

Findings from

Being LGBTQI+ in Ireland



Sub-report

Substance use among
LGBTQI+ young people
aged 14-30

Being
LGBTQI+
in Ireland



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Glossary

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

Binegativity refers to the negative attitudes, stereotypes, and prejudice directed specifically at bisexual individuals.

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

Chemsex refers to the use of high-risk drug(s) (e.g. gamma-hydroxybutyric acid/gamma-butyrolactone (GBH/GBL)) to enhance sexual experience.

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.

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 dysphoria is the intense distress or discomfort a person may feel when their gender identity (their internal sense of gender) does not match their sex assigned at birth.

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

Gender incongruence is a term used to describe people whose gender identity does not align, to a greater or lesser extent, with the sex assigned at birth.

Gender minority is a term for individuals whose gender identity or expression differs from their assigned sex at birth or does not adhere to traditional societal gender norms.

Gender non-conforming 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.

gbMSM is an abbreviation for gay, bisexual and other men who have sex with men.

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

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

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

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

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

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

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

LGBTQI+ stands for 'lesbian, gay, bisexual, transgender, queer/questioning and intersex' with the '+' signifying inclusivity to all sexual and gender identities. This is the acronym used in the present study.

LGBTQIA+ is an acronym for lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, and the + indicates expanding and new understandings of diverse gender and sexual identities.

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

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.

Monosexual is an umbrella term for sexual orientations involving attraction to only one gender or sex.

Non-binary 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.

Non-monosexual refers to people capable of attraction—romantic, emotional, or physical—to more than one gender.

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

Plurisexual is an umbrella term for sexual or romantic orientations that involve attraction to more than one gender.

Polysubstance use is the simultaneous use of two or more substances on the same occasion, or the concurrent use of two or more different substances in a given time period.

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.

Sexual minority is an umbrella term for individuals whose sexual orientation, attraction, or behaviours differ from the majority heterosexual population.

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

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

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.

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

Table of contents

Executive summary	10
Chapter 1: Introduction	14
Current Study	15
Substance use and young people in Ireland	15
Drug use among young people in Ireland	16
Alcohol use among young people in Ireland.....	17
International research on drug and alcohol use among S&GM populations	17
Drug and alcohol use among the S&GM populations in Ireland	18
Chemsex.....	19
Risk factors for substance use.....	20
Protective factors for substance use.....	22
Chapter 2: Methodology.....	23
Objectives.....	23
Research design	23
Survey questions	23
Demographic Profile of overall sample (14-30 age group)	27
Chapter 3: Findings	29
Drug use	29
Types of drugs taken	31
Reasons for taking drugs.....	32
Drug use settings.....	33
Alcohol use.....	34
Factors associated with drug use.....	35
Factors associated with alcohol use.....	38
Summary of findings	41
Chapter 4: Discussion.....	43
References.....	52
Appendices.....	62
Appendix A.....	62
Appendix B	64
Appendix C	66

List of tables

Table 2.1: Scoring of the DASS-42	26
Table 2.2: Internal consistency analysis	27
Table 2.3: Socio-demographic profile	27
Table 3.1: Top five drug substances used by people who used drugs in the past-year	31
Table 3.2: Top five drug substances among people who used drugs in the past-year by age cohort.....	32
Table 3.3: Reasons for drug use	32
Table 3.4: Drug use setting (past year).....	33
Table 3.5: Side effects of using drugs during or after chemsex	34
Table 3.6: Factors associated with drug use	36
Table 3.7: Factors associated with alcohol use	39
Table 4.1: Alcohol risk among LGBTQI+ young people compared to general youth population	44

List of figures

Figure 3.1: Drug use	29
Figure 3.2: Last time took drugs.....	29
Figure 3.3: Drug use risk.....	30
Figure 3.4: Drug use risk with categories merged	31
Figure 3.5: AUDIT	35
Figure 3.6: Results of logistic regression model of moderate/substantial/severe drug use ...	38
Figure 3.7: Results of logistic regression model of hazardous alcohol use.....	41

Executive summary

Introduction and research questions

National drug and alcohol policy has increasingly recognised the LGBTQI+ community as an at-risk group, requiring targeted prevention and early intervention responses to address their specific needs. This report, which was funded by the Department of Health in support of the National Drug Strategy, draws on data from *Being LGBTQI+ in Ireland*, a national study of the well-being and mental health of LGBTQI+ people in Ireland, to address the following research questions:

Q1: What proportion of sexual and gender minority young people (14-30 years) use drugs?

Q2: What types of drugs are most prevalent amongst sexual and gender minority young people (14-30 years)?

Q3: What are the reasons sexual and gender minority young people (14-30 years) give for using drugs, including location of use?

Q4: What proportion of sexual and gender minority young people (14-30 years) use alcohol?

Q5: What is the association between socio-demographic characteristics (e.g., ethnicity, age, sexual orientation, gender identity and area living) and drug and alcohol use amongst sexual and gender minority young people (14-30 years)?

Q6: What is the association between life experiences (e.g., experiencing/ witnessing bullying in school, experiencing/ witnessing online hate speech, parental support) and drug and alcohol use amongst sexual and gender minority young people (14-30 years)?

Q7: What is the association between drug and alcohol use and other mental health outcomes, including anxiety, depression, stress, suicidal distress (suicidal thoughts, suicidal behaviour), non-suicidal self-harm (NSSH), happiness, self-esteem and resilience?

Data collection

An online survey collected demographic information; life experiences; well-being and mental health status; and drug and alcohol use. Data were collected via a series of closed-ended questions, including the use of validated tools, namely the Depression Anxiety and Stress Scale (DASS-42), the Rosenberg Self-Esteem Scale (RSES), the Brief Resilience Scale (BRS), the Alcohol Use Disorders Identification Test (AUDIT) and the Drug Abuse Screening Test (DAST-10).

Findings

This report presents findings from 1,591 LGBTQI+ young people aged 14-30. The mean age of the sample was 21 years (N=1591, SD=5.03). Just over two-fifths identified as Transgender and gender non-conforming (TGNC) (42.5%) and nearly two-fifths as cis women (38.1%). A high

level of mental health difficulties were evident, with high rates of non-suicidal self-harm (NSSH) (65.8%) and suicidal thoughts (72.3%), and high levels of symptoms of severe/extremely severe depression (37.4%), anxiety (49.2%) and stress (30.6%).

Drug use

- 46.6% of participants used drugs in their lifetime. The lifetime rate of drug use among subgroups was: 17.4% for 14-17-year-olds, 52% for 18-24-year-olds and 69.7% for 25-30-year-olds.
- Two-fifths of the sample (39.9%) reported past-month drug use, one third reported past-year drug use (32.7%) and 27.4% reported that they had last taken drugs over one year ago.
- Among those who had taken drugs, past-year drug use was 91% among 14-17-year-olds, 80.2% among 18-24 year-olds and 60.7% among 25-30 year-olds.
- Approximately one tenth of the sample (11.9%) had DAST-10 scores indicative of moderate/substantial/severe risk drug use. This risk level increased with increasing age, being lowest for 14-17-year-olds at 6.2%, rising to 13.9% for 18-24-year-olds, and rising again to 15.1% for 25-30-year-olds.
- The vast majority of participants who took drugs in the past-year used Cannabis (89%), followed by Codeine-based drugs (48%), Cocaine (37%), Sedatives/tranquilisers (33%) and Solvents (29%).
- The vast majority of participants who took drugs in the past-year reported taking drugs 'to get high/for fun/for pleasure' (81.4%). Other prominent reasons included 'to reduce stress/relax' (60.0%), 'to socialize' (55.7%), 'out of curiosity/to experiment' (37.8%), 'to treat depression/anxiety' (37.1%) and to improve sleep (31.7%).
- The top three settings in which drugs were used were: 1) At home; 2) In a club/pub; and 3) Public space, such as street or park.
- A small proportion of the total sample (1.8%, n=28) reported that they attended chemsex parties/sex parties/afterparties, with alcohol, poppers and cocaine the top three substances used. Although most reported no immediate side effects, notable risks were identified, including hallucination, delusions, loss of consciousness and non-consensual sexual activity.
- Factors associated with higher odds of moderate-severe risk drug use are:
 - Being an urban dweller (compared to rural dweller)
 - Attempted suicide (compared to no history of attempted suicide)
- Factors associated with lower odds of moderate-severe risk drug use are:
 - Being a cis woman (compared to being a cis man)
 - Identifying as TGNC (compared to being a cis man)
 - Aged 14-17 (compared to being aged 25-30)
 - Witnessed anti-LGBTQI+ hate speech in public (compared to neither witnessed nor experienced anti-LGBTQI+ hate speech in public)

Alcohol use

- 7 in 10 (69.4%) participants had low risk alcohol consumption on AUDIT. Of these, 28% reported that they never drank alcohol.
- 3 in 10 (30.6%) participants had AUDIT scores indicative of harmful or hazardous drinking.
- Nearly one quarter (23.4%) of the sample scored within the moderate category on AUDIT, 3.3% of participants scored with the high-risk category, while 3.6% scored within the very high-risk category.
- More 14-17-year-olds scored as having low risk alcohol consumption (89.7%) compared to 18-24-year-olds (60.6%) and 25-30-year-olds (61.1%).
- Factors associated with higher odds of hazardous drinking are:
 - Urban dweller (compared to rural dweller)
 - Symptoms of moderate/severe anxiety (compared to none or mild symptoms of anxiety)
 - High resilience (compared to normal resilience) based on the RSES scale
- Factors associated with lower odds of hazardous drinking are:
 - Being a cis woman (compared to being a cis man)
 - Identifying as TGNC (compared to being a cis man)
 - Aged 14-17 (compared to being aged 25-30)
 - Q+ (Included queer, asexual, questioning and other) compared to being monosexual (lesbian/gay)

Study implications

The findings from our study, alongside the wider literature, indicate that individuals from the LGBTQI+ community may be at higher risk of substance use problems, and that these difficulties often co-occur with mental health and other difficulties. Consequently, it is imperative that LGBTQI+ young people are regarded as a key group when developing and implementing actions in relation to minority groups as part of the new National Drugs Strategy 2026-2029.

Recommendations

Recommendations to support harm reduction responses to drug and alcohol use among LGBTQ+ youth include the following:

- Drug and alcohol treatment services should adopt an LGBTQI+ affirmative service model and embed LGBTQI+ inclusion within policies, clinical standards and pathways to care, and reduce barriers to access, particularly for underserved groups.
- The findings reaffirm the need for ring-fenced multiannual investment in community-based LGBTQI+ inclusive supports for young people experiencing problematic drug and alcohol use. LGBTQI+ people with lived experience should have a key role in shaping these services.
- Interventions developed to support young people experiencing problematic drug and alcohol use should be evaluated to determine their appropriateness for sexual and

gender minority (S&GM) populations and their efficacy in reducing substance use and associated harms.

- Fund regional LGBTQI+ initiatives, including community groups, to provide access to alcohol and drug free spaces and facilities for LGBTQI+ young people.
- In line with the aims of *The National Sexual Health Strategy 2025-2035*, scope public health responses to reduce the sexual health and drug related harms associated with chemsex.
- Conduct a national mapping exercise of substance use prevention and intervention programmes delivered through LGBTQI+ youth organisations. Use findings to strengthen existing programmes and develop evidence-based, LGBTQI affirmative initiatives that are co-designed with LGBTQI+ young people and other relevant experts.

Research recommendations to address knowledge gaps include the following:

- There is a need to pursue further research on youth mental health and alcohol and drug use to facilitate comparisons between minority groups, including gender and sexual minorities, and the general population. This type of knowledge is critical to support equitable allocation of services.
- There is also a need for further research into chemsex to facilitate comparisons between S&GM young people and their non-S&GM peers.
- Although various socio-demographic factors were included in the analysis, there is a need for further research that explores intersectional effects (i.e., how different intersecting identities may influence alcohol and drug use, such as, gender identity, minority sexual orientations, ethnicity, education, family/housing context etc.).
- Existing health surveys and future research on mental health and drug and alcohol use should capture gender identity and sexual orientation data as well as have targeted recruitment strategies for including minority groups within studies, including sexual and gender minorities.
- Fund a repeat survey of *Being LGBTQI+ in Ireland* in 2030.

Chapter 1: Introduction

Irish drug and alcohol policy has increasingly recognised the LGBTQI+ community as an at-risk group, requiring targeted prevention and early intervention responses to address their specific needs (Department of Community, Rural & Gaeltacht Affairs, 2005; Department of Health (DoH), 2017). While early references to LGBTQI+ people within policy were limited to noting high levels of drug use among men involved in prostitution (Department of Tourism, Sport & Recreation, 2001), and that “gay/lesbian/bisexual young people” potentially warranted consideration from a prevention perspective (Department of Community, Rural & Gaeltacht Affairs, 2005, p. 27), it wasn’t until the publication of the National Drug Strategy in 2009 that more focus was given to the LGBTQI+ community.

Despite acknowledging the limited research available at the time, the LGBT¹ community was identified as an at-risk group from recreational drug use requiring targeted prevention and tailored treatment (Department of Community, Rural and Gaeltacht Affairs, 2009). The most recent national drug strategy (2017-2025) noted that LGBTQI+ young people were more likely to use illicit substances and binge drink compared to the general population (Department of Health (DoH), 2017) and drew attention to the phenomena of chemsex². Consequently, the strategy included several strategic actions aimed at improving service capacity to accommodate the needs of the LGBTQI+ community, strengthening early harm reduction responses alongside increasing collaboration with the LGBTQI+ community to ensure that education and prevention were appropriately delivered (Department of Health (DoH), 2017, p. 30).

A subsequent progress report on this strategy reaffirmed the need for improved access and tailored services for the LGBTQI+ community (Drugs Policy and Social Inclusion Unit, 2021), and similarly noted the need for “a stronger focus” on research related to drug and alcohol use in the LGBTQI+ community. The dearth of research has also been recognised in the recently published National LGBTQI+ Inclusion Strategy II (2024-2028) (Department of Children, Disability & Equality, 2025), which contains an action (point 18) focused on conducting research to understand drug use among LGBTQI+ young people. Although it explicitly mentions drug use, research on alcohol use among LGBTQI+ youth populations is also required given the high levels of hazardous drinking and alcohol use disorder found among Irish youth (Doyle et al. 2022; HRB National Drugs Library, 2025). While there are good sources of data on drug and alcohol use among people in Ireland, the Health Research Board (Doyle et al. 2024) noted limited information or a lack of up-to-date information on drug and alcohol use among certain minority populations, including sexual and gender minority groups (S&GM). This is possibly due to the absence of questions in population-based surveys that capture gender beyond the binary of male and female, and the absence of questions on sexual orientation. In this context, the current study aims to address some of this gap.

¹ LGBT has since expanded to LGBTQI+ and other variations of this in policy documents to reflect the sexual and gender diversity that exists within the community.

² Chemsex refers to the use of high-risk drug(s), such as gamma-hydroxybutyric acid/gamma-butyrolactone (GBH/GBL), as part of the sexual experience.

Current Study

The *Being LGBTQI+ in Ireland* study is a national cohort study which examined the mental health and well-being of the LGBTQI+ community in Ireland (N=2,802). This national survey included questions relating to substance use. Data were collected 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 (Higgins et al. 2024). This report, which was funded by the Department of Health in support of the National Drug Strategy, draws on data from young people aged 14-30 (n=1,591) to address the following research questions:

Q1: What proportion of sexual and gender minority young people (14-30 years) use drugs?

Q2: What types of drugs are most prevalent amongst sexual and gender minority young people (14-30 years)?

Q3: What are the reasons sexual and gender minority young people (14-30 years) give for using drugs, including location of use?

Q4: What proportion of sexual and gender minority young people (14-30 years) use alcohol?

Q5: What is the association between socio-demographic characteristics (e.g., ethnicity, age, sexual orientation, gender identity and area living) and drug and alcohol use amongst sexual and gender minority young people (14-30 years)?

Q6: What is the association between life experiences (e.g., experiencing/ witnessing bullying in school, experiencing/ witnessing online hate speech, parental support) and drug and alcohol use amongst sexual and gender minority young people (14-30 years)?

Q7: What is the association between drug and alcohol use and other mental health outcomes, including anxiety, depression, stress, suicidal distress (suicidal thoughts, suicidal behaviour), non-suicidal self-harm (NSSH), happiness, self-esteem and resilience?

To set the study in context, the remainder of this chapter provides a brief overview of data relating to drug and alcohol use among young people in Ireland generally before presenting data on the LGBTQI+ population in Ireland. It also provides an overview of literature on chemsex as well as the international literature on risk and protective factors related to drug and alcohol use.

Substance use and young people in Ireland

Adolescence and young adulthood are critical developmental periods characterised by increased experimentation and risk-taking behaviours (Feldstein & Miller, 2006). During these stages, young people may be particularly susceptible to engaging in substance use due to personal, social, and environmental influences (Kirby et al. 2008). The gravity of the issue of substance use among young people in Ireland is evident from the fact that substance-related hospitalisations among young people is increasing (Doyle et al. 2022). The consequences of

substance use are potentially significant, including increased risk of injury, accidents, and engagement in risky behaviour, including risky sexual behaviour (Feldstein & Miller, 2006). In addition, alcohol and drug related harm can extend to academic underperformance, family and peer conflict, as well as carry long term physical and mental health consequences (Yap et al. 2017; Esposito et al. 2025). Irish research has also found that substance use is associated with mental health issues, including anxiety, NSSH and suicide, and criminal behaviour, with the majority of young people referred to Probation Services reporting alcohol and/or drug misuse (HRB National Drugs Library, 2025).

Drug use among young people in Ireland

Cannabis is the most used illicit drug among adolescents in Ireland, with one-in-five having tried it (Doyle, 2022). Ireland ranks highest for cocaine use among young adults aged 15 to 34 in Europe (European Drug Report, 2023). Trend data also shows a rise in the use of stimulants, including ecstasy and cocaine, while treatment for cocaine use among young people has increased by 171% between 2011 and 2019 (Doyle et al. 2022). In the ESPAD (European Schools Project on Alcohol and Other Drugs, 2024) survey involving 1,880 students aged 15-16 years, in Ireland, 14 years of age was the most frequently reported starting age for using cannabis. Further, one tenth of students (10.2%) reported using cannabis in the last 12 months and 5% (4.9%) in the previous 30 days (Hanafin et al. 2025).

A representative survey of drug and alcohol use among the general public (5,000+) aged 15+ found that 15–24 year-olds were most likely to report recent illegal drug use (18.5%) and that the median age of first drug use has decreased for most illegal drugs since 2002–03. The report also found that among males aged 15–24 years, recent illegal drug use increased from 17.1% in 2002–03 to 25.4% in 2014–15, but decreased to 20.6% in 2019–20, and that the prevalence of illegal drug use among females aged 15–24 years and 25–34 years has doubled since 2002–03, although it remains comparatively lower than males (Mongan et al. 2021).

Data from the 2023 Healthy Ireland Survey found that 15-24 year-olds are most likely to report last year drug use (20%), with a higher prevalence among men aged 15-24 than women of this age (23% vs. 16%; Ipsos B&A, 2023). The survey also reported lifetime cannabis prevalence of 31% among 15-24s, while past-year and past-month prevalence of cannabis among this cohort were 18.5% and 8% respectively.

Data from the Growing up in Ireland (GUI) studies found that 30% of the 17/18-year-old cohort reported having tried cannabis, with this figure increasing to 59% among the 20-year-old cohort. Of this cohort, 18% reported occasional use while 6% reported using it more than once per week (HRB National Drugs Library, 2025). Factors associated with increased odds of cannabis use specifically among Irish adolescents include being outside after midnight in the previous week, a lack of parental rule-setting, parental monitoring, intergenerational closure, and lack of participation in sports or volunteering (Daly et al. 2025).

Alcohol use among young people in Ireland

While recent data shows that Ireland's per capita alcohol consumption has decreased, alcohol use remains a significant public health issue, being the eighth leading cause of death in Ireland with one person dying every day due to alcohol-related liver disease (Doyle et al. 2024). Although data from the Health Research Board (HRB) shows that the average age of first consuming alcohol among young people is increasing, approximately 50,000 young people start drinking alcohol every year, with 16.6 years old being the average age of having their first alcoholic drink (Alcohol Action Ireland, 2025). Between 2018 and 2024, there has been an increase in alcohol consumption from 66% to 78% among the 15-24 age cohort, reversing the earlier trend of a decline in alcohol consumption since the 2000s which could mostly be attributed to a decline among the youngest adolescents under the age of 17. Data shows that most young adults (90%) have consumed alcohol by the age of 18, which increases to 96% by the age of 20 (HRB National Drugs Library, 2025). Research also indicates that 78% of individuals aged 15-24 report consuming alcohol in the previous 12 months, with nearly 2 in 5 (39%) men aged 15-24 who consume alcohol at risk of hazardous drinking (females aged 15-24: 25%) (Ipsos B&A, 2025).

Binge drinking is particularly prevalent, with data indicating that this is particularly prevalent among men aged between 15 and 24, with 51% of young men compared to 24% of women of the same age engaging in binge drinking (Ipsos B&A, 2025). In the NDAS general population representative survey of over 5000+ people aged 15+, among men aged 15–24 years who consumed alcohol, 63.1% engaged in monthly heavy episodic drinking compared to 49% of women aged 15-24 who consumed alcohol, and 37% had an alcohol use disorder (38% for females) (Mongan et al. 2021).

Several factors have been linked to alcohol misuse among young people in Ireland, including parental provision of alcohol, parental substance use, early initiation of alcohol use and exposure to alcohol marketing (Doyle et al. 2022; HRB National Drugs Library, 2025). Factors associated with increased odds of binge drinking specifically include poor self-rated mental health, current tobacco or cannabis use, having friends who drink alcohol, and participation in team/club sports (Kelly et al. 2023). Protective factors identified include less tolerance of drunkenness among parents, more parental supervision, and positive parental relationships (Doyle et al. 2022; HRB National Drugs Library, 2025).

International research on drug and alcohol use among S&GM populations

Recent scoping reviews consistently report elevated risks of harmful alcohol use and drug use among S&GM populations, including youth (Kidd et al. 2018; Hughes et al. 2020; Hughes et al. 2023; McCabe, 2025), with UK-based studies demonstrating higher rates of harmful alcohol and drug use among S&GM populations compared to heterosexual and cisgender populations (Meads et al. 2023; Murray et al. 2024).

Data from various sources also indicates that there may be disparities between S&GM and heterosexual and cisgender subcommunities. For example, evidence suggests that substance use (alcohol and drug) inequities are more pronounced among sexual minority women than

men (Paschen-Wolff et al. 2019), with a recent global scoping review (Hughes et al. 2020) reporting that sexual minority women have higher levels of substance use compared to heterosexual women. In particular, bisexual women have higher levels compared to other sexual minority women and heterosexual women. Similarly, research also indicates higher substance use disorders among transfeminine people compared to transmasculine people (Connolly et al. 2025; Mammadli et al. 2025).

Hazardous alcohol use, substance use disorder and misuse of prescription drugs is reported among transgender and gender non-conforming (TGNC) populations (Gilbert et al. 2018; Connolly and Gilchrist, 2020), including in a systematic review which found that 14.7% of 577 participants with a diagnosis of gender dysphoria reported substance-related disorders (de Freitas et al. 2020). While Connolly and Gilchrist's (2020) systematic review suggests higher rates of substance use among transgender adults compared to cisgender peers, more recent meta-analytic findings comparing the two cohorts found that while lifetime substance use was comparatively higher among the transgender sample, there were no differences in current alcohol and drug use, and substance use disorders (Cotaina et al. 2022).

Among sexual minority youth, recent meta-analytic evidence indicates higher levels of substance use (alcohol and drug), earlier initiation, and greater polysubstance, particularly among plurisexual participants (bisexual, pansexual), girls and young women, and those 18 years of age or younger (Mereish et al. 2025). Similar patterns are observed among gender minority youth, in terms of earlier initiation, and higher levels of substance use (drug and alcohol), when compared to cisgender peers (Mereish, 2019). There are, however, some inconsistencies across the literature. For example, although a scoping review of Transgender and Gender Diverse (TGD) youth found higher levels of recent alcohol consumption, binge drinking and marijuana use compared to cisgender peers, for non-binary youth, the research found that their alcohol outcomes did not differ from their cisgender peers (Fahey et al. 2023).

These variations in findings highlight potential differences in outcomes measures and definitions of hazardous alcohol or drug use across the studies (Gilbert et al. 2018). Furthermore, the overrepresentation of socially and economically marginalised individuals in some studies may inflate estimates of drug and alcohol use, complicating efforts to generalise findings to the broader sexual and gender minority populations (Connolly and Gilchrist, 2020; Cotaina et al. 2022).

Drug and alcohol use among the S&GM populations in Ireland

Evidence on drug and alcohol use among S&GM populations in Ireland remains limited. This section provides an overview of available research in order of the earliest publication.

A 2007 study of young LGBT adults aged 18-25 (n=173) reported a high level of past-year drug use (60%), with 21% reporting frequent use (60+ occasions), alongside negative consequences such as impaired work performance (56%), absenteeism (49%), blackouts (49%) and engagement in unprotected sex (46%) (Sarma, 2007).

Later, a 2015 survey of MSM in Ireland found that 48% of those aged 18-25, reported past-year illegal drug use, with cannabis being the most used substance (43%). Associated factors

included being a student, living in Dublin, tobacco use, binge drinking, greater openness about sexual identity, and HIV testing status (Barrett et al. 2019).

The *LGBTIreland* Study, a national survey of the health and wellbeing of over 2,000 LGBTI+ participants, reported lifetime recreational drug use of 30% among those aged 14–18, increasing to 63% among those aged 19-25. Additionally, among those who drank, 38% of 14–18-year-olds and 52% of those aged 19-25s had AUDIT scores of 8 or higher, indicating hazardous alcohol use (Higgins et al. 2016).

Irish data from the European MSM Internet Survey found that 29.1% of MSM aged 18-24 without a HIV diagnosis reported recreational drug use, while 20% reported sexualised drug use (chemsex). Factors associated with higher odds of recreational drug use included younger age, living in Dublin and engaging in condomless anal intercourse (CAI) in the previous year. Factors associated with higher odds of sexualised drug use included living in Dublin and engaging in CAI (Daly et al. 2023).

A qualitative study of the experiences of homeless LGBTQI+ youth (aged 18-30; n=22) found that this group faces elevated risks of substance use. Participants frequently reported that substance use either began or escalated following experiences of homelessness, often as a coping response to the stress of the situation and influenced by negative peer environments (Quilty & Norris, 2020).

A survey of over 2,200 LGBTQ+ youth aged 14-24 exploring experiences of lockdown during the COVID-19 pandemic reported that, among those who used drugs, 74% indicated that their LGBTQ+ identity was not accepted at home, suggesting a potential link between substance use and parental rejection (GCN, 2025).

A 2021 survey of nearly 1,000 gay, bisexual and other men who have sex with men (gbMSM) found that 27% of gbMSM who had drunk in the last year screened positive for alcohol use disorder (Witzel et al. 2022). Statistically significant higher prevalences of alcohol use disorder were found among those who lived in Dublin. The three most used drugs in the past year for this cohort were: cannabis (62%, n=188), cocaine (58%, n=174) and MDMA (46%, n=138).

Chemsex

Chemsex, which refers to the use of high-risk drug(s) such as gamma-hydroxybutyric acid/gamma-butyrolactone (GBH/GBL) to enhance sexual experience, is a phenomenon particularly present among MSM. It often involves gatherings where people engage in both drug use and prolonged period of sexual activity, frequently with multiple partners.

Internationally, a recent global meta-analysis reported prevalence rates of 22% for chemsex and 25% for sexualised drug use among MSM (Georgiadis et al. 2025). In Ireland, the reported past-year prevalence of chemsex among MSM is slightly higher at 27%. This figure is based on a 2016 survey conducted among men attending the Gay Men's Health Service (GMHS) in Dublin over a six-week period (Glynn et al. 2018).

Chemsex represents a significant public health concern. It has been associated with increased engagement in high-risk sexual behaviours as well as increased risk of transmission of HIV,

hepatitis B and C, and other sexually transmitted infections (Health Protection Surveillance Centre, 2018; Kenyon et al. 2018; Satapathy et al. 2025). In addition, chemsex has been linked to adverse mental health outcomes, including symptoms of depression and anxiety, and has been shown to negatively impair social functioning across multiple life domains, including work, family life, and personal relationships (Bohn et al. 2020; Whitlock et al. 2021; Lagojda et al. 2025). Furthermore, MSM populations report experiencing a range of adverse consequences during or immediately following chemsex, such as loss of consciousness, non-consensual sex and sexual assault (Glynn et al. 2018; Bohn et al. 2020). The risk of drug related harms, including addiction and dependency, is also significantly increased (Strong et al. 2022; Wang et al. 2023).

Risk factors for substance use

Minority Stress Theory is the dominant framework used to explain health disparities among S&GM populations (Meyer, 2003). It proposes that, in addition to general life stressors, S&GM individuals experience unique, chronic stressors grounded in prejudice and stigma (Parent et al. 2019). These include external or distal stressors, such as discrimination, harassment, violence and structural inequalities, as well as internal or proximal stressors, such as identity concealment, internalizing stigma and expectation of rejection. Together these stressors accumulate to produce worse health outcomes for individuals with minority identities. The Minority Stress Theory has been extended to acknowledge the experiences of gender minority populations (Miller-Perusse et al. 2024), through the Gender Minority Stress and Resilience model (GMSR) (Hendricks and Testa, 2012). This model identifies external stressors such as gender-related stigma, victimisation and non-affirmation alongside internal stressors, like internalised transphobia and identity incongruence.

There is an abundance of research evidence which supports the Minority Stress Model as an explanatory framework for substance use disparities in S&GM youth. A meta-analysis of LGB youth found that victimization, lack of support from parents and adults in school, negative disclosure reactions and housing instability were strong predictors of substance use (drug and alcohol) (Goldbach et al. 2014). More recent scoping reviews of substance use among S&GM youth affirm many of these risk factors, including experiences of victimisation, discrimination, bullying and violence (Kidd et al. 2018; Fahey et al. 2023), with a study of S&GM youth in the Netherlands reporting that the experience of prejudice, internalised stigma and concealment of one's identity contributed to greater alcohol and cannabis use (Hughes et al. 2023). A longitudinal research study, involving 30 GM adolescents aged 13–17 years, found that exposure to gender minority stressors, namely experiences of victimisation and rejection of one's identity, and internalised transphobia were associated with higher odds of alcohol use (Katz-wise et al. 2021). Brown et al.'s (2024) review of qualitative data from LGBTQIA+ adolescents identified negative peer interactions and homelessness as key risk factors for drug use. Housing instability, incarceration, and foster care involvement also emerged as factors contributing to substance use in Mammadli et al.'s (2025) study of TGNC youth and young adults in the US. Indeed, longitudinal research shows that sexual minority youth who were rejected and evicted by their parents had a higher likelihood of substance issues as adults

(Pearson et al. 2017), which in turn may increase economic challenges, discrimination, and challenges to health care utilisation (Connolly et al. 2025).

At subgroup level, binegativity and intersectional disadvantage can compound the risk of substance misuse (Xin et al. 2023; Rothstein et al. 2024). High rates of drug use may also be influenced by co-occurring trauma and mental health problems (Brown et al. 2024), with both general and identity-related psychological stress, depression, anxiety and suicidal ideation, and behavioural challenges being predictors of substance use in LGB youth (Goldbach et al. 2014).

Social learning theory offers another perspective, suggesting that substance use behaviours are shaped by both perceived and actual norms within peer groups and social networks (Mereish, 2019; Boyle et al. 2020). LGBTQI+ community affiliation may be associated with higher substance use due to more permissive attitudes and norms towards substance use compared to the general population, because the social and cultural landscape is often tied to bars and clubs where substances are readily available (Dimova et al. 2022; Murray et al. 2024). Indeed, research indicates that some sexual minority young people may hold more permissive attitudes towards substance use compared to heterosexual peers (Mereish, 2019), with a meta-analysis linking LGBTQI+ community connectedness with increased smoking and alcohol use (Lefevor et al. 2024).

Research also suggests that substance use among S&GM youth may be, at least in part, associated with motives such as social enhancement and conformity (Mereish et al. 2025). For example, a study of LGB youth found that alcohol consumption can facilitate identity expression and temporarily relaxing of gender norms (Peralta, 2008). Another study of trans and non-binary people (n=462) in the UK found that coping motives, enhancement motives, and drinking to manage dysphoria were associated with higher AUDIT scores (Davies et al. 2024). However, empirical evidence on the influence of social context and enhancement motives is sparse (McCabe, 2025).

The literature on the risk factors for the S&GM adult population echoes some of the research evidence from youth populations. Like younger populations, where alcohol consumption was a coping response to worries (Hughes et al. 2023), alcohol also served as a coping resource and was relied upon for emotional support in adults (Meads et al. 2023). In addition, a systematic review of alcohol use among S&GM adults in the US found a relationship between structural stigma, in terms of state law and policies and adverse alcohol outcomes among sexual minority women, particular bisexual women (Zollweg et al. 2023). Among sexual minority women, excess alcohol consumption has been found to co-occur with anxiety and depression (Kidd et al. 2022). Connolly and Gilchrist's (2020) systematic review report several risk factors for substance use among trans adults, including having a sexual minority identity, gender dysphoria, socially visible gender non-conformity, experiencing discrimination, stigma and violence, unemployment and engaging in sex work.

Protective factors for substance use

Although the Minority Stress theory (Meyer, 2003) and the Gender Minority Stress and Resilience (GMSR) model (Hendricks and Testa, 2012) recognise the importance of protective and resilience factors, including community connectedness and gender related pride, which may mitigate the effects of minority stress (Cotaina et al. 2022; Miller-Perusse et al. 2024), there remains a notable research gap on protective factors for substance use among S&GM youth (Kidd et al. 2018; Fahey et al. 2023; Zollweg et al. 2023). In particular, there is a need for studies to disaggregate adolescents and young adults in order to identify factors unique to each group (Mereish, 2019).

That said, existing evidence suggests several potential protective factors, including sexual and gender-affirming policies and environments, parental monitoring and connectedness, school connectedness, peer support, and individual characteristics, such as higher self-esteem (Kidd et al. 2018; Mereish, 2019). One study of gender minority adolescents identified resilience and gender-related pride as protective with family functioning and social support also being protective, albeit to a lesser extent (Katz-Wise et al. 2021). Similarly, social support, community connectedness and gender affirmation have been identified as protective among TGNC youth and young adults (Mammadli et al. 2025). However, findings are not entirely consistent as Fahey et al. (2023) found no evidence that gender affirmation reduced the risk of substance use among gender minority youth.

Chapter 2: Methodology

Objectives

Drawing on the *Being LGBTQI+ in Ireland* dataset, this report addresses the following research questions:

Q1: What proportion of sexual and gender minority young people (14-30 years) use drugs?

Q2: What types of drugs are most prevalent amongst sexual and gender minority young people (14-30 years)?

Q3: What are the reasons sexual and gender minority young people (14-30 years) give for using drugs, including location of use?

Q4: What proportion of sexual and gender minority young people (14-30 years) use alcohol?

Q5: What is the association between socio-demographic characteristics (e.g., ethnicity, age, sexual orientation, gender identity and area living) and drug and alcohol use amongst sexual and gender minority young people (14-30 years)?

Q6: What is the association between life experiences (e.g., experiencing/ witnessing bullying in school, experiencing/ witnessing online hate speech, parental support) and drug and alcohol use amongst sexual and gender minority young people (14-30 years)?

Q7: What is the association between drug and alcohol use and other mental health outcomes, including anxiety, depression, stress, suicidal distress (suicidal thoughts, suicidal behaviour), non-suicidal self-harm (NSSH), happiness, self-esteem and resilience?

Research design

The *Being LGBTQI+ in Ireland* 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). As stated, this report draws on data from young people aged 14-30 in the *Being LGBTQI+ in Ireland* study (n=1591).

Survey questions

Substance use

AUDIT: Alcohol Use Disorders Identification Test (AUDIT), which is a 10-item self-report screening tool, was used to assess alcohol consumption (Babor et al. 2001). Scores are calculated by scoring responses from zero to four and totalling (maximum score =40). Scores of 8 or more are indicative of hazardous and harmful alcohol use, as well as possible alcohol dependence. Alcohol consumption falls into four categories: low risk level of alcohol consumption (0-7), moderate risk level of alcohol consumption (8-15), high risk level of

alcohol consumption (16-19), and a very high-risk level of alcohol consumption (20+).

Drug use: To assess drug use, participants were first asked whether they had ever taken drugs, (other than those required for medical reasons) in their lifetime. Those who indicated yes to this question were subsequently asked the last time they had taken drugs, with three response options available: Within the last month; within the last year; more than one year ago. The Drug Abuse Screening Test (DAST-10), which is a brief 10 item, self-report instrument for drug use in the previous 12 months, was then administered to participants who indicated past year drug abuse. DAST-10 scores range from 0 to 10. A score of zero indicates no evidence of drug related problems in the past 12 months. As the DAST score increases there is a corresponding rise in the level of drug problems reported. The level of drug problems may be categorised as follows: Low (1-2); Moderate (3-5); Substantial (6-8) and Severe (9-10) (Skinner, 1982). Participants who took drugs within the last year were asked additional questions related to their drug use. They were provided with a list of drugs and asked which they had taken in the past month and past year while they were also asked to select reasons for taking drugs in the past year from a list and in which settings they had taken drugs in the past year.

Chemsex: Questions relating to chemsex were only visible to survey participants aged 18 and over. If the 18+ age cohort reported that they had taken drugs at a 'Chemsex party/Sex party/After party', they were then asked a series of questions, including how often they attended such parties with the intention of using drugs to enhance their experience of sex, which substances they had used, any side effects and hospitalisation experienced related to chemsex, and an open-ended question regarding their reasons for engaging in chemsex.

Socio-demographic variables

Gender identity: A two-step approach to collecting gender identity was used. Participants were asked: 1) how they identified their gender, with four response options available: i) man; ii) woman; iii) non-binary; iv) not listed: please describe; and 2) whether their gender identity matched the sex they were assigned at birth. Participants who responded 'no' to this latter question were then asked if they identified as transgender. Based on the responses to these gender questions, a new gender variable was created consisting of three categories in order to ensure a comparable number of participants in each group: cisgender women, cisgender men, and Transgender and Gender Non-Conforming people (TGNC).

Age: Age in years was asked. For the purpose of analysis, age was recoded into three groups: 14-17, 18-24 and 25-30 to differentiate between adolescence and young adulthood.

Sexual orientation: Participants were asked: 'What term do you usually use to describe your sexual orientation?' Nine response categories were provided: Lesbian, gay, bisexual, queer, heterosexual, asexual, pansexual, questioning, and other. For the purpose of analysis, sexual orientation was regrouped as follows: Monosexual (Lesbian, gay); Non-monosexual (Bisexual, Pansexual); Q+ (Included queer, asexual, questioning and other³).

³ Other included sexual orientations such as omnisexual, demisexual, aromantic, panromantic and a small number of people who identified their sexual orientation as heterosexual (n=14)

Ethnicity: The Census 2022 (CSO, 2022) question on ethnicity was used, with the addition of the category Latino/Latina/Latinx. For the purpose of analysis, ethnicity was recoded into two groups: White Irish; Ethnic minorities (all other groups: i.e. Irish Traveller, Roma, Any other White background, African, Any other Black background, Chinese, Indian/Pakistani/Bangladeshi, Any other Asian background, Latino/Latina/Latinx, Arabic, Mixed, Other)

Area living: Five response options were available for area living, including rural/countryside, village, town, suburb and city. For the purpose of analysis, area living was recoded into two categories: Rural (countryside/village); Urban (town/suburb/city).

Life experience variables

LGBT bullying in school: Participants who were currently enrolled in secondary school or had attended school in the Republic of Ireland within the past five years were asked if they ever experienced or witnessed homophobic, biphobic or transphobic bullying in school. Response options were 'yes' and 'no'.

Support from immediate family: Support for one's LGBTQI+ identity from one's immediate family was ascertained by asking participants how supportive family were with five response categories available: very unsupportive, somewhat unsupportive, neither, somewhat supportive, very supportive. For the purposes of analysis, support was recoded into two groups: Very unsupportive/unsupportive/neither; and very supportive/supportive.

Anti-LGBTQI+ Hate Speech: Participants were asked if they had ever experienced or witnessed anti-LGBTQI+ hate speech either online or in public media (Newspapers, TV, Radio, Social media)?". Three response options were given: 1) Yes, experienced it; 2) Yes, witnessed it; and 3) No, never.

Mental health variables

Depression, anxiety and stress: The Depression Anxiety and Stress Scales (DASS-21; Lovibond & Lovibond, 1995) were developed to provide self-report measures of anxiety, depression and stress by assessing negative emotional symptoms experienced in the previous week. The scale has three subscales 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 subscale 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 subscale (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 0 to 42, with higher scores reflecting higher levels of distress. Scores are categorised into five groups: normal, mild, moderate, severe, and extremely severe. While not a diagnostic tool, this categorisation provides an indicator of the severity of the negative emotions of depression, anxiety, and stress. Interpretation of severity is based on cut-off points, with higher scores indicating greater levels of distress; for example, 'mild' means that the person is above the population mean, but still well below the typical

severity of people seeking help (see Table 2.1 for cut-off points). For the purpose of analysis, five categories were reduced to three: Normal/mild; Moderate; Severe/extremely severe.

Table 2.1: 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+

Non-suicidal self-harm and suicidality: NSSH and suicidality questions were derived from the Lifestyle and Coping Survey (Madge et al. 2008). For NSSH, 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.

Self-esteem: Rosenberg's Self-Esteem Scale (RSES) 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. Self-esteem scores were categorised as follows: Low (0-25); Normal/medium (26-29); High (30-40).

Resilience: The Brief Resilience Scale (BRS) (Smith et al. 2008) is a reliable and valid six item scale that assesses self-perceived ability to bounce back or recover quickly from stress. Each item is scored on a 5-point Likert scale ranging from 1 (low resilience) to 5 (high resilience). Resilience scores were categorised as follows: Low (1.00-2.99); Normal/medium (3.00-4.30); High (4.31-5.00).

Happiness: Participants were asked, 'Taking all things together, how happy would you say you are?' on a scale of 0 meaning 'extremely unhappy' to 10 meaning 'extremely happy'. Happiness scores were categorised as follows: Low (0-4); Normal/medium (5-7); High (8-10).

Data analysis

Quantitative data

The quantitative data were analysed in SPSS Statistics Version 27 (IBM Corporation, 2020). Frequencies and percentages were generated for nominal/ordinal variables, and means, medians, standard deviations and ranges were reported for continuous variables. 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 scales achieved high Cronbach's Alpha values (>.70) for the sample (14-30) indicating that they are reliable measures (Table 2.2).

Chi-square tests were performed to identify statistically significant associations between the categorical predictor variables and the dependent variables (Alcohol use, Drug use). Statistically significant associations and those approaching statistical significance ($0.05 < p\text{-value} \leq 0.1$) in the bivariate analyses were then entered into multivariate logistic regression models. Listwise deletion was selected to handle missing data. A p-value of ≤ 0.05 was used to benchmark statistical significance. Two variables, experienced and witnessed LGBT+ bullying in school, were excluded from the multivariate analysis as only a subset of the sample answered this question.

Table 2.2: Internal consistency analysis

Measure	Cronbach's Alpha
AUDIT	0.83
DAST-10	0.74
DASS-42 - Depression subscale	0.92
DASS-42 - Anxiety subscale	0.87
DASS-42 - Stress subscale	0.85
RSES	0.91
BRS	0.87

Demographic profile of overall sample (14-30 age group)

Participants' socio-demographic profile and other background information is outlined in Table 2.3. The mean age of the 14-30 sample was 21 years ($N=1591$, $SD=5.03$). Two-fifths identified as Transgender and gender non-conforming (TGNC). Many sexual orientations were represented, 36.2% identified as monosexual (lesbian or gay) and 35.3% as non-monosexual (bisexual or pansexual). A high level of mental health difficulties were evident, with high rates of NSSH and suicidality, and high levels of symptoms of depression, anxiety and stress (Table 2.3). The means scores for happiness, resilience and self-esteem were 5.57 ($N=1487$, $SD=2.18$, $\text{Range}=0-10$), 2.69 ($N=1588$, $SD=0.84$, $\text{Range}=1-5$) and 24.49 ($N=1568$, $SD=6.25$, $\text{Range}=10-40$) respectively.

Table 2.3: Socio-demographic profile

Characteristic	Category	N	%
Age	14-17	496	31.2
	18-24	613	38.5
	25-30	482	30.3
Gender identity	Cis man	307	19.4
	Cis woman	602	38.1
	TGNC	671	42.5
Sexual orientation	Monosexual (Lesbian/gay)	576	36.2
	Non-monosexual	561	35.3
	Q+	453	28.5
Ethnicity	White Irish	1304	82.0
	Ethnic minority	287	18.0
Area living	Rural	452	30.8
	Urban	1015	69.2

Living situation	Live alone	41	2.8
	Live with parents/ guardian, family members	997	68.0
	Live with partners/ spouses (same/opposite sex)	163	11.1
	Live with friends/house mates	240	16.4
	Supported/state accommodation/homeless	5	0.3
	Other	19	1.3
Support for LGBTQI+ identity from immediate family	Unsupportive/Neither	406	27.8
	Supportive	1052	72.2
Experienced or witnessed anti-LGBTQI+ hate speech in public media	Yes, experienced it	387	24.3
	Yes, witnessed it	919	57.8
	No	178	11.2
Experienced LGBT bullying in school	Yes	488	48.8
	No	512	51.2
Witnessed LGBT bullying in school	Yes	790	78.9
	No	211	21.1
Non Suicidal Self-harm	Yes	981	65.8
	No	509	34.2
Suicidal thoughts	Yes	1068	72.3
	No	409	27.7
Suicidal attempts	Yes	431	30.7
	No	973	69.3
Depression	Normal/mild	592	40.0
	Moderate	334	22.6
	Severe/extremely severe	553	37.4
Anxiety	Normal/mild	499	33.6
	Moderate	256	17.2
	Severe/extremely severe	730	49.2
Stress	Normal/mild	721	48.5
	Moderate	312	21.0
	Severe/extremely severe	455	30.6
Resilience	Low	975	61.4
	Normal/medium	566	35.6
	High	47	3.0
Self-esteem	Low	910	58.0
	Normal/medium	326	20.8
	High	332	21.2
Happiness	Low	454	30.5
	Normal/medium	776	52.2
	High	257	17.3

Chapter 3: Findings

This chapter presents the findings on drug and alcohol use among sexual and gender minority people aged 14-30, including an analysis of the factors associated with drug and alcohol use.

Drug use

Approximately half of the sample (46.6%) had taken drugs (other than those required for medical reasons) in their lifetime. Lifetime drug use was 17.4% for 14-17s, 52% among 18-24s and 69.7% among 25-30-year-olds (Figure 3.1).

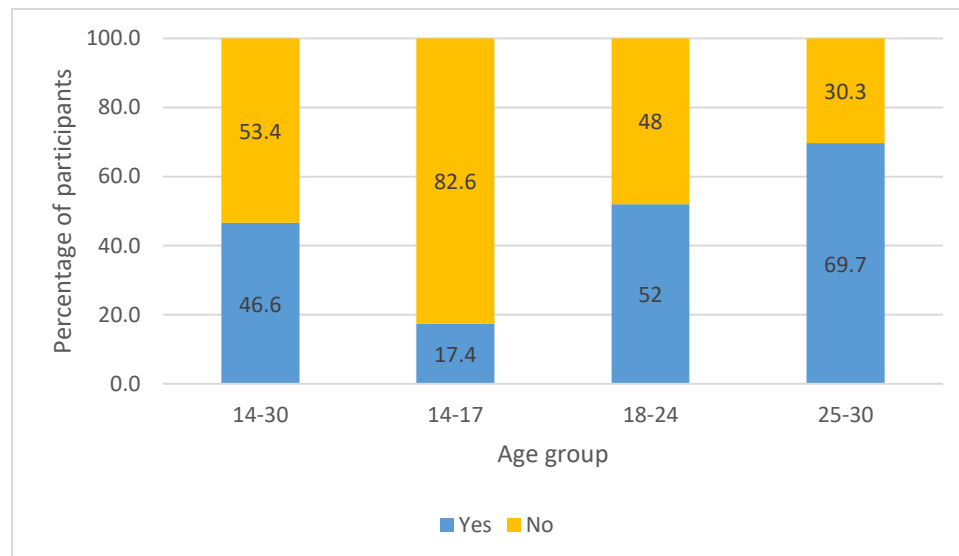


Figure 3.1: Drug use

Two-fifths of the sample reported past month drug use. One third had taken drugs within the last year and 27.4% reported that they had last taken drugs over one year ago. For under 17s, their drug use was relatively recent, with 91% having taken drugs with the last year. Two-fifths of 25-30-year-olds had taken drugs more than one year ago compared to one fifth of 18-24-year-olds (Figure 3.2).

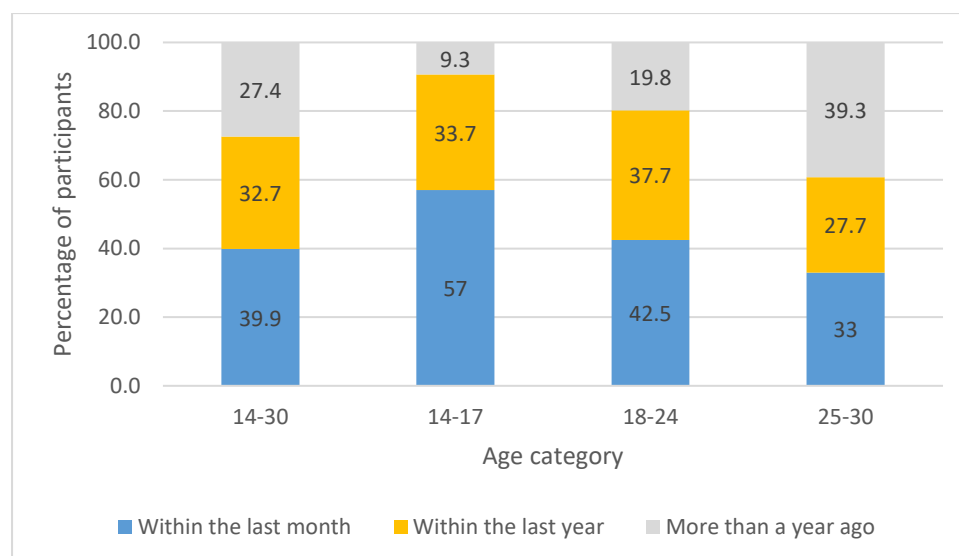


Figure 3.2: Last time took drugs

DAST-10 was administered to those who had taken drugs within the previous year. To ascertain drug use risk among the sample, the following categories were created: 1) No/low-risk drug use (those who had never used drugs, used drugs more than one year ago or scored as having no or a low level of drug use on DAST-10), which accounted for 88% of the sample; 2) Less than one tenth of participants (8.8%) scored at a moderate level of risk, which, clinically, would indicate that further investigation is required; 3) 3.1% scored at a substantial/severe level of risk, with intensive assessment the recommended course of action at these levels. There was a similar level of risk status for those in the 18-24 and 25-30 age brackets, with 85-86% scoring as low risk, approximately one tenth as at moderate risk and 2.7% as at substantial risk. By comparison, the 14-17s had 4.3% within the moderate risk category. A low number of participants fell within the highest risk category (Figure 3.3).

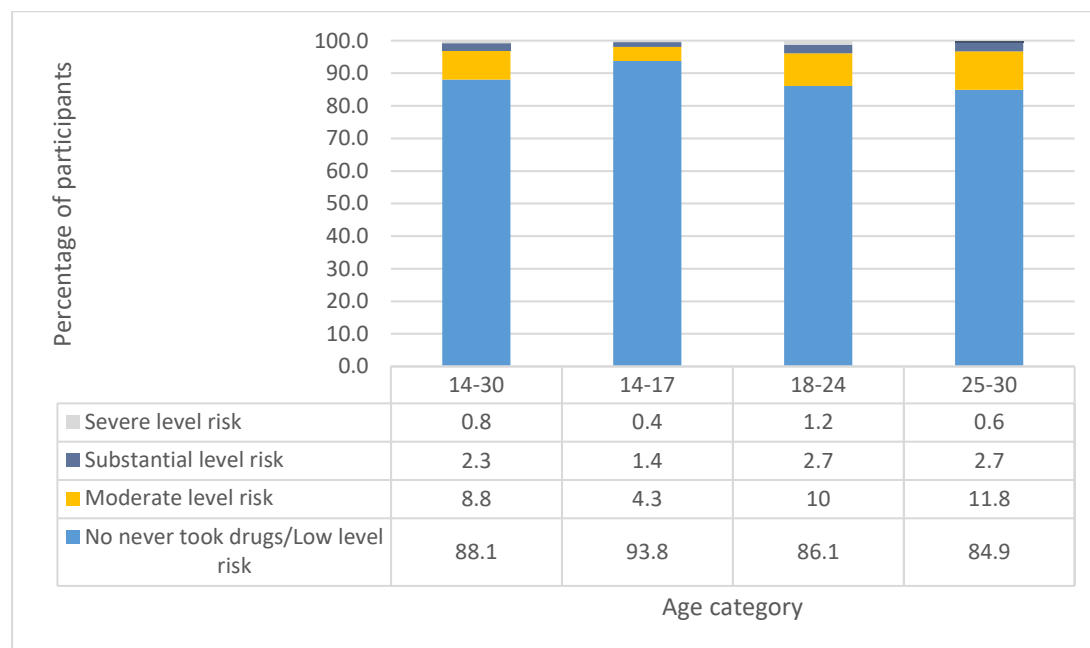


Figure 3.3: Drug use risk

For the purpose of inferential analysis, which is reported later in the chapter, the moderate, substantial and severe risk categories were collapsed. Just over one tenth of the sample (11.9%) scored within the moderate/substantial/severe risk drug use category. The 25-30s scored as having the highest risk of drug use (15.1%) and the 14-17s, the lowest (6.2%) (Figure 3.4).

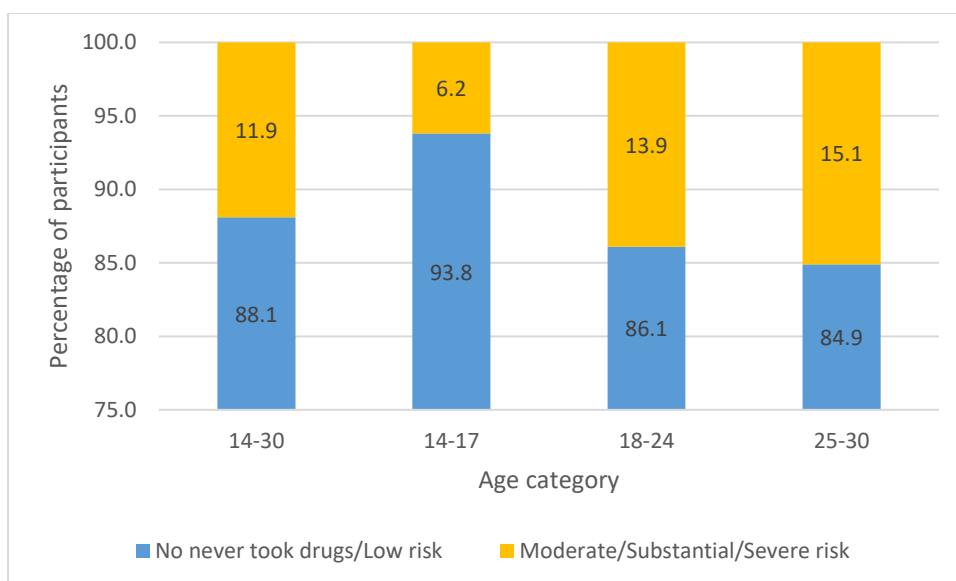


Figure 3.4: Drug use risk with categories merged

Types of drugs taken

Participants who had taken drugs in the past year were also asked to indicate the types of drugs taken within the past month and past year from a list. The most commonly used drug taken within the past month and past year was Cannabis, with half taking this drug in the past month and 89% in the past year. Codeine-based drugs were the second most commonly used drug in the past year (48%), followed by Cocaine (37%), Sedatives/tranquilisers (33%) and Solvents (29%) (Table 3.1).

Table 3.1: Top five drug substances used by people who used drugs in the past-year

	Used in the past year (including past month)	n	% of people who used drugs in the past-year (n=537)	Used in the past month	n	% of people who used drugs in the past-year (n=537)
No. 1	Cannabis	476	88.6	Cannabis	275	51.2
No. 2	Codeine-based drugs	259	48.2	Codeine-based drugs	154	28.7
No. 3	Cocaine	199	37.1	Poppers	78	14.5
No. 4	Sedatives, Tranquilisers	176	32.8	Cocaine	71	13.2
No. 5	Solvents	156	29.1	Sedatives, Tranquilisers	46	8.6

Table 3.2 shows the top five most used drugs among people who used drugs in the past-year across the three age subgroups.

Table 3.2: Top five drug substances among people who used drugs in the past-year by age cohort

	14-17			18-24			25-30		
	Used in past-year	n	%	Used in past-year	n	%	Used in past-year	n	%
No. 1	Cannabis	69	88.5	Cannabis	239	93.7	Cannabis	168	82.4
No. 2	Codeine-based drugs	37	47.4	Codeine-based drugs	126	49.4	Cocaine	99	48.5
No. 3	Sedatives, Tranquilisers	24	30.8	Solvents	89	34.9	Codeine-based drugs	96	47.1
No. 4	Ecstasy	17	21.8	Sedatives, Tranquilisers	86	33.7	Ecstasy	72	35.3
No. 5	Amphetamines, Speed	17	21.8	Cocaine	85	33.3	Sedatives, Tranquilisers	66	32.4

Notes: Examples of Codeine-based drugs provided to participants included painkillers, Oxycodone, Nurofen Plus and Solpadine. Examples of Sedatives and Tranquilizers provided to participants included Benzos, Valium, Xanax and Pregabalin. Examples of Solvents provided to participants included Glue and aerosol spray cans.

Reasons for taking drugs

The top three reasons for taking drugs were: 1) To get high/for fun/for pleasure; 2) To reduce stress/relax; and 3) To socialize. The frequencies of each reason for taking drugs are shown in Table 3.3. We explored if there were any different patterns in reasons for taking drugs among age, gender and sexual orientation subgroups. Curiosity/experimentation appeared to be a higher motivating factor for drug taking in the younger age groups (ranked 3rd for 14-17s and 4th for 18-24s) compared to the older age group (ranked 6th for 25-30s). Otherwise, the primary reasons for taking drugs were similar across all subgroups (see Appendix A).

Table 3.3: Reasons for drug use

Reason	n	%
To get high/for fun/for pleasure	437	81.4
To reduce stress/relax	322	60.0
To socialize	299	55.7
Out of curiosity/to experiment	203	37.8
To treat depression/anxiety	199	37.1
To improve sleep	170	31.7
To reduce pain/inflammations	115	21.4
To enhance sexual pleasure*	84	18.3
To reduce psychological barriers to sexual performance*	35	7.6
To enhance school/work performance	22	4.1
Other reason/s	15	2.8
To enhance physical body appearance	11	2.0
To reduce physiological barriers to sexual performance (e.g. lack of erection)*	8	1.7
To enhance athletic performance	4	0.7

NB: Participants could choose multiple categories

*Response option only displayed for participants aged 18 and over

Drug use settings

The top three settings in which drugs were used by participants in the past year were: 1) At home; 2) In a club/pub; and 3) Public space, such as street or park (Table 3.4). Those taking drugs in pub/club setting were mostly 18 and over as would be expected (n=208/215). For adolescents, home and in public spaces were the main places drugs were used.

Table 3.4: Drug use setting (past year)

Setting	n	%
Home	383	71.3
Club or pub	215	40.0
Public space (street, park, etc.)	194	36.1
Concert/Music festival	167	31.1
Organised party ('rave')	147	27.4
School/university	40	7.4
Chemsex party/Sex party/After party*	28	6.1
Work	27	5.0
Other setting	19	3.5
Sauna or sex clubs or other sex on premises*	10	2.2

NB: Participants could choose multiple categories. 'Other setting' mainly referred to a friend's house or house party.

*Response option only displayed for participants aged 18 and over

Participants who indicated that they had used drugs at a Chemsex party/Sex party/After party were asked further questions regarding chemsex (n=28). Nearly 3 in 5 reported that they attended these parties less than once a year (n=14, 58.3%), 29.2% (n=7) reported less than monthly attendance while three people (12.5%) reported attending on a monthly basis. Alcohol was most commonly used (n=19), followed by poppers (n=17), cocaine (n=14), MDMA (n=12), Cannabis (n=10), Ketamine (n=9), GHB / GBL/G (gamma hydroxybutyrate/gamma butyrolactone) (n=8) and Viagra (n=7). While 5 or less people used drugs such as Benzodiazepines, Amphetamine, Crystal Meth, Mephedrone and New Psychoactive Substances. Small numbers reported side effects (Table 3.5). Reasons for engaging in chemsex included 'for fun', for 'pleasure', to experiment, 'to relax', to 'reduce anxiety', to enhance 'staying power' and to numb depression. Two people mentioned that they hadn't planned it, rather it happened spontaneously.

Table 3.5: Side effects of using drugs during or after chemsex

Have you ever experienced any of the following either during or immediately following chemsex? -			
		n	%
Hallucinations	Yes	4	16.7
	No	17	70.8
	Don't remember	3	12.5
	Total	24	100.0
Delusions	Yes	5	20.8
	No	17	70.8
	Don't remember	1	4.2
	Prefer not to say	1	4.2
	Total	24	100.0
Going-under/losing consciousness	Yes	4	16.7
	No	20	83.3
	Total	24	100.0
Non-consensual sexual activity	Yes	4	16.7
	No	18	75.0
	Don't remember	2	8.3
	Total	24	100.0
Medical issues caused by chemsex	No	22	91.7
	Yes	2	8.3
Psychological issues caused by chemsex	No	22	91.7
	Yes	2	8.3

Alcohol use

In total, nearly 7 in 10 (69.4%) had low risk alcohol consumption on AUDIT, with the remainder (30.6%) scoring 8+, indicating harmful or hazardous drinking. Of the low risk group, 28% scored '0' on AUDIT as they never drank alcohol (n=445/1587). Nearly one quarter of the sample scored within the moderate category (23.4%) with AUDIT guidelines recommending that, at this level, the best course of treatment by healthcare professionals is to provide advice and information to reduce hazardous drinking behaviour. In total, 3.3% of participants had scores indicative of high-risk alcohol consumption, with brief counselling and continued assessment the recommended treatment at this level while 3.6% scored within the very high-risk level category, indicating a need for further diagnostic assessment for alcohol dependence by a healthcare provider. More 14-17s scored as having low risk alcohol consumption (89.7%) compared to 18-24s (60.6%) and 25-30s (61.1%) (Figure 3.5).

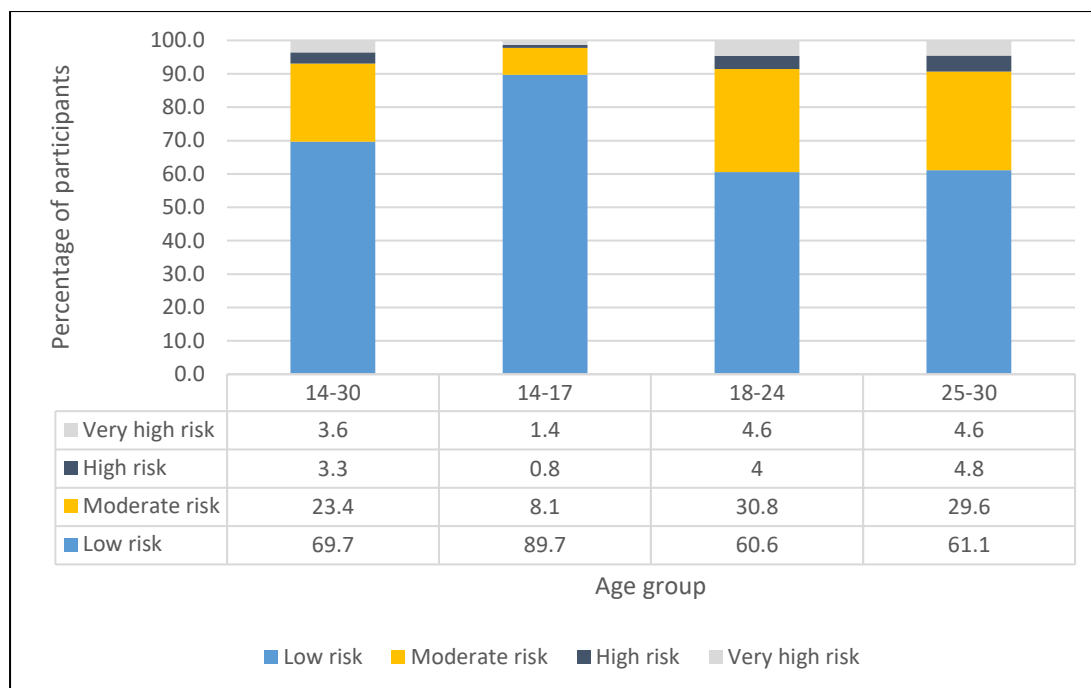


Figure 3.5: AUDIT

Factors associated with drug use

Bivariate analysis: The results of the bivariate analysis (Table 3.6) show that eleven factors were statistically associated with drug use. These included socio-demographic characteristics (gender, age, area living), life experience factors (exposure to anti-LGBTQI+ hate speech and LGBT bullying in school), and mental health factors (depression, stress, happiness, NSSH, suicidal thoughts, suicide attempt).

Table 3.6: Factors associated with drug use

Characteristic	Categories	Drug use				X ²	P value
		No/low risk		Moderate/substantial/severe risk			
		n	%	n	%		
Gender	Cis man	250	84.2%	47	15.8%	6.448	0.040*
	Cis woman	532	90.0%	59	10.0%		
	TGNC	575	88.2%	77	11.8%		
Age	14-17	453	93.8%	30	6.2%	21.878	<.001***
	18-24	509	86.1%	82	13.9%		
	25-30	404	84.9%	72	15.1%		
Area living	Rural	413	92.2%	35	7.8%	9.522	0.002**
	Urban	855	86.5%	133	13.5%		
Ethnicity	White Irish	1112	87.6%	157	12.4%	1.679	0.195
	Ethnic minority	254	90.4%	27	9.6%		
Sexual orientation	Lesbian/Gay (monosexual)	491	88.0%	67	12.0%	1.620	0.445
	Non-monosexual	476	87.0%	71	13.0%		
	Q+	398	89.6%	46	10.4%		
Support for LGBTQI+ from immediate family	Supportive	903	87.8%	125	12.2%	0.11	0.918
	Not supportive	346	88.0%	47	12.0%		
Anti-LGBTQI+ hate speech	No	152	85.9%	25	14.1%	7.576	0.023*
	Yes, witnessed it	811	90.1%	89	9.9%		
	Yes, experienced it	320	85.1%	56	14.9%		
Experienced LGBT+ school bullying	No	464	92.4%	38	7.6%	6.263	0.012*
	Yes	411	87.6%	58	12.4%		
Witnessed LGBT+ school bullying	No	190	91.3%	18	8.7%	.444	0.502
	Yes	686	89.8%	78	10.2%		
Depression	Normal/mild	528	90.9%	53	9.1%	11.160	0.004**
	Moderate	291	88.7%	37	11.3%		
	Severe/extremely severe	450	84.4%	83	15.6%		
Anxiety	Normal/mild	441	89.8%	50	10.2%	3.110	0.211
	Moderate	218	88.3%	29	11.7%		
	Severe/extremely severe	613	86.5%	96	13.5%		

Stress	Normal/mild	640	90.3%	69	9.7%	11.274	0.004**
	Moderate	268	88.7%	34	11.3%		
	Severe/extremely severe	370	83.7%	72	16.3%		
Self-esteem	Normal/Medium	271	86.0%	44	14.0%	4.467	0.107
	Low	776	87.5%	111	12.5%		
	High	299	91.2%	29	8.8%		
Resilience	Normal/Medium	486	87.7%	68	12.3%	.154	.926
	Low	837	88.3%	111	11.7%		
	High	41	89.1%	5	10.9%		
Happiness	Normal/Medium	679	89.1%	83	10.9%	7.445	0.024*
	Low	373	85.2%	65	14.8%		
	High	231	91.7%	21	8.3%		
NSSH	No	451	90.4%	48	9.6%	4.635	0.031*
	Yes	826	86.5%	129	13.5%		
Suicidal thoughts	No	365	90.8%	37	9.2%	5.131	0.023*
	Yes	897	86.4%	141	13.6%		
Suicide attempt	No	861	90.7%	88	9.3%	26.020	<0.001***
	Yes	339	80.9%	80	19.1%		

Note: * indicates that the Chi-square statistic is significant at the 0.05 level; ** indicates significant at the 0.01 level; *** indicates significant at the 0.001 level

Multivariate analysis: Lower odds of moderate/substantial/severe drug use were found among participants who identified as TGNC compared to cisgender men (OR=0.51,95% CI [0.30-0.88], $p=.015$), cisgender women compared to cisgender men (OR=0.53,95% CI [0.31-0.89], $p=.017$) and those aged 14-17 compared to those aged 25-30 (OR=0.28,95% CI [0.16-0.51], $p<.001$). Additionally, those who witnessed anti-LGBTQI+ hate speech had lower odds of moderate/substantial/severe drug use (OR=0.52,95% CI [0.29-0.93], $p=0.027$) compared to those who had neither witnessed nor experienced it. Participants who lived in urban areas had higher odds of moderate/substantial/severe drug use (OR=1.66,95% CI [1.05-2.62], $p=0.031$) compared to participants living rurally. Participants who had attempted suicide had higher odds of moderate/substantial/severe use (OR=2.17,95% CI [1.39-3.37], $p<.001$) compared to those who never attempted suicide. The full results of the multivariate logistic regression model is presented in appendix B while figure 3.6 provides an overview.

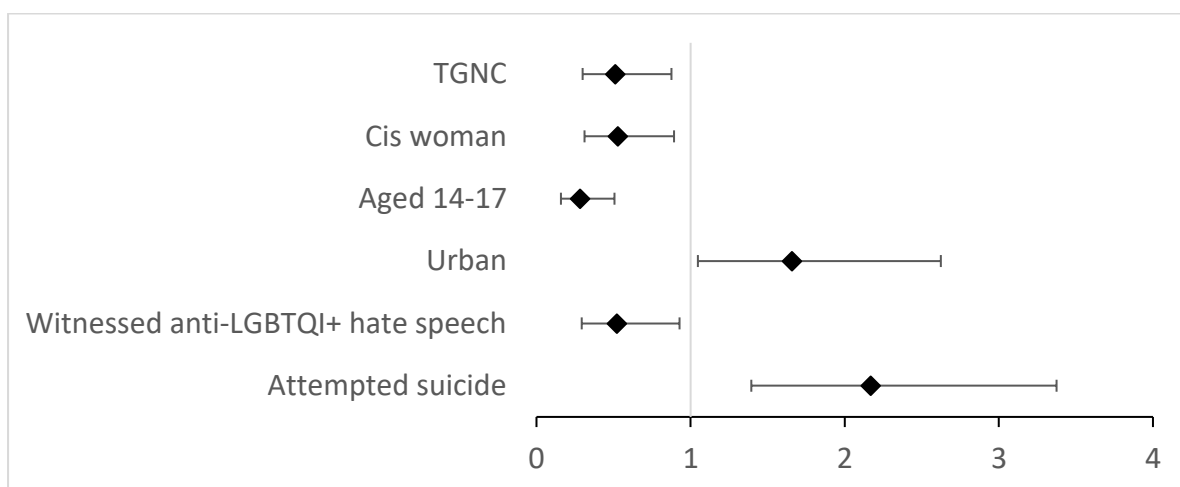


Figure 3.6: Results of logistic regression model of moderate/substantial/severe drug use

Factors associated with alcohol use

Bivariate analysis: The results of the bivariate analysis (Table 3.7) show that seven factors were statistically associated with alcohol use and a further three factors approached statistical significance. Together, these included socio-demographic characteristics (gender, age, area living, ethnicity, sexual orientation), life experience factors (immediate family who were supportive of one's LGBTQI+ identity, witnessing LGBT+ bullying in school), and mental health factors (anxiety, self-esteem, resilience).

Table 3.7: Factors associated with alcohol use

Characteristic	Categories	Alcohol use				X ²	P value
		No/low risk		Moderate/high/very high risk			
		n	%	n	%		
Gender	Cis man	161	52.8%	144	47.2%	71.526	<.001 [*]
	Cis woman	398	67.5%	192	32.5%		
	TGNC	525	79.3%	137	20.7%		
Age	14-17	434	89.7%	50	10.3%	132.150	<.001 [*]
	18-24	366	60.6%	238	39.4%		
	25-30	293	61.0%	187	39.0%		
Area living	Rural	355	79.4%	92	20.6%	26.086	<.001 [*]
	Urban	662	66.1%	339	33.9%		
Ethnicity	White Irish	884	68.8%	401	31.2%	2.810	0.094 ^{as}
	Ethnic minority	209	73.9%	74	26.1%		
Sexual orientation	Lesbian/Gay (monosexual)	361	63.7%	206	36.3%	25.583	<.001 [*]
	Non-monosexual	381	68.9%	172	31.1%		
	Q+	350	78.3%	97	21.7%		
Support for LGBTQI+ from immediate family	Supportive	703	67.7%	335	32.3%	3.414	0.065 ^{as}
	Not supportive	291	72.8%	109	27.3%		
Anti-LGBTQI+ hate speech	No	124	70.5%	52	29.5%	.140	0.932
	Yes, witnessed it	641	70.7%	266	29.3%		
	Yes, experienced it	266	69.6%	116	30.4%		
Experienced LGBT+ school bullying	No	383	75.8%	122	24.2%	.209	0.647
	Yes	355	74.6%	121	25.4%		
Witnessed LGBT+ school bullying	No	170	82.1%	37	17.9%	6.650	0.01 ^{**}
	Yes	569	73.4%	206	26.6%		
Depression	Normal/mild	404	68.9%	182	31.1%	.774	0.679
	Moderate	229	69.0%	103	31.0%		
	Severe/extremely severe	387	71.1%	157	28.9%		
Anxiety	Normal/mild	340	68.8%	154	31.2%	5.688	0.058 ^{as}
	Moderate	164	64.8%	89	35.2%		
	Severe/extremely severe	522	72.5%	198	27.5%		

Stress	Normal/mild	499	70.0%	214	30.0%	1.935	0.380
	Moderate	223	72.4%	85	27.6%		
	Severe/extremely severe	304	67.7%	145	32.3%		
Self-esteem	Normal/Medium	210	64.6%	115	35.4%	8.459	.015*
	Low	648	72.4%	247	27.6%		
	High	218	66.7%	109	33.3%		
Resilience	Normal/Medium	365	64.9%	197	35.1%	16.962	<.001*
	Low	702	73.3%	256	26.7%		
	High	25	54.3%	21	45.7%		
Happiness	Normal/Medium	530	69.0%	238	31.0%	1.528	0.466
	Low	321	72.0%	125	28.0%		
	High	182	71.9%	71	28.1%		
NSSH	No	349	69.1%	156	30.9%	.090	0.764
	Yes	677	69.9%	292	30.1%		
Suicidal thoughts	No	274	67.5%	132	32.5%	1.587	0.208
	Yes	749	70.9%	308	29.1%		
Suicide attempt	No	677	70.3%	286	29.7%	.648	0.421
	Yes	291	68.1%	136	31.9%		

Note: * indicates that the Chi-square statistic is significant at the 0.05 level; ** indicates significant at the 0.01 level; *** indicates significant at the 0.001 level; ^{as} indicates a p-value approaching statistical significance (0.05<p-value≤0.1).

Multivariate analysis: Participants who identified as TGNC and cisgender women had significantly lower odds of hazardous alcohol use (OR=0.37,95% CI [0.25-0.55], $p<.001$; OR=0.52,95% CI [0.36-0.73], $p<.001$ respectively) compared to cisgender men. Participants aged 14-17 also had lower odds of hazardous alcohol use (OR=0.17,95% CI [0.11-0.26], $p<.001$) compared to those aged 25-30 while lower odds were also found among Q+ participants (OR=0.64,95% CI [0.44-0.93], $p=0.02$) compared to participants who identified as monosexual (lesbian/gay). Participants living in urban areas had higher odds of hazardous alcohol use (OR=1.74,95% CI [1.28-2.37], $p<0.001$) compared to those living in rural areas. Participants who reported symptoms of moderate anxiety or severe/extremely severe anxiety had higher odds of hazardous alcohol use (OR=1.59,95% CI [1.07-2.37], $p=0.02$; (OR=1.70,95% CI [1.18-2.43], $p=0.004$) compared to those who reported normal/mild symptoms of anxiety. Finally, participants with high resilience had higher odds of hazardous alcohol use (OR=2.42,95% CI [1.17-5.02], $p=0.017$) compared to those with normal resilience. The full results of the multivariate logistic regression model is presented in appendix C while figure 3.7 provides an overview.

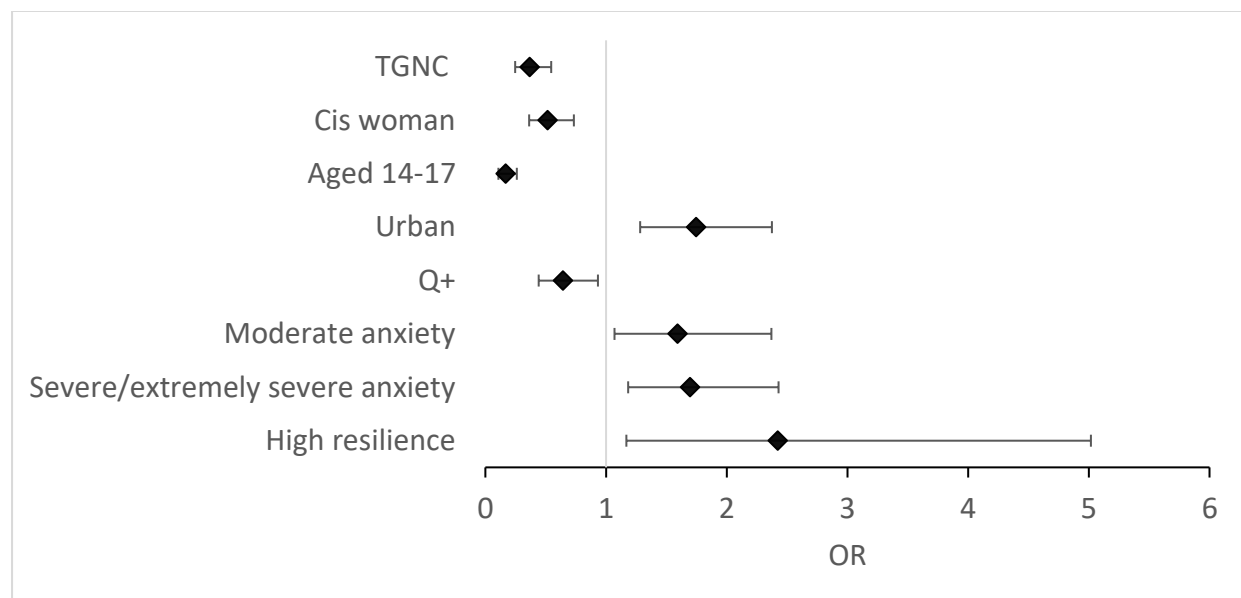


Figure 3.7: Results of logistic regression model of hazardous alcohol use

Summary of findings

Drug use

- The lifetime rate of drug use among the sample was 46.6%. The lifetime rate of drug use among the subgroups was: 17.4% for 14-17-year-olds, 52% for 18-24-year-olds and 69.7% for 25-30-year-olds.
- Two-fifths of the sample (39.9%) reported past-month drug use while one third reported past-year drug use (32.7%).
- Among those who had taken drugs, past-year drug use was 91% among 14-17-year-olds, 80.2% among 18-24 year-olds and 60.7% among 25-30 year-olds.
- Approximately one tenth of the sample (11.9%) had DAST-10 scores indicative of moderate/substantial/severe risk drug use. This risk level increased with increasing age,

being lowest for 14-17-year-olds at 6.2%, rising to 13.9% for 18-24-year-olds, and rising again to 15.1% for 25-30-year-olds.

- The vast majority of participants who took drugs in the past-year used Cannabis (89%), followed by Codeine-based drugs (48%), Cocaine (37%), Sedatives/tranquilisers (33%) and Solvents (29%).
- The vast majority of participants who took drugs in the past-year reported taking drugs 'to get high/for fun/for pleasure' (81.4%). Other prominent reasons included 'to reduce stress/relax' (60.0%), 'to socialize' (55.7%), 'out of curiosity/to experiment' (37.8%), 'to treat depression/anxiety' (37.1%) and to improve sleep (31.7%).
- A small proportion of the total sample (1.8%, n=28) reported that they attended chemsex parties/sex parties/afterparties, with alcohol, poppers and cocaine the top three substances used. Although most reported no immediate side effects, notable risks were identified, including hallucination, delusions, loss of consciousness and non-consensual sexual activity.
- Factors associated with higher odds of moderate-severe risk drug use are:
 - Being an urban dweller (compared to rural dweller)
 - Attempted suicide (compared to never attempted suicide)
- Factors associated with lower odds of moderate-severe risk drug use are:
 - Being a cis woman (compared to being a cis man)
 - Identifying as TGNC (compared to being a cis man)
 - Aged 14-17 (compared to being aged 25-30)
 - Witnessed anti-LGBTQI+ hate speech in public (compared to neither witnessed nor experienced anti-LGBTQI+ hate speech in public)

Alcohol use

- 3 in 10 (30.6%) participants had AUDIT scores indicative of harmful or hazardous drinking.
- Nearly one quarter (23.4%) of the sample scored within the moderate category, 3.3% of participants scored with the high-risk category, while 3.6% scored within the very high-risk category.
- More 14-17-year-olds scored as having low risk alcohol consumption (89.7%) compared to 18-24-year-olds (60.6%) and 25-30-year-olds (61.1%).
- Factors associated with higher odds of hazardous drinking are:
 - Urban dweller (compared to rural dweller)
 - Symptoms of moderate/severe anxiety (compared to none or mild symptoms of anxiety)
 - High resilience (compared to normal resilience)
- Factors associated with lower odds of hazardous drinking are:
 - Being a cis woman (compared to being a cis man)
 - Identifying as TGNC (compared to being a cis man)
 - Aged 14-17 (compared to being aged 25-30)
 - Q+ (Included queer, asexual, questioning and other) compared to being monosexual (lesbian/gay)

Chapter 4: Discussion

To set the findings in context, this section discusses the findings in the context of the broader literature. However, variance in how drug and alcohol use was operationalised within studies, differences in the tools used to measure substance use, as well as differing age samples make direct comparison difficult. In some cases, the figures referenced for the *Being LGBTQI+ in Ireland* group aren't cited in the findings section of the report, as they are recalculations made in order to facilitate comparison with ages used in some of the studies cited.

Drug use

Drawing on data from young LGBTQI+ people aged 14-30 (n=1,591) in the *Being LGBTQI+ in Ireland* study, the study found a lifetime drug use rate of 47%, with three in five of these reporting past year drug use. To put the figures in context, the 2019–20 Irish National Drug and Alcohol Survey (Mongan et al. 2021) and the 2023 Healthy Ireland Survey (Ipsos B&A, 2023) found lower prevalences of drug use (27% and 29% respectively) among 15-24-year-olds compared to LGBTQI+ people of the same age in our study (39.9%)⁴. However, both surveys reported on illegal drug use, whereas our study included non-medical drug use, which would cover prescription and over-the-counter (OTC) drugs in addition to illegal drugs. This could account for the higher rate.

Among 14-17-year-olds in the *Being LGBTQI+ in Ireland* study, 17.4% reported lifetime drug use compared to 13% of 15-16-year-olds in the general population who reported lifetime illicit drug use (The ESPAD Group, 2025a). Cannabis was the most common drug reported in the adolescent group (14-17 years) in the *Being LGBTQI+ in Ireland* study with 13.9%⁵ of this group reporting use in the past year. The equivalent figure for the general population of 16 year olds in Ireland is 12% (The ESPAD Group, 2025b). A further survey of Irish college students, median age 21, reported that 55.3% of the population had used an illicit drug in their lifetime (Byrne et al. 2022), which is higher than the 47% who reported lifetime drug use in our study. Similar to our study, Byrne et al.'s (2022) college study also administered DAST-10 to students who used drugs in the past year (recent drug use). In their study, 16.2% were categorised as having recently used drugs, with one third of these (32.8%), or 5.02% of all college students, reporting a moderate or greater risk level on the DAST-10 (Byrne et al. 2022). By comparison, 11.9% of LGBTQI+ participants in our study had DAST-10 scores indicative of a moderate or greater risk from their substance use, with the risk increasing across the age groups.

While the ESPAD study did not use the DAST-10 measure, it did use the Cannabis Abuse Screening Tool (CAST) and reported that 4% of Irish teens meet the criteria for a possible cannabis use disorder while 6.2% of the adolescent LGBTQI+ sample were found to have at least a moderate risk of a drug use disorder.

⁴ The figures referenced aren't cited in the findings section as they are recalculations made in order to facilitate comparison with the general youth population aged 15-24.

⁵ The figure referenced isn't cited in the findings section as it has been calculated in order to facilitate comparison with the general population of a similar age.

While cannabis, ecstasy and cocaine are the most commonly used substances in the general population of youth in Ireland (HRB National Drugs Library, 2025), sedatives/tranquilisers (benzodiazepines) are less commonly used, with 6.1% of 15-24-year-olds reporting last year use of them (Ipsos B&A, 2023). In the *Being LGBTQI+ in Ireland* study, codeine-based drugs and benzodiazepines are among the most commonly used drugs by LGBTQI+ youth in the past year. The European Union Drugs Agency has noted that the non-medical use of benzodiazepines among young people is increasing, particularly in combination with alcohol (EUDA, 2023). It has also been noted that despite the addictive potential of abuse of codeine, it is largely under-documented in research studies (McDonnell, 2019). Given the harms associated with abuse of codeine and benzodiazepines, monitoring usage is important to identify patterns, trends and indeed potential disparities between subgroups of the population, including gender and sexual minority populations.

Alcohol use

In the *Being LGBTQI+ in Ireland* study, approximately 7 in 10 (69.4%) of the 14-30-year-olds reported low risk alcohol consumption, with 3 in 10 (30.6%) reporting harmful or hazardous alcohol use. The most recent Healthy Ireland Survey (2025), which only provides a binary breakdown of gender, reported hazardous drinking rates (AUDIT 8+) of 39% among men aged 15-24 and 25% among women aged 15-24 (Ipsos B&A, 2025). By comparison, in our study, 32.5% of participants aged 15-24 scored as having hazardous alcohol use. Excluding the TGNC population, the rates for men and women aged 15-24 were 45.6% and 29.6% respectively, which are higher than the figures reported for men and women in the Healthy Ireland Survey⁶.

A comparison of hazardous drinking (using AUDIT) between LGBTQI+ youth in our study and the general youth population in the My World Survey 2 (Dooley et al. 2019) suggests that, among those who consumed alcohol, there may be a lower prevalence of hazardous drinking among LGBTQI+ youth aged 18-25 (46% vs. 51%) (Table 4.1). A slightly lower prevalence was also observed among the LGBTQI+ adolescent sample aged 14-19 compared to the My World Survey sample aged 12-19 (33.2% vs. 35%). However, the My World Survey 2 sample was two years younger which hinders comparability.

Table 4.1: Alcohol risk among LGBTQI+ young people compared to general youth population

Of those who reported consuming alcohol	Being LGBTQI+ in Ireland 14-19	My World 2 12-19	Being LGBTQI+ in Ireland 18-25	My World 2 18-25
Low risk (1-7)	66.8%	65%	54.0%	49%
Moderate risk issue (8-15)	25.5%	28%	35.4%	38%
High risk (16-19)	2.9%	4%	5.0%	7%
Very high risk (20+)	4.8%	3%	5.6%	6%
Total 8+	33.2%	35%	46%	51%

⁶ The figures referenced aren't cited in the findings section as they are recalculations made in order to facilitate comparison based on age and gender.

Factors associated with substance use

The current study found that factors associated with lower odds of both hazardous alcohol use and moderate-severe drug use were being aged 14-17, TGNC, and being a cisgender woman. Like the general youth population in Ireland, substance use accelerates after the age of 17, with men typically having higher rates of problematic drug and alcohol use compared to women (Mongan et al. 2021; Ipsos B&A, 2025), and this pattern appears to hold for the LGBTQI+ population in our study. However, the international literature suggests greater substance use disparities between sexual minority women and their heterosexual counterparts, and research is needed to ascertain if this is also the case in Ireland. The previously referenced survey on substance use among college students in Ireland found that males and non-binary students reported higher prevalences of previous and current use of illicit drugs compared to females (Byrne et al. 2022), which diverges from our finding of lower odds of drug use among the TGNC group. Internationally, gender minority populations have been found to have elevated rates of substance use compared to cisgender peers (Mereish, 2019; Connolly and Gilchrist, 2020), and further research is also needed to establish the rates in comparison to not only cisgender sexual minority peers, as in this study, but also to cisgender heterosexual peers.

Drug and hazardous alcohol use were also associated with some, but not all, mental health difficulties. Higher odds of hazardous alcohol use were found among those with moderate and severe/extremely severe symptoms of anxiety while higher odds of moderate-severe drug use were found among those who had attempted suicide. The strong interrelationship between substance-use and mental health difficulties in LGBTQI+ populations has been documented through previous research (Goldbach et al. 2014; Brown et al. 2024) and underlines the need for substance use treatment to address both issues concurrently rather than separately.

While higher resilience was associated with increased odds of hazardous alcohol use, this finding should be interpreted with caution. The confidence interval was relatively wide (1.17-5.02) suggesting a lack of precision in the estimate. In addition, the association is somewhat counterintuitive, as resilience is usually thought of as a protective factor (Cotaina et al. 2022; Miller-Perusse et al. 2024). This may reflect limitations of the resilience scale used, or other factors, such as perceived confidence to cope with alcohol use, and consequently warrants further investigation.

Urban dwellers were found to have higher odds of both moderate-severe drug use and hazardous alcohol use, and perhaps this is related to LGBTQI+ events and social life being urban-centric and often centred around clubs/pubs spaces where alcohol and drugs are readily available. However, this is speculative as to what might lie behind the apparent urban-rural disparity for LGBTQI+ young people. Other research has reported that hazardous alcohol use is more prevalent among young people in rural areas while polysubstance use and benzodiazepine use is greater among those from urban areas, though it must be noted that the data from this study were collected more than 15 years ago (Murphy et al. 2014). The increasingly availability and accessibility of drugs in rural areas may mean that picture has changed, and urban-rural disparities in substance use appear to be rarely examined in an Irish

context, something which also needs to be addressed to understand drivers of substance use among LGBTQI+ populations.

As discussed in chapter 1, minority stress theory is the dominant framework used to explain health disparities among S&GM populations (Meyer, 2003). Interestingly, none of the minority stressors examined in this study (experiencing/ witnessing LGBT bullying in school, exposure to anti-LGBTQI hate in public media) increased the odds of hazardous substance use. This is in contrast to much of the research evidence which supports the Minority Stress Model as an explanatory framework for substance use disparities in S&GM populations, including a recent US study which found that S&GM adults who had experienced S&GM related victimisation reported a slight but significant increased rate of hazardous alcohol use (Hinds et al. 2022). This difference may be related to the different social contexts in the two countries, the difference in how victimisation was defined and measured, or the significantly older sample (mean age 30 years) in Hinds et al. (2022).

Implications for treatment

It has long been recognised that prevention and intervention efforts must focus on children and adolescents as this is the time when substance use typically starts and research links early initiation to a range of adverse health and social outcomes in later life (Griffin & Botvin, 2010). Population-wide approaches to substance use prevention recognise the importance of including schools, families, and communities, with connectedness in these three domains consistently cited as protective against substance use (Kidd et al. 2018; Mereish, 2019; Mammadli et al. 2025; HRB National Drugs Library, 2025).

While LGBTQI+ youth may encounter universal prevention and intervention substance use programmes in schools and through youth services, these may not acknowledge or include the relevant knowledge on risk and protective factors for substance use specific to LGBTQI+ youth. Therefore, it is important that tailored, evidence-based, education prevention is provided to LGBTQI+ youth, and developed in partnership with LGBTQI+ youth and representative organisations.

Research suggests that schools have an important role in fostering connectedness for LGBTQI+ students, an important protective factor against substance use (Kidd et al. 2018; Mereish, 2019), and ensuring that gender and sexual identity is recognised, supported and affirmed through the curriculum and inclusive policies and practices. However, school-based initiatives alone are insufficient to address the wider determinants of substance use among youth. Existing evidence in Ireland suggests LGBTQI+ youth living in vulnerable contexts, such as those experiencing homelessness or experiencing parental rejection, may face heightened risks of substance use (Quilty & Norris, 2020; GCN, 2025). Research also indicates that many of the risk and protective factors for substance use among young people relate to parents; such as parents' own substance use patterns, the degree of involvement in their children's lives and the choices they make around substance use (Doyle et al. 2022; HRB National Drugs Library, 2025). Given the central influence of parental involvement and relationships for youth generally but also for LGBTQI+ youth in terms of acceptance and support for one's identity, it is important that prevention efforts involve families to target risk and protective factors that

determine their substance use behaviours, with particular emphasis on enhancing the family environment for LGBTQI+ youth by promoting affirming behaviours and communication around LGBTQI+ identity. There is also a need for education on substance use, as parents have been found to lack knowledge and understanding of drug related risks and harm-reduction principles (Van Hout, 2009). Family involvement in interventions is also needed given that empirical evidence suggests that family-based interventions may improve retention and reduce substance use among youth (Hogue et al. 2021; Wells et al. 2024).

For LGBTQI+ youth, LGBTQI+ community is an important source of social support as well as identity affirmation (O’Sullivan et al. 2026). However, there are mixed findings about the links between participation and connectedness in LGBTQI+ communities and substance use, with some research suggesting a correlation between LGBTQI+ community connectedness and increased substance use (Demant et al. 2018; Lefevor et al. 2024). Community-level approaches to substance use prevention therefore should consider how best to foster belonging and support through connection to LGBTQI+ communities while challenging community norms and practices which may contribute to problematic substance use. Additionally, opportunities for LGBTQI+ connectedness must be provided outside of club/pub spaces, as many young LGBTQ+ adults perceive that many LGBT social events are “substance saturated environments” and that sobriety and gay bars are incompatible (Felner et al. 2020).

LGBTQI+ people often encounter a range of barriers to accessing and engaging in substance use treatment services or interventions which delays help-seeking and adversely impacts treatment engagement and outcomes (Hughto et al. 2021; Murray et al. 2024). These include a lack of sexual and gender identity recognition and affirmation; experiences of rejection, harassment, and violence; concern about the effectiveness of services, and whether their substance use warranted professional services; and fear of discrimination (Lyons et al. 2015; Paschen-Wolff et al. 2024; Murray et al. 2024). For example, sexual and gender minority people who engaged in a 12-step AA programme reported that while they experienced mutual understanding and support which was beneficial to their recovery, they also experienced negative aspects which threatened their safety, including homophobia, transphobia, marginalisation related to intersecting identities, and discomfort with the role religion played (McGeough et al. 2023; McGeough et al. 2024).

It is important that substance use treatment services and interventions are affirmative and inclusive of sexual and gender diversity. Services can create affirmative environments by ensuring policies and practices are inclusive and non-discriminatory, LGBTQI+ visibility in services (e.g. rainbow flags), peer support, and cultural competency and gender sensitivity training for staff, all of which has been found to contribute to a greater sense of safety and facilitates ongoing engagement with substance use treatment services (Paschen-Wolff et al. 2024; Murray et al. 2024). For affirmative and inclusive care for transgender populations, Nuttbrock et al. (2012) suggest incorporating transgender competent practices and policies into services (e.g. respect for pronouns and chosen name), facilitating the continuation of hormone replacement therapy, and exploring how gender identity conflict and gender abuse shape substance use and recovery.

While there is a need to adapt substance use treatment services to make them more inclusive and affirmative for sexual and gender minority populations, there may also be a need for more specialist or specific services to address issues which are beyond mainstream services. However, the international literature notes that there is a lack of LGBTQI+ specific substance use treatment services as well as culturally tailored interventions (Cochran et al. 2007; Williams & Fish, 2020; Kidd et al. 2022).

For transgender populations, specialist services may require the development of services or interventions which are informed by gender minority theoretical frameworks and developed in conjunction with trans people so that relevant issues are addressed (Glynn & van den Berg, 2017). As an example, the Transgender Recovery Program, primarily a peer led and peer support programme, focused on affirming one's gender identity, community building and developing networks with housing and employment services, and was shown to have a good retention rate among trans participants (Oggins & Eichenbaum, 2002). Specialist services or interventions may also be more appropriate for LGBTQI+ people who have been shown to experience multiple intersecting forms of stigma within substance use treatment services, including transgender people, bisexual people, and people of colour (Dawes et al. 2023; Xin et al. 2023). Qualitative research from the UK indicates that many people from the LGBTQ+ community favoured accessing online or self-help options in relation to substance use concerns, and future research should explore the efficacy of such interventions for LGBTQI+ populations (Murray et al. 2024).

A recent scoping review of substance use interventions for S&GM populations found that they are mainly targeted at sexual minority men who have sex with men and conducted within the US (Kidd et al. 2022), and suggested a need for research which evaluates treatment interventions that focus on the needs of sexual minority women and gender minorities, as well as on cannabis and opioid use in the LGBTQIA+ community (Kidd et al. 2022). Particularly scarce is research evaluating tailored substance use interventions for trans populations (Glynn & van der Berg, 2017).

In light of our findings and other research that highlights the co-occurrence of substance use and mental health difficulties, integrated mental health support, which is key to facilitating recovery generally, is also central for LGBTQI+ populations. This support needs to include, peer social support, adaptative coping strategies to address stressors related to sexual and gender minority stigma as well as ways to connect to LGBTQI+ communities that support sobriety (Nieder et al. 2025). The latter can only be facilitated if structural supports are put in place to enhance the social environment for LGBTQI+ people, ensuring that drug and alcohol-free spaces and events are available.

Likewise, both national and international literature highlights that substance use and risky sexual behaviour are co-occurring issues in LGBTQI+ populations (Daly et al. 2023; Satapathy et al. 2025), which must be tackled in tandem to optimise holistic long-term health and wellbeing (Glynn & Van den Berg, 2017). A small proportion of the total youth sample (1.8%, n=28) reported that they attended chemsex parties/sex parties/afterparties, with alcohol, poppers and cocaine the top three substances used. Although most reported no immediate side effects, notable risks were identified, including hallucination, delusions, loss of

consciousness and non-consensual sexual activity. These findings are concerning for a number of reasons, including that adolescence and young adulthood represents a critical period for the onset and escalation of mental health difficulties (Solmi et al. 2022). Substance use in high-risk contexts, such as chemsex, may exacerbate underlying vulnerabilities, increasing the likelihood of psychological distress and trauma related outcomes (Íncera-Fernández et al. 2021). This reinforces the need to ensure that support services and youth appropriate information are available and accessible to those who engage in chemsex, enabling informed decision-making and the reduction of both physical and mental harm.

Other co-occurring issues have also been identified, with research indicating that when entering substance use treatment, LGBT clients report increased levels of homelessness, domestic violence and physical health problems (Cochran & Cauce, 2006; Flentje et al. 2015), which all need to be addressed alongside substance use. The literature also points to broader structural supports and responses to address substance use among TGNC populations, including community and school supports targeted at enhancing resiliency and coping, housing supports and gender inclusive data collection systems to determine the extent of substance use problems and related harms (Mammaldi et al. 2025; Connolly et al. 2025).

In conclusion, the findings from our study, alongside the wider literature, indicate that individuals from the LGBTQI+ community may be at higher risk of substance use problems, as well as additional mental health or housing needs. They may also exhibit distinct patterns of substance use. Providing timely and efficient support is therefore essential. The outgoing national drug strategy (DoH, 2017) has two strategic actions of particular relevance:

1.3.11: Strengthening early harm reduction responses to current and emerging trends and patterns of drug use including chemsex.

2.1.27: Improve the capacity of services to accommodate the needs of people who use substances from specific communities including the GLBTQI community.

Research has shown that, compared to other mental health conditions, substance use problems are associated with the longest delay in accessing treatment (James et al. 2026). Services must therefore evolve in ways that reduces barriers to access, particularly for marginalised individuals. While this aligns with strategic action 2.1.27 from the outgoing strategy (DoH, 2017), the new draft strategy (Department of Health, 2026), although referencing the needs of minority groups, must continue to prioritise the needs of the LGBTQI+ community.

Limitations

The study results should be considered in the context of several limitations. It is unknown how representative the sample is of the wider LGBTQI+ population as there is no national population data collection of people's gender identity or sexual orientation. Furthermore, we do not have a matched control group of S&GM young people, and as such, the report is not methodologically positioned to address differences between LGBTQI+ young people and their peers.

The sample was missing representation of LGBTQI+ young people living in vulnerable contexts, as only a small number lived in supported accommodation or were homeless/using homeless services, which is an important limitation given the link between housing instability and substance use. The survey was hosted online and available in English only so the researchers can't rule out the possibility of sample bias as participants may have had greater accessibility to digital devices and internet connectivity, while people who were not proficient in English may have been unable to partake. Furthermore, as the data are self-reported, there is a possibility of underreporting, given the emerging evidence that young people may under-report substance use (e.g., Steinhoff et al., 2023). There may also be an overrepresentation of people who are interested in LGBTQI+ issues or connected to LGBTQI+ media and groups who strongly promoted the survey. Responses to the survey questions on gender identity, sexual orientation and ethnicity yielded a wide range of responses which the researchers managed by collapsing categories together in order to enable meaningful comparison. However, by doing so, the unique experiences of specific groups may have been overlooked. The cross-sectional nature of the survey means that we cannot infer causality from the results. The AUDIT tool's standard cut-off point of 8 may not be appropriate for some populations (e.g. women; youth) who may experience alcohol-related harm at lower levels of consumption (Liskola et al. 2018). This means that there could be an underestimation of hazardous alcohol use among these subgroups in this study. Furthermore, AUDIT hasn't been extensively validated with TGNC populations (Gilbert et al. 2018) and, as described in the scoring manual, the effects of alcohol vary depending on various factors, such as body weight or metabolic functioning, which was not collected in this study (Higgins-Biddle & Babor, 2018). Relatedly, despite demonstrating robust psychometric properties, it is possible that the recommended threshold of 3 items on the DAST-10 might over identify problematic drug use (see Johnson et al. 2025).

The questions around chemsex were limited to those who indicated that they used drugs within the past year and that they attended chemsex parties/sex parties/after parties which may have excluded those who participated in chemsex in other settings/contexts and in their lifetime. Further, the researchers didn't provide participants with a definition of chemsex so there is the potential that some participants may not have understood their drug use and sexual activity as such.

Recommendations

Substance use services

- The findings indicate that LGBTQI+ young people should be regarded as a key group when developing and implementing actions in relation to minority groups as part of the new *National Drugs Strategy 2026-2029*.
- Drug and alcohol treatment services should adopt an LGBTQI+ affirmative service model and embed LGBTQI+ inclusion within policies, clinical standards and pathways to care, and reduce barriers to access, particularly for underserved groups.
- The findings reaffirm the need for ring-fenced multiannual investment in community-based LGBTQI+ inclusive supports for young people experiencing problematic drug and

alcohol use. LGBTQI+ people with lived experience should have a key role in shaping these services.

- Interventions developed to support young people experiencing problematic drug and alcohol use should be evaluated to determine their appropriateness for S&GM populations and their efficacy in reducing substance use and associated harms.
- Fund regional LGBTQI+ initiatives, including community groups, to provide access to alcohol and drug free spaces and facilities for LGBTQI+ young people.
- In line with the aims of *The National Sexual Health Strategy 2025-2035*, scope public health responses to reduce the sexual health and drug related harms associated with chemsex.
- Conduct a national mapping exercise of substance use prevention and intervention programmes delivered through LGBTQI+ youth organisations. Use findings to strengthen existing programmes and develop evidence-based, LGBTQI affirmative initiatives that are co-designed with LGBTQI+ young people and other relevant experts.

Substance use research

- There is a need to pursue further research on youth mental health and alcohol and drug use to facilitate comparisons between minority groups, including gender and sexual minorities, and the general population. This type of knowledge is critical to support equitable allocation of services.
- There is also a need for further research into chemsex to facilitate comparisons between S&GM young people and their non-S&GM peers.
- Although various socio-demographic factors were included in the analysis, there is a need for further research that explores intersectional effects (i.e., how different intersecting identities may influence alcohol and drug use, such as, gender identity, minority sexual orientations, ethnicity, education, family/housing context, etc.).
- Existing health surveys and future research on mental health and drug and alcohol use should capture gender identity and sexual orientation data as well as have targeted recruitment strategies for including minority groups within studies, including sexual and gender minorities.
- Fund a repeat survey of Being LGBTQI+ in Ireland in 2030.

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Appendices

Appendix A

Reason for taking drugs	14-17		18-24		25-30	
	N	Rank		Rank		Rank
To reduce stress/relax	48	2	154	2	130	2
To improve sleep	23	6	85	6	62	5
To treat depression/anxiety	36	4	96	5	67	4
To reduce pain/inflammations	11		60		44	7
Out of curiosity/to experiment	39	3	108	4	56	6
To get high/for fun/for pleasure	59	1	211	1	167	1
To socialize	34	5	145	3	120	3
To enhance sexual pleasure	0		49		35	
To reduce physiological barriers to sexual performance (e.g. lack of erection)	0		5		3	
To reduce psychological barriers to sexual performance	0		20		15	
To enhance school/work performance	3		11		8	
To enhance athletic performance	2		2		0	
To enhance physical body appearance	4		6		1	
Other (please specify):	4		6		5	

Reason for taking drugs	Cis men		Cis women		TGNC	
	N	Rank	N	Rank	N	Rank
To reduce stress/relax	68	3	121	2	138	2
To improve sleep	33		60		75	
To treat depression/anxiety	36	5	69	5	92	4
To reduce pain/inflammations	15		35		63	
Out of curiosity/to experiment	49	4	76	4	76	5
To get high/for fun/for pleasure	110	1	159	1	165	1
To socialize	80	2	114	3	104	3
To enhance sexual pleasure	33		18		33	
To reduce physiological barriers to sexual performance (e.g. lack of erection)	3		1		4	
To reduce psychological barriers to sexual performance	13		9		12	
To enhance school/work performance	2		5		15	
To enhance athletic performance	3		1		0	
To enhance physical body appearance	4		3		4	
Other (please specify):	3		3		9	

Reason for taking drugs	Monosexual		Non-monosexual		Q+	
	N	Rank	N	Rank	N	Rank
To reduce stress/relax	109	3	137	2	86	2
To improve sleep	49		81	5	40	
To treat depression/anxiety	62	5	86	4	51	5
To reduce pain/inflammations	35		48		32	
Out of curiosity/to experiment	71	4	73		59	4
To get high/for fun/for pleasure	161	1	163	1	113	1
To socialize	114	2	112	3	73	3
To enhance sexual pleasure	44		24		16	
To reduce physiological barriers to sexual performance (e.g. lack of erection)	3		2		3	
To reduce psychological barriers to sexual performance	16		12		7	
To enhance school/work performance	7		9		6	
To enhance athletic performance	1		2		1	
To enhance physical body appearance	3		6		2	
Other (please specify):	6		3		6	

Setting drugs used	14-17		18-24		25-30	
	N	Rank	N	Rank	N	Rank
Concert/Music festival	11	4	65	5	91	3
Organised party ('rave')	19	3	72	4	56	4
Club or pub	7		105	2	103	2
Home	53	1	184	1	146	1
Work	4		12		11	
School/university	19	3	18		3	
Chemsex party/Sex party/After party	0		13		15	
Public space (street, park, etc.)	49	2	89	3	56	4
Sauna or sex clubs or other sex on premises	0		3		7	
Other (please specify):	1		14		4	

Appendix B

Logistic regression results of moderate/severe/extremely severe drug use

Parameter Estimates										
Parameter	B	Std. Error	95% Wald Confidence Interval		Hypothesis Test			Exp(B)	95% Wald Confidence Interval for Exp(B)	
			Lower	Upper	Wald Chi-Square	df	Sig.		Lower	Upper
[Gender_3_Groups=transgender and gender non-conforming]	-0.669	0.2739	-1.206	-0.133	5.976	1	0.015	0.512	0.299	0.876
[Gender_3_Groups=Cis woman]	-0.640	0.2684	-1.166	-0.114	5.681	1	0.017	0.527	0.312	0.893
[Gender_3_Groups=Cis man]	0 ^a							1		
[AGE_14_TO_30_AP=14-17]	-1.261	0.2960	-1.841	-0.681	18.158	1	0.000	0.283	0.159	0.506
[AGE_14_TO_30_AP=18-24]	-0.331	0.2267	-0.776	0.113	2.135	1	0.144	0.718	0.460	1.120
[AGE_14_TO_30_AP=25-30]	0 ^a							1		
[AreaLiving_recode_AP=Urban]	0.505	0.2343	0.046	0.965	4.653	1	0.031	1.658	1.047	2.624
[AreaLiving_recode_AP=Rural]	0 ^a							1		
[ANTI_LGBTQ_HATE_SPEECH=Experienced it]	-0.112	0.3159	-0.731	0.508	0.125	1	0.724	0.894	0.482	1.661
[ANTI_LGBTQ_HATE_SPEECH=Witnessed it]	-0.650	0.2938	-1.226	-0.074	4.899	1	0.027	0.522	0.293	0.928
[ANTI_LGBTQ_HATE_SPEECH=No]	0 ^a							1		
[DEPRESSION_3CATS_AP=severe/ex.severe]	0.346	0.3317	-0.305	0.996	1.086	1	0.297	1.413	0.737	2.707
[DEPRESSION_3CATS_AP=Moderate]	0.102	0.3070	-0.500	0.704	0.110	1	0.740	1.107	0.607	2.021
[DEPRESSION_3CATS_AP=Normal]	0 ^a							1		
[STRESS_3CATS_AP=severe/ex.severe]	0.428	0.2808	-0.122	0.979	2.327	1	0.127	1.535	0.885	2.661
[STRESS_3CATS_AP=Moderate]	0.151	0.2881	-0.414	0.716	0.275	1	0.600	1.163	0.661	2.046
[STRESS_3CATS_AP=Normal/mild]	0 ^a							1		
[HAPPINESS_3CATS_AP=High]	-0.615	0.3578	-1.317	0.086	2.958	1	0.085	0.540	0.268	1.090
[HAPPINESS_3CATS_AP=Low]	0.210	0.2539	-0.287	0.708	0.685	1	0.408	1.234	0.750	2.029
[HAPPINESS_3CATS_AP=Normal]	0 ^a							1		

[Have you ever deliberately harmed yourself in a way that was NOT intended as a means to take your life?=Yes]	0.067	0.2607	-0.444	0.578	0.066	1	0.798	1.069	0.641	1.782
[Have you ever deliberately harmed yourself in a way that was NOT intended as a means to take your life?=No]	0 ^a							1		
[Have you ever seriously thought about taking your own life?=Yes]	-0.037	0.2902	-0.606	0.532	0.016	1	0.899	0.964	0.546	1.703
[Have you ever seriously thought about taking your own life?=No]	0 ^a							1		
[Have you ever made an attempt to take your life?=Yes]	0.774	0.2255	0.332	1.216	11.782	1	0.001	2.169	1.394	3.374
[Have you ever made an attempt to take your life?=No]	0 ^a							1		
Dependent Variable: DRUG_USE_COMBINED_AP Model: (Intercept), Gender_3_Groups, AGE_14_TO_30_AP, AreaLiving_recode_AP, ANTI_LGBTQ_HATE_SPEECH, DEPRESSION_3CATS_AP, STRESS_3CATS_AP, HAPPINESS_3CATS_AP, Have you ever deliberately harmed yourself in a way that was NOT intended as a means to take your life?, Have you ever seriously thought about taking your own life?, Have you ever made an attempt to take your life?										
a. Set to zero because this parameter is redundant.										
b. Fixed at the displayed value.										

Appendix C

Logistic regression results of hazardous alcohol use

Parameter Estimates										
Parameter	B	Std. Error	95% Wald Confidence Interval		Hypothesis Test			Exp(B)	95% Wald Confidence Interval for Exp(B)	
			Lower	Upper	Wald Chi-Square	df	Sig.		Lower	Upper
[Gender_3_Groups=transgender and gender non-conforming]	-1.002	0.2023	-1.399	-0.606	24.566	1	0.000	0.367	0.247	0.545
[Gender_3_Groups=Cis woman]	-0.662	0.1796	-1.014	-0.310	13.602	1	0.000	0.516	0.363	0.733
[Gender_3_Groups=Cis man]	0 ^a							1		
[AGE_14_TO_30_AP=14-17]	-1.786	0.2245	-2.226	-1.346	63.264	1	0.000	0.168	0.108	0.260
[AGE_14_TO_30_AP=18-24]	0.096	0.1518	-0.201	0.394	0.402	1	0.526	1.101	0.818	1.482
[AGE_14_TO_30_AP=25-30]	0 ^a							1		
[AreaLiving_recode_AP=Urban]	0.557	0.1571	0.249	0.865	12.562	1	0.000	1.745	1.283	2.374
[AreaLiving_recode_AP=Rural]	0 ^a							1		
[ETHNICITY_2CATS_AP=Ethnic minorities]	-0.277	0.1871	-0.644	0.089	2.196	1	0.138	0.758	0.525	1.094
[ETHNICITY_2CATS_AP=White Irish]	0 ^a							1		
[SEXUAL_ORIENTATION_AP=Q+]	-0.443	0.1906	-0.817	-0.070	5.412	1	0.020	0.642	0.442	0.933
[SEXUAL_ORIENTATION_AP=Non monosexual]	0.101	0.1639	-0.220	0.423	0.381	1	0.537	1.107	0.802	1.526
[SEXUAL_ORIENTATION_AP=Monosexual]	0 ^a							1		
[SUPPORT_IMMEDIATE_FAMILY_AP=No]	0.100	0.1616	-0.217	0.416	0.381	1	0.537	1.105	0.805	1.517
[SUPPORT_IMMEDIATE_FAMILY_AP=Yes]	0 ^a							1		
[ANXIETY_3CATS_AP=severe/ex.severe]	0.528	0.1836	0.168	0.888	8.269	1	0.004	1.695	1.183	2.429
[ANXIETY_3CATS_AP=Moderate]	0.465	0.2029	0.068	0.863	5.259	1	0.022	1.592	1.070	2.370
[ANXIETY_3CATS_AP=Normal/mild]	0 ^a							1		
[RSE_3CATS_AP=High]	-0.258	0.2085	-0.667	0.151	1.531	1	0.216	0.773	0.513	1.163
[RSE_3CATS_AP=Low]	-0.032	0.1779	-0.381	0.317	0.032	1	0.858	0.969	0.684	1.373

[RSE_3CATS_AP=Normal]	0 ^a							1		
[BRS_3CATS_AP=High]	0.884	0.3718	0.155	1.613	5.655	1	0.017	2.421	1.168	5.017
[BRS_3CATS_AP=Low]	-0.147	0.1538	-0.448	0.155	0.910	1	0.340	0.864	0.639	1.167
[BRS_3CATS_AP=Normal]	0 ^a							1		
(Scale)	1 ^b									
Dependent Variable: AUDIT_GROUP_COMBINED_AP										
Model: (Intercept), Gender_3_Groups, AGE_14_TO_30_AP, AreaLiving_recode_AP, ETHNICITY_2CATS_AP, SEXUAL_ORIENTATION_AP, SUPPORT_IMMEDIATE_FAMILY_AP, ANXIETY_3CATS_AP, RSE_3CATS_AP, BRS_3CATS_AP										
a. Set to zero because this parameter is redundant.										
b. Fixed at the displayed value.										