting five disabilities had experienced serious suicidal thoughts. Lifetime prevalence of self-harm was 35% for participants with none of the six disabilities but it was over half for those with one disability, two thirds for those with two, three quarters for those with three and over 80% for those with four or more disabilities. For the lifetime prevalence of attempted suicide there was a fivefold increase from 14.6% for those reporting no disability to 72.5% for those reporting experience of five disabilities.

Participants reporting experience of one disability had twice the risk of having symptoms of severe or extremely severe depression, anxiety and stress compared to those experiencing none. Participants reporting five disabilities had 4.5 times the risk of having symptoms of severe/extremely severe depression (62.5% vs. 13.8%) and 5.6 times higher risk of having symptoms of severe/extremely severe anxiety (90.2% vs. 16.0%). The small number of participants reporting all six disabilities had six times higher risk of having symptoms of severe/extremely severe stress (71.4% vs. 11.7%).

Approximately, one-quarter of participants with none of the disabilities had low self-esteem. The prevalence increased with each additional disability, reaching 86.4% for those reporting experience of all six.

The pattern of increasing number of disabilities being associated with increasing risk of poor mental health-related outcomes was not observed for alcohol problems. A different pattern was evident whereby the prevalence was highest for those reporting no disability and, in general, risk of alcohol problems was less common among those with an increasing number of disabilities.

Table 3.6: Lifetime prevalence of suicidal behaviours, point prevalence of symptoms of severe/extremely severe depression, anxiety and stress and point prevalence of low self-esteem and alcohol problems by number of disabilities reported

Number of disabilities	Suicidal thoughts	Self-harm	Suicide attempt	Severe/extremely severe depression	Severe/extremely severe anxiety	Severe/extremely severe stress	Low self-esteem	Alcohol problems
None (n=1,110)	48.9%	34.9%	14.6%	13.8%	16.0%	11.7%	26.6%	46.5%
One (n=647)	65.7%	52.5%	22.8%	28.0%	34.0%	23.8%	43.4%	39.1%
Two (n=355)	80.4%	65.9%	36.5%	40.0%	50.9%	33.6%	61.4%	36.7%
Three (n=233)	86.6%	76.0%	48.3%	46.0%	59.2%	38.9%	69.3%	37.9%
Four (n=105)	88.2%	84.8%	45.4%	53.5%	70.1%	37.4%	72.4%	34.7%
Five (n=42)	97.6%	90.5%	72.5%	62.5%	90.2%	52.5%	78.0%	38.5%
Six (n=22)	85.7%	81.0%	61.1%	54.5%	86.4%	71.4%	86.4%	33.3%

Note: The number of long-standing conditions/difficulties/disabilities was not known for 10.4% of participants and the questions on suicidal thoughts, self-harm, attempted suicide, depression, anxiety, stress, self-esteem and alcohol problems were unanswered by 1.6-23.1% of participants.

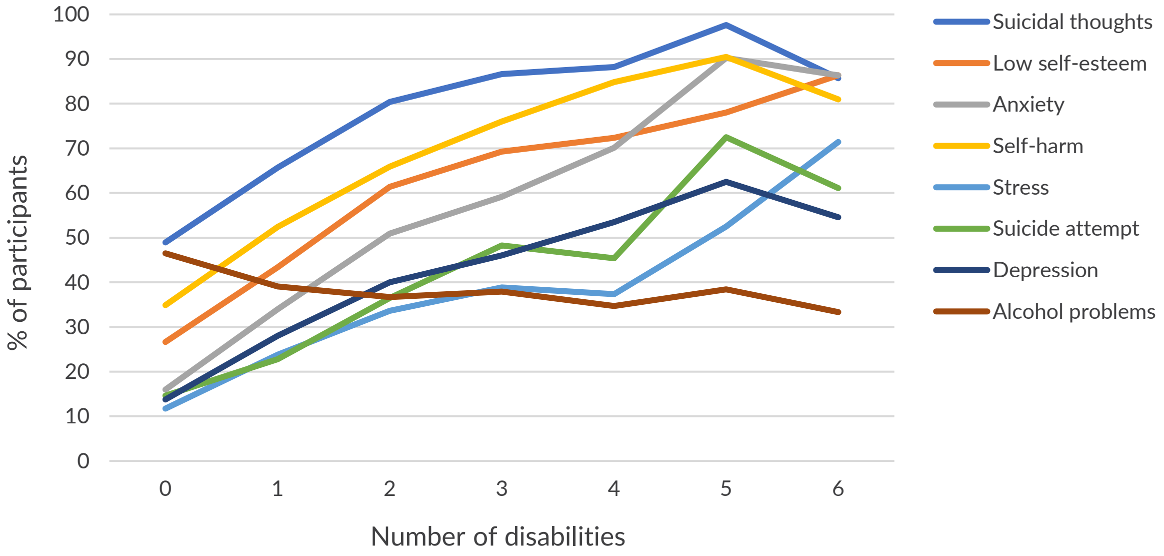

Figure 3.2: Lifetime prevalence of suicidal behaviours, point prevalence of symptoms of severe/extremely severe depression, anxiety and stress and point prevalence of low self-esteem and alcohol problems by number of disabilities reported.

Findings Objective 3: Present commentary people made in the survey related to disabilities and LGBTQI+ identities

Analysis of the qualitative data across all the open questions in the survey resulted in the following ten themes: Type of disability; experiences of abuse/discrimination; engaging with the LGBTQI+ community; LGBTQI+ identity not taken seriously; services access; financial challenges; dating and romantic relationships; other challenges; positive experiences; and suggestions for improvement. The disability aspects mentioned, in particular those around type of disability and experiences of abuse/discrimination, did not always mention a specific relationship with the LGBTQI+ identity. However, within the other themes, intersectionality was often highlighted.

Wide variety of disabilities reported

Participants did not always specify what type of disability/condition they had in the qualitative comments, referencing having a ‘disability’ without any additional details. Others offered more specific detail, such as, being a wheelchair user; having experiences of chronic pain; being a cane user, having a walking aid or use of crutches; having a hearing impairment; having additional needs; a chronic illness; HIV status; an eating disorder; or having an invisible disability. Many participants referred to being neurodivergent; some specifically referring to being autistic, having dyslexia, dyspraxia or dyscalculia, or having tics or Tourette's syndrome. Some participants indicated that they had two or more types of disabilities/conditions, while others expressed that they had mental health difficulties alongside existing disabilities/conditions.

> *"Disability: autism, ADHD, depression, anxiety, BPD, DID, as well as needing a cane to walk from time to time."* (23, non-binary, transgender man, demisexual, ID 2084)

Experiencing abuse/discrimination because of disability

Having a disability or condition was identified by many participants as a reason why they experienced harassment or violence other than because of being LGBTQI+. Some participants expanded on their responses to describe the different kinds of harassment/violence they experienced which included verbal abuse, being attacked, bullied, harassed, shamed, ridiculed, being subject to ableist comments or being infantilised because of disability and/or neurodivergence. Mostly, these responses referred to the negative experiences rather than the offenders, but some identified specific offenders, such as students, teachers, medical professionals, family members or ex-partners.

> *"…and ableism for being disabled due to severe anxiety and autism. My ex-partner would often emotionally-mentally abuse me and would berate me for things I could not help due to my disabilities and make fun of how I acted."* (22, man, transgender man, bisexual, ID 701)

> *"Been mocked as physically disabled and autistic. Been discriminated against and bullied for both. Been shamed by family for autistic-ADHD traits and inability to perform certain tasks, physically or mentally."* (30, woman, bisexual, ID 1432)

> *"I have been laughed at for being unable to walk due to [mentions a specific incident]. I'm not in a wheelchair but I am disabled and sometimes need a walking aid."* (22, woman, pansexual, ID 1367)

> *"I have an eating disorder (or rather I'm recovering from one) and I have been harassed for my appearance (very thin)."* (50, man, gay, ID 2502)

> *"I've been called stupid or retarded because of my autism and made fun of for my Tourette's."* (16, non-binary, queer, ID 1112)

> *"I'm multiply neurodivergent and have experienced bullying, violence and harassment as a result of these differences."* (45, non-binary, questioning, ID 371)

Specific sites where abuse or harassment occurred were also identified, such as school or the workplace.

> *"I experienced harassment in my workplace due to a diagnosis of ADHD. I had to file multiple complaints about members of management who were constantly trying to gaslight me and lie about the quality of my work since I disclosed the diagnosis to them."* (25, non-binary, bisexual, ID 2200)
>
> *"I've been continuously harassed at school for being autistic."* (14, man, transgender man, gay, ID 236)

Some participants also stated that they had experienced years of harassment for problems that they did not know they had at the time.

> *"For being autistic, but neither I nor the others knew at the time that the behaviours I was bullied for were related to autism."* (25, man, transgender man, bisexual, ID 908)

Others received accusations of being attention-seeking or were generally not believed about their disability.

> *"I have an invisible disability. I don't look disabled, so people don't believe me and refuse to accommodate me. Both medical professional and teachers, etc.. at school don't believe I'm ill and think I do it for attention. So, I'm often ridiculed in public for things I have to do to help me live my life."* (18, woman, queer, ID 1753)

A small number of responses highlighted experiencing harassment due to being an immigrant with a disability and/or being neurodivergent.

> *"Bullying and discrimination and regular microaggressions relating to my ethnicity-race and also my autism." (19, non-binary, asexual, ID 1234)*
>
> *"Being an immigrant who is disabled."* (16, woman, lesbian, ID 1846)

Challenges in engaging with the LGBTQI+ communities

Some participants indicated that engaging with the LGBTQI+ communities was challenging for them due to having a disability and/or being neurodivergent. Reasons for these challenges included references to a 'cliquey' community that is difficult for neurodivergent people to access; the LGBTQI+ communities being superficially inclusive; that Pride is inaccessible for physically disabled people; that the LGBTQI+ is a constantly changing community, something that autistic people find difficult; or that the LGBTQI+ community is an ableist, and/or classist and/or cis middle class male dominant community.

> *"I feel isolated and alienated because I'm fat and disabled. The queer community is for the thins and the able bodied."* (37, genderqueer, queer, ID 926)
>
> *"I think the LGBTQI+ community is largely structured to cater to white middle class cis able-bodied gay men. No one else really gets a look in. As a disabled woman, it can be hard to find a foothold."* (30, woman, queer, ID 2016)
>
> *"Most LGBT events, clubs or social nights are in completely inaccessible locations, and many pride events that would be suited for a remote audience are frequently not. LGBT groups do not care about disabled people."* (28, non-binary, bisexual, ID 2036)
>
> *"It's hard for me to feel included and involved in queer communities due to a lack of accessibility for neurodivergencies."* (29, transmasculine, pansexual, ID 686)
>
> *"It's hard to be part of the LGBTQ+ community and be autistic at the same time, things are constantly changing within my community and it's a commonly known fact (at least it is to me) that autistic people hate-find it hard to deal with change."* (15, genderfluid, bisexual, ID 1202)

Being HIV positive (n=5/18) was linked to feeling stigmatised, being judged and unaccepted within the LGBTQI+ communities, as well as negatively impacting the potential for intimacy or relationships.

> *"Being HIV positive, life has become very small and I have basically withdrawn from life. A long-term partner gave it to me. A life sentence without parole or pardon. No one wants to be with a HIV positive person."* (53, man, gay, ID 2368)
>
> *"I have been HIV+ 22 years, I have found the gay scene to be very judgemental and found that HIV stigma continues to thrive."* (47, man, gay, ID 2336)
>
> *"I am HIV+, something that still primarily affects gay men and in high numbers but is rarely discussed among gay men. It spoils the party to talk about it and it isn't even mentioned when guys engage in unsafe sex. But the elephant is most definitely in the room. It prevents proper intimacy and relationships because discussion is avoided."* (61, man, gay, ID 416)

This participant added that the topic of HIV is rarely addressed by LGBTQI+ organisations or within academia. This gap in LGBTQI+ related discussions was believed to contribute to the absence of any challenge to the stigma around HIV that has long existed.

> *"While there are many supports for lots of different LBGT+ issues in the LBGT+ community, people living with HIV are always having to knock on doors as it were, remind them we are here. We are made to feel like we are the bad LBGT+ people, we give the community a bad name. I feel that the LBGT+ community on the whole need to realise that we are a part of the community, many of us are growing older with HIV, and many have never spoken out about living with HIV because they have been made to feel ashamed. There needs to be real education in the LBGT+ community about HIV issues."* (65, man, queer, ID 2029)

One person commenting on a diagnosis of HIV stated that:

> *"The LGBTQI+ community can be both the most supportive, but also the most stigmatising."* (31, man, gay, ID 213)

An alcohol focused LGBTQI+ community was also identified as being problematic in terms of community connection for people with alcoholism, as well as people disinterested in alcohol.

> *"I am very happy about being gay but being gay and alcoholic can be tough everything involves alcohol."* (55, man, gay, ID 2424)

> *"I'm a disabled man with limited funds, no interest in alcohol and chronic fatigue. It's incredibly difficult to meaningfully participate in any community. They will go to pubs (expensive, drunks are triggering), go on excursions (expensive, costly in energy levels) and even local social events I can only attend for an hour or two [but] is noticed and commented upon. I feel different at all times."* (34, man, gay, ID 253)

Some of the issues raised in the qualitative comments in relation to sense of belonging, inclusion and representation within LGBTQI+ communities were also evident within the quantitative analysis. LGBTQI+ participants with a disability were more likely to agree that their identity isn't given equal recognition in the communities (34.7%) and that they feel isolated and separate from other people who share their identity (30.9%) compared to those without a disability (22.3% and 20.3% respectively). They were also more likely to agree that the LGBTQI+ organisations did a good job of advocating for them (62.7%) and that their identity is visible in the LGBTQI+ communities (60.1%) compared to those without a disability (72.8% and 66.2% respectively).

Not being taken seriously

Twelve participants indicated that their disabilities or disorders meant their LGBTQI+ identity was often not taken seriously/ recognised by people in society in general or by medical professionals. Eleven of these participants were trans or non-binary. Responses contained experiences of feeling ‘dismissed’, experiencing greater ‘gatekeeping’,[7] being ‘less believed’, viewed as being ‘incapable of knowing who they are’, being ‘naïve’, or being falsely ‘protected against Trans ideology’.

> *“Being autistic and trans is extremely difficult because a lot of people simply don't want to believe me.”* (32, woman, transgender woman, queer, ID 2555)

> *“There is also a lot of rhetoric about protecting autistic girls from "trans ideology" even though autistic people have far higher rates of being queer and trans than neurotypicals and it's not because we are deluded or vulnerable but the idea that we are too stupid to know our gender is so harmful and degrading.”* (19, non-binary, asexual, ID 1234)

One person highlighted their experience as one of infantilisation, due to having no option but to be dependent on parents for support because of not being able to access disability services. In addition, this has meant feeling that their sexual orientation has been erased because of having to live in a heteronormative context.

> *“I’m disabled & chronically ill and it’s impossible to access supports to assist me to live a truly independent life. [Being in my forties] I’m dependent on my parents for financial and practical assistance – this is infantilism. It leads me to living a straight existence because even though my family are aware I’m bisexual it’s erased the majority of the time I’m forced to exist in heteronormativity and I hate it.”* (43, woman, bisexual, ID 2523)

Healthcare/service access challenges

Challenges in accessing healthcare/services were also identified. For one person this related to difficulties understanding service information and using (online) services. Two responses highlighted difficulties they experienced accessing PrEP,[8] and two others referred to challenges, or anticipated challenges, around accessing Trans healthcare.[9] One participant reported using DIY (do it yourself) HRT (Hormone

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[7] Gatekeeping refers to the controlling or limiting of access to something, generally services or resources.

[8] Pre-exposure prophylaxis (PrEP) is a medication taken by HIV-negative people to reduce the chance of them getting HIV.

[9] A more detailed analysis on challenges in relation to trans health care is in the main report.

Replacement Therapy) because of the difficulties they anticipate accessing Trans healthcare, being autistic.

> *"Being an autistic trans person I have no real options when it comes to accessing transition related care. I've heard that the NGS just refuse to provide HRT to autistic trans people. This has meant I had to do DIY HRT which is illegal, but I can't afford GenderGP or go through the NGS here in Ireland. DIY HRT is my only option."* (26, non-binary, bisexual, ID 56)
>
> *"Being autistic means there is a high chance that I may be not allowed to transition medically."* (19, non-binary, asexual, ID 1234)
>
> *"I've been trying to get prep for almost a year, have not yet been able to get an appointment. I feel getting prep should be as easy to obtain as STIs."* (23, non-binary, gay, ID 593)
>
> *"Being a part of the disabled community, some things are not accessible to me such as not being able to understand information or not being able to use a service, especially online services."* (20, non-binary, bisexual, ID 2045)

Financial challenges

Financial challenges were highlighted by five participants with disabilities, and these challenges generally accompanied other difficulties as well (as was already highlighted above in relation to the costs associated with community connection), such as living below the poverty line; experiencing housing insecurity; or not being able to afford the cost of inquiring into an ADHD or autism diagnosis which, it seems to be suggested, would meet the need of having workplace disability needs met.

> *"Being a disabled person (specifically, being autistic and suffering from mental illness) and living below the poverty line on disability allowance."* (26, woman, bisexual, ID 2157)
>
> *"Yes, am disabled and poor. Suffer from housing insecurity."* (31, non-binary, sapphic/queer, ID 222)
>
> *"I am chronically ill. I struggle to have my needs met in the workplace. I am searching for an ADHD diagnosis, but due to the expense and lack of facilities, I don't know if I'll ever [get one]."* (25, woman, lesbian, ID 1616)

For this participant who has Tourette's syndrome, the intersection of a range of challenges together, including financial challenges, were identified as making their life difficult.

> *"My financial situation, my divided family, mental issues and my Tourette's Syndrome are usually the things that make my life difficult."* (19, woman, queer, ID 1122)

Obstacles to dating and romantic Relationships

A few participants highlighted disability related challenges regarding dating and romantic relationships.

> *"Chronically ill and disabled so not able to date or be part of the scene."* (55, woman, queer, ID 2543)
>
> *"Dating with borderline personality disorder sucks."* (34, woman, lesbian, ID 1906)
>
> *"I'm autistic. …differences in communication make getting into relationships a lot more challenging for me."* (22, woman, gay, ID 2135)

Other Challenges

Other disability related challenges were linked to being in school, and the development of eating disorders because of identity related struggles.

> *"I'm also autistic and so school is difficult for me."* (15, non-binary, asexual and bisexual, ID 1672)

Two participants stated that they had developed eating disorders because of their identity related struggles.

> *"I couldn't understand why I didn't fit in with social norms when I was young - this led to some pain[ful] experiences and relationships, eating disorders, anxiety and confusion."* (44, man, queer, ID 96)

Positive Experiences

A small number of positive comments (n=5) linked being LGBTQI+ and disabilities/conditions. Some were nuanced responses, for example, pointing to the benefits of being part of a community that is *generally* more aware of neurodivergence than society at large.

> *"I find them (LGBTQI+ people) generally more accepting of other diversity such as neuro or physical diversity."* (39, woman, pansexual, ID 731)

Also indicated was that knowing that an LGBTQI+ community exists was a positive; one that could be accessed if, and when, needed.

> *"The fact that there's a community I suppose, but it's not something I think much about. I'm autistic and have complex mental health challenges so romance hasn't ever been on my radar. I think I'm probably asexual but not sure - I like that the LGBTQI+ community is a thing so once I do figure out my sexuality I know there's a big community out there."* (27, woman, questioning, ID 330)

Finally, one participant pointed out that having labels to communicate and help others understand who they are is positive for them; that while the participant is clear about who they are, without having labels to express this, others may not be.

> *"Being queer and autistic is just who I am. The labels help other people understand. I make more sense when people know those things about me, otherwise I probably seem a bit "weird."* (44, non-binary, transgender man, queer, ID 2211)

Suggestions for Improvement

Suggestions for improvement were offered that related to (i) the LGTBQI+ communities, and secondly, (ii) to society more generally.

Within the LGBTQI + Community

Participants offered some suggestions for improvement within the LGBTQI+ community for people with disabilities. For example, the introduction of more accessible events, including sensory friendly events, as well as more designated seating at events, events that are not focused around alcohol, as well as the suggestion of making hybrid events (online and in-person) the norm.

> *"Queer spaces, like pride, need to be accessible to disabled people. Even just having more seating or having sensory friendly events would improve this. I've seen on some websites that accessibility needs have been considered and that's great and I hope it continues."* (19, non-binary, bisexual & demisexual, ID 2570)

> *"Disabled queer people are being left behind. We need accessible venues and services, including online access to events and support, low-sensory environments and events not focused around alcohol."* (30, non-binary, queer, ID 2567)

> *"As a disabled and chronically ill person who has had to cocoon for the majority of the past few years I feel isolated from society as a whole. Pandemic aside the world is ableist and it's exhausting and endlessly hostile for me to exist outside my apartment. Access such as online access in the pandemic made interactions easier for me but now folks are meeting up in person and I mainly can't do that due to mobility issues. I also avoid highly populated indoor settings because I'm high risk. I think able and non-chronically ill LGBTQ folks doing online and accessible things*

> *for disabled & chronically ill queers would help. Because we are often too sick and disabled to be managing all of those events too. Like it's grand to have events online if it suits able folks … but it's unfair that hybrid events aren't the norm ALWAYS. It's deeply unfair and ableist and exhausting."* (43, woman, bisexual, ID 2523)

The LGBTQI+ community and beyond

Suggestions (n=9) with a wider reach than the LGBTQI+ communities included the need for (i) accessible trans healthcare, (ii) more recognition of autistic people, (iii) greater enforcement of the UNCRPD (United Nations Convention on the Rights of People with Disabilities, and (iv) supports for questioning autistic adults trying to figure out their sexuality.

Participants calling for better access to trans healthcare did so regarding people with disabilities, and in terms of financial accessibility. The need for an *informed consent model* of Trans healthcare,[10] and the separation of neurodivergence from Trans healthcare needs by Gender Service providers was also highlighted.

> *"More accessible [Trans healthcare] especially for people with disability and low income."* (17, man, transgender man, bisexual, ID 1732)

> *"PLEASE give us immediate access to HRT following the informed consent model set out by WRATH. PLEASE I cannot wait 6 to 10 years only for the National Gender Service to turn me away because of my Autism diagnosis."* (24, non-binary, transgender man, queer, ID 671)

> *"Maybe something that could support questioning autistic adults who don't know how to figure out their sexuality."* (27, woman, questioning, ID 330)

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[10] The informed consent model of Trans healthcare applies to the use of gender affirming hormonal treatment. This 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 counselled the transgender person on the risks and benefits of hormonal treatment.

Chapter 4 : Discussion and Recommendations

There is a growing recognition that people who belong to more than one minority group simultaneously, including sexual and gender minority disabled people, face increased risk of what Bollier et al. (2022, p2) refer to as 'being left behind' due to heterosexism, cisgenderism and ableism. The review of the literature on LGBTQI+ populations with a disability, demonstrates that the little research that exists points to (a) disparately elevated levels of disability within LGBTQI+ populations in comparison to non-LGBTQI+ populations; (b) higher levels of disability reported in LGBTQI+ youth studies relative to adult LGBTQI+ population studies; and (c) disparities for which no explanation or theory is offered.

Comparison to the Irish census 2022 disability data underlines the higher level of disability reported by the LGBTQI+ participants in this study, particularly in relation to having a mental health difficulty, but also in relation to having an intellectual disability and a difficulty with learning/remembering concentrating difficulties. The three most prevalent forms of disability among the study sample are an emotional/psychological/mental health issue, followed by a difficulty with learning, remembering or concentrating, followed by a difficulty with pain, breathing or any chronic illness or condition. By contrast, only a difficulty with pain, breathing or any chronic illness or condition feature in the top three disabilities in the general population; instead, a difficulty with basic physical activities, and vision impairment, strongly age-related conditions, make the top three.

Whereas with the census of the population, the proportion of people experiencing a long-lasting condition or difficulty to any extent generally increased with age (Census 2022), the proportion of people reporting having a long-lasting condition or difficulty to any extent generally decreased with age in the *Being LGBTQI+ in Ireland* study. This reverse trend is due in part to the age profile of study participants being predominantly younger. Whereas those aged 46+ represent nearly half of the population aged 14+ in Ireland in 2022, it represents just 16% of the *Being LGBTQI+ in Ireland* sample. Nevertheless, the higher rates of disability reported by the younger LGBTQI+ participants in this study echo findings from the international literature, in the sense that many of the studies involving younger LGBTQI+ participants had higher prevalence rates of disability compared to the studies involving the adult LGBTQI+ population.

When age and other socio-demographic characteristics are taken into account in determining the influence of disability status on mental health and substance use outcomes, we see that two out of six disabilities remain highly influential in determining mental health outcomes: namely having a difficulty with learning, remembering or concentrating and a difficulty with pain, breathing or other chronic illness, both of which increased the risk of adverse mental health outcomes in this LGBTQI+ sample. The cumulative impact of disability is clearly illustrated with those with an increasing number of disabilities having a higher risk of adverse mental health issues. We know from extensive literature that the LGBQTI+ population has higher prevalence rates of mental health issues relative to the heterosexual and cisgender population (Surfus, 2023). However, our findings add a new perspective in the sense that the prevalence of disabilities may contribute to a higher risk of adverse mental health outcomes.

The qualitative data shed new light on stressors that LGBTQI+ people with disabilities encounter that may also impact adversely on mental health, with a range of issues identified including discrimination and harassment, a sense of exclusion and disconnection from the LGBTQI+ communities, stigma, financial dependence and poverty, service access barriers, and housing insecurity to name but some.

In line with the literature (Dinwoodie et al., 2020), experiences of bullying, discrimination and exclusion due to a disability or being HIV-positive were found both in the wider community and within the LGBTQI+ communities. The negative commentary by some of our participants is especially concerning considering the importance of community connectedness in the creation of positive self-identity and reduced feelings of isolation for sexual minorities (Smith et al., 2020). Because social support, as a moderating factor in the relationship between disabilities and mental distress is well-established (Einfeld et al., 2011; Tough et al., 2017), this is an important finding for LGBTQI+ organisations.

In line with the sexual minorities and learning/ intellectual disability literature (Toft et al., 2019; Dinwoodie et al., 2020) similar experiences of infantilism and/or assumptions that people with disabilities may not know their own mind were identified in this study. Transgender people diagnosed with autism reported not being believed or being dismissed as not having the capacity to know their own gender. Also identified was that infantilism can be experienced by LGBTQI+ people with disabilities who have no option but to be dependent on parents for financial and practical support in the event of disability supports for living an independent life not being accessible. In addition, the findings highlight the need for family/carer education and support to ensure that the support context is one that balances care provision and the rights of an adult LGBTQI+ person (Robinson et al., 2020).

The findings also highlight that this population experience challenges accessing healthcare. This included information processing challenges, long waiting lists for getting an appointment for PrEP, and perceived challenges around accessing medical transition for trans people with autism (Rotondi et al., 2013). This highlights one of the problems that can result in the event of people being unsure whether it is safe to disclose their multiple identities in services (O'Shea, 2020).

To conclude, results from the study shine a light on the intersection of disability, gender, and sexual orientation. Importantly, the results demonstrate that disabilities are not only high among sexual and gender minorities, but in particular that learning, remembering or concentrating and a difficulty with pain, breathing or other chronic illness, are associated with an increased risk of adverse mental health outcomes. The cumulative impact of having an increasing number of disabilities is also clearly illustrated with those with an increasing number of disabilities having a higher risk of adverse mental health issues. Our findings highlight the need for services to be able to cater for complex supports and needs not only in relation to LGBTQI+ identities *and* disabilities, but also for additional challenges that LGBTQI+ people with disabilities experience such as financial, housing or workplace related challenges, and as such is in line with the findings in O'Shea (2020) that warns against a 'one size fits all' approach to disability services.

Strengths and limitations

While the main strength of the study is the high number of participants, it is not possible to ascertain whether the sample is representative of the general population in Ireland. There are indications that the transgender and young participants may be overrepresented and that people from ethnic minority communities, including Travellers, Roma people, and people from Black and Asian communities are underrepresented. Furthermore, hosting the survey online may have prevented people with visual, intellectual and memory disabilities from participating. As a result, people with more severe forms of disabilities may be underrepresented. The use of validated measures of mental distress and the Census question on disabilities is of course another strong point. However, because of the phrasing of the latter we didn't include a definition or time frame for long-lasting conditions or difficulties, hence we are unable to say if people included recently acquired disabilities in their definition of each of the seven disabilities listed.

Recommendations

Recommendations for policy

While people with disabilities and LGBTQI+ people are mentioned separately as priority groups within health and social care policies, LGBTQI+ people with disability are rarely explicitly referenced. Therefore, it is recommended that:

- LGBTQI+ people with disability be given greater visibility and should be explicitly referenced in future health and wellbeing policies and regulatory standards, including mental health and disability policies.
- In line with principles of coproduction, every opportunity should be taken to ensure that the voices of LGBTQI+ people with disability are represented at the policy table.
- Funding needs to be increased to LGBTQI+ services to develop specific supports and resources for LGBTQI+ people with disability that is co-designed with LGBTQI+ people with disability.

Recommendations for Research

Having accurate data on the prevalence of disability among sexual and gender minorities is important if policy makers and service providers are to meet people's needs equitably and effectively. Therefore, it is recommended that:

- Data on people's sexual, gender and disability status should be collected in all future disability studies. This needs to include people with an intersex variation. In designing the questions consideration should be given to the various terms people use to describe sexual orientation and gender identity and include options to capture those who are questioning or are unsure of their sexual attraction/identity or do not experience sexual attraction.
- Given the significant gap in research on LGBTQI+ people with disability in Ireland, additional research, both quantitative and qualitative, is needed to deepen our knowledge of their experiences.
- In light of the findings from this and other studies indicating that in the prevalence of disabilities is higher in comparison to general population data among sexual and gender minorities and in the absence of an explanation or reason there is a need for further research to explore why this may be the case.
- In line with emerging discourses on the importance of participatory methodologies future research needs to be co-designed with LGBTQI+

communities, with a greater focus on minority communities not represented in this study. This research needs to be appropriately funded to ensure that methodologies are not only participatory but accessible to people with all forms and degrees of disability.

Recommendations for service provision

People with a disability may have specific needs based on their personal circumstances and intersecting identities, which has implications for access to and provision of health and social care services. Therefore, it is recommended that:

- Health, social care and disability services review policies, strategies, systems, infrastructure and processes to ensure they are providing inclusive and culturally safe environments for LGBTQI+ people with disability.
- Professionals working in health, social care and disability organisations need to be educated on LGBTQI+ issues that address the intersection of disability, gender, and sexual orientation and is co-designed with LGBTQI+ people with disability.

Recommendations for the LGBTQI+ community

There is a need for the LGBTQI+ community and support organisations to better understand and represent the needs of people with a disability and LGBTQI+ identity. Therefore, it is recommended that:

- Education is provided to staff within LGBTQI+ organisations that addresses the intersection of disability, gender, and sexual orientation.
- LGBTQI+ organisations review policies, strategies, systems, infrastructure and processes to ensure they are representing the voice of LGBTQI+ people with disability, advocating for their needs and providing inclusive and culturally safe environments, services and supports.

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