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Belong To LGBTQ+
Youth Ireland

Wellbeing and Mental Health in the Older LGBTQI+ Population in Ireland

Findings from the Being LGBTQI+ in Ireland Study

January 2025

An Roinn Leanaí, Comhionannais, Míchumais, Lánpháirtíochta agus Óige
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Being LGBTQI+ in Ireland

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Note

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

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

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

Glossary

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

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

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

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

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

Epicene is a term used to indicate a lack of gender distinction. It can also be used as a gender, or as a way to describe a range of genders.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Minority stress is based on the premise that LGBTQI+ people, like members of any minority group, are subject to chronic psychological stress due to their group's

stigmatised and marginalised status. While LGBTQI+ people are not inherently any more prone to mental health problems than other groups in society, coping with the effects of minority stress can be detrimental to LGBTQI+ people's mental health.

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

MSM is an abbreviation for: Men Who Have Sex with Men.

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

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

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

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

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

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

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

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

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

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

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.

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

Executive Summary

This report presents findings on the self-reported mental health and wellbeing of older LGBTQI+ people (60+ years) in Ireland. It draws on data from the 2022 national online survey '*Being LGBTQI+ in Ireland*' (n=2,806) which is a detailed exploration of the wellbeing and mental health of lesbian, gay, bisexual, transgender, queer/questioning, intersex, and other sexual and gender minority communities. Findings from the main study can be found elsewhere (Higgins et al. 2024). This sub report focuses specifically on older LGBTQI+ people, defined here as 60+ years of age and provides a timely update to a prior report on the experiences and needs of older LGBTQI+ people in Ireland (Higgins et al. 2011). The report objectives are to:

1. provide a descriptive analysis of older LGBTQI+ people's wellbeing and mental health;
2. compare the wellbeing and mental health issues of this population stratified by gender identity, sexual orientation, marital status, employment status and area living;
3. provide a descriptive analysis of older LGBTQI+ people's experiences of healthcare, safety, harassment and community belonging;
4. summarise commentary participants made in response to open questions in the survey regarding experiences and challenges in ageing;
5. position findings in the context of wider national and international literature on older LGBTQI+ people.

The study made use of validated tools to measure indicators of wellbeing and mental health, including happiness, self-esteem, resilience, depression, anxiety, stress, eating disorder, alcohol and drug use. Participants were also asked questions related to comfort with one's sexual orientation and gender identity, self-harm and suicidality, community belonging, safety in public, experiences of violence and harassment, health status and healthcare experiences, and degree of 'outness' with family, friends and other groups in their lives. While no open-ended questions specifically relating to ageing were included, all of the open-ended questions were analysed to explore if issues specifically related to older people or ageing could be identified.

The results from the 99 LGBTQI+ participants, most of whom were in their 60s (age range: 60-84), indicate that that the majority of older LGBTQI+ participants are in good physical and mental health. The majority rated their general health as good or

very good (74%) and had not sought help for a mental health problem in the last five years (67%). Older people scored higher on happiness, comfort with one's sexual orientation and gender identity, resilience and self-esteem measures than all of the younger age groups in the main *Being LGBTQI+ in Ireland* study. The mean happiness score was 7.69 (SD=1.54), significantly higher than the average happiness ratings of the youngest participants in the study (14-18 years: Mean=5.02, SD=2.04). Similarly, mean self-esteem and resilience scores among older participants were significantly higher (M=32.81, SD=5.44; M=3.53, SD=0.79) compared to the 14-18-year-olds (M=22.46, SD=5.63; M=2.54, SD=0.78). This is positive, particularly in the context of participants recounting growing up in an environment dominated by heterosexism, homophobia, and stigmatisation, and, for some, experiences of internalised stigma that persist.

In contrast to these positive findings, lifetime prevalence of suicidal thoughts was high at 42%, with the majority reporting that they had suicidal thoughts more than one year ago. However, lower rates of lifetime self-harm and suicide attempt (13% and 17%) were reported. Thirty one per cent (31%) of those who drank alcohol, scored as being at risk for harmful alcohol use, 15% reached the risk threshold indicative of having a potential eating disorder, and moderate/severe/extremely severe symptoms of depression and anxiety were experienced by 14% and 15% of the sample respectively.

Participants reported generally positive experiences when accessing healthcare and engaging with healthcare professionals (HCPs). The vast majority were never told by a HCP that their LGBTQI+ identity could be changed (98%), were never asked unnecessary/invasive questions about their LGBTQI+ identity by a HCP (82%) and never felt discriminated against by a HCP because of their LGBTQI+ identity (84%). However, they did report more varying answers relating to their comfort disclosing their LGBTQI+ identity to a HCP with 43% never/sometimes feeling comfortable disclosing their LGBTQI+ identity and 30% never/sometimes receiving acknowledgement of their LGBTQI+ identity once disclosed to a HCP. In addition, participants reported generally feeling safe in public, going about their day on public transport, or utilising LGBTQI+ venues, but felt less so when it came to showing affection in public. A total of 47% reported feeling unsafe/very unsafe holding hands with a same-sex partner in public (14% would not do it at all), and 51% felt unsafe/very unsafe showing affection with a same-sex partner in public (13% would not do it at all).

Around two-fifths of the older LGBTQI+ adults reported living alone. Nearly half (49%) reported feeling isolated and separate from others who share their LGBTQI+ identity. Ageism within the LGBTQI+ communities, and an emphasis on younger LGBTQI+ people in spaces and activities were reported which might explain some of the experiences of isolation. For those living alone, isolation during COVID-19 lockdowns was particularly difficult in terms of mental and physical health. Preferences for more and less engagement with the LGBTQI+ community were also expressed, with some wishing to feel more included in the community, and others happy to dip in and out of LGBTQI+ events or pursue connections within non-LGBTQI+ communities. Some participants also expressed some concerns about getting older, such as a lack of LGBTQI+ inclusive health care options available to them or having to go back 'in the closet' when they would be in need of care. Older LGBTQI+ people suggested that they have a lot to offer to the LGBTQI+ community by way of sharing their histories and experiences, and the ways in which these inform LGBTQI+ related social justice, as well as being a way of bridging inter-generational experiences.

In interpreting the findings, certain limitations need to be considered. The self-selected and homogeneous sample consisted of well educated, and 'out' LGBTQI+ older individuals. It is unknown if these findings would extend to more diverse, disadvantaged or hidden older LGBTQI+ populations. It is of particular importance to note that due to the virtual absence of octogenarians in our study it is not possible to identify in more detail how ageing at that stage in life relates to LGBTQI+ identities. The small sample size limits analyses of differences in mental health and wellbeing indicators between subgroups. In addition, the small numbers of non-binary and transgender older adults and older adults who identified with emerging sexual identities means that there is little or no focus on their experiences. In the *Being LGBTQI+ in Ireland* study, no focussed questions were developed for the older LGBTQI+ cohort specifically and this may have limited the scope and richness of the data gathered.

Notwithstanding the limitations, the emerging findings have led to the following recommendations:

Recommendations for Policy

In some policy documents LGBTQI+ older people are identified as a priority group but exploration about how this group's needs and aspirations might be addressed is

missing, while in other policy documents older people are a priority group without any specific focus on older LGBQTI+ people. Therefore, it is recommended that:

- Older LGBTQI+ people should be included in all health and wellbeing policies, government and non-government, not only as a specific target group, but with data on their experiences to inform policy and regulatory standards. This should not only relate to policies about older people, but also other topics that also affect older LGBTQI+ people such as housing or healthcare policy.
- Government should ensure that there is LGBTQI+ representation, based on co-production principles, on policy and strategy advisory groups across all of government so that older LGBTQI+ people's challenges, needs and experiences are included in planning and evaluation processes in the work of government. In terms of the current study, this is particularly important in the areas of health and housing.
- Funding should be allocated to LGBTQI+ organisations for the continued development of older LGBTQI+ people's initiatives. These initiatives should be co-produced with LGBTQI+ older people, with a view to being valuable not only for older LGBTQI+ people, but the entire LGBTQI+ community, and indeed society more generally.
- Health educators should conduct a review of current curricula to ensure that they are more inclusive and are not reinforcing heteronormative, cisgender, or ageist biases.
- Professional bodies which accredit health professional education, (for example, the Nursing and Midwifery Board of Ireland, Medical Council) should include competencies related to providing culturally sensitive care for older LGBTQI+ people.

Recommendations for Research

There were gaps in terms of the participation of some older LGBTQI+ sub-groups in this study. In addition, research undertaken with older people is not always inclusive of older LGBTQI+ people's voices. We recommend that:

- Research into the experiences of older LGBTQI+ people should be undertaken again with a view to actively including transgender and non-binary people, and people who identify with emerging sexualities. LGBTQI+ people that come out at an older age should also be targeted for research as they may have unique experiences.
- Research into the experiences of LGBTQI+ people who are not out or are disconnected from the LGBTQI+ community should also be undertaken in order to capture and address their specific needs.
- Research being undertaken with older people should include LGBTQI+ identifiers to ensure that the voices of LGBTQI+ people are heard and that their experiences, needs and aspirations go towards informing policy and practice, particularly in terms of health, wellbeing, housing, and health care.

- Research focused on a comparison of the LGBTQI+ community with the general population in terms of psychological, social and economic factors in ageing is needed to identify where patterns converge or diverge. This will identify in more detail how needs of older LGBTQI+ people relate to those of the general population.
- A longitudinal study of older LGBTQI+ people should be conducted to learn about how ageing affects this population overtime. All future research on ageing should include sexual orientation and gender identity in demographics in order to provide data on health and other outcomes for the older LGBTQI+ population.

Recommendations for Service Provision

While participants' health and healthcare use experiences were positive on many levels, the findings indicate that there are still some areas that require attention. These include participants' discomfort disclosing LGBTQI+ identities and having their identity acknowledged by health care professionals. In addition, some indicators of poorer mental health were identified. Based on these findings we recommend that:

- The HSE and other healthcare providers should continue to work with LGBTQI+ organisations to build capacity among all healthcare and support staff through training and ongoing continuing professional development on the provision of inclusive and affirmative approaches to the provision of care to older LGBTQI+ people. This is with a view to providing culturally competent health and social care across state and NGO services.
- All existing health and social care services for older LGBTQI+ people need to be proofed to ensure that their policies and practices are LGBTQI+ inclusive, for example, ensuring patient/resident forms are inclusive of sexual and gender minority identities and reviewing visitation policy to include 'family of choice'.
- In particular, the HSE dementia services should be proofed to ensure that they are inclusive of older LGBTQI+ people and their families in general, and transgender and non-binary people in particular; this includes having health care providers who are knowledgeable on LGBTQI+ issues and are equipped to provide an affirmative service to the individual.
- To ensure the quality of and access to mental healthcare for the older LGBTQI+ community, specific emphasis on exploring indicators of mental health challenges should be explored such as alcohol and drug use, and symptoms of depression and anxiety. This will go towards creating accessible, safe, high-quality mental health services with improved access with tailored and specific supports for older LGBTQI+ people.
- In terms of planning for the housing needs of older LGBTQI+ individuals, housing policies should consider ways to support and develop options for secure housing which meets the needs and wishes of older LGBTQI+ people.

Recommendations for the LGBTQI+ community

Despite the work focused on older LGBTQI+ people that is already ongoing within the LGBTQI+ community, the study findings indicate that a degree of isolation exists among this population (more so than among younger LGBTQI+ people). Consequently, it is recommended that:

- LGBTQI+ organisations review policies, strategies, systems, infrastructure and processes to ensure they facilitate connection for older LGBTQI+ people to the wider LGBTQI+ community. These should be proofed not only from an age perspective, but also from an accessibility perspective to ensure that the community, events, activities and spaces are user-friendly and relevant. This proofing work should be done with older LGBTQI+ people using co-production principles.
- More emphasis should be placed on developing initiatives that aim to strengthen intergenerational links within the LGBTQI+ community, that draw on the knowledge and experiences of older LGBTQI+ people and younger LGBTQI+ people, and should be designed and developed with LGBTQI+ people from across the life course.

Chapter 1 : Introduction

People worldwide are living longer, and ageing populations are increasing year on year and this is no different in Ireland. This sub report of *Being LGBTQI+ in Ireland* is focused on LGBTQI+ older people (n=99) and focuses on the mental health and wellbeing of 99 participants drawn from a larger sample (n=2806). For the purposes of this report, older people are defined as those who are aged 60 and over. According to the most recent Census figures for Ireland taken in 2022, there were 1,048,985 people aged 60 and older living in Ireland, an increase of 19.7% since 2016 (Central Statistics Office (CSO), 2023). In addition, based on 2016 estimates, Ireland is well on the way to meeting the projected figures of an approximate doubling of the older population (based on 65 years and older) to almost 1.6 million by 2051 (CSO, 2020).

There continues to be no official estimate of the LGBTQI+ population in Ireland. The percentages of LGBT+ people in the population reported by the Oireachtas Library & Research Service (2019) range between 1.2% and 3.8% drawn from a range of estimates in 15 other OECD countries (adult population aged 15/16+). Based on these figures, we estimate that the LGBT+ population aged 60+ in Ireland could range between 12,587 and 39,859 people. In the CSO Pulse Survey (2021) involving over 10,000 self-selecting participants, 7% identified as gay or lesbian, 5% as bisexual and 1% as 'other' (CSO, 2021). At a total of 13%, the estimate of LGB population in Ireland would be in the region of 136,368 people. Age Action Ireland suggest that a conservative estimate of at least 20-30,000 older persons aged 60+ (2-3%) are lesbian, gay or bisexual in Ireland. In terms of transgender people, Age Action Ireland also estimate at least 5,000 transgender people in Ireland, 1,000 of these estimated to be older persons (60+) (O'Connor and Murphy, 2022). The UN estimates the prevalence of intersex people as ranging between 0.5-1.7% of the population (Ní Mhuirthile et al. 2022). When applied to Ireland, this would mean that the number of intersex people 60+ in Ireland might range between 5,244 and 17,832.

Visible Lives was the first comprehensive study in Ireland to explore the experiences and needs of older LGBT people (Higgins et al. 2011). The study gathered survey data from 144 people and interview data from 36 people aged 55 and over in Ireland. The picture that emerged from that study was one of many LGBT people having lived through their teenage years and young adulthood in isolation, due to living in a very conservative culture, where homosexuality was criminalised and where all non-heterosexual relationships were stigmatised. In that study, the mean age for 'coming

out' was 31 years (SD=12.6), and many participants reported not 'being out' to close family, work colleagues, or friends. While overall, participants reported a high degree of comfort with their sexual orientation and gender identity, fears of harassment, and fears of rejection from loved ones associated with coming out persisted. Lifetime prevalence for a mental health problem was one in three, with one in ten reporting they were currently taking prescribed medication for a mental health issue. Barriers to community involvement included the youth-orientated nature of LGBT activities, the absence of social networks outside of urban locations, and access for people in rural areas. Approximately one quarter of survey participants in *Visible Lives* reported receiving poor quality healthcare with two-fifths associating this with them being part of the LGBT community, and nearly a quarter reported not revealing their identity to healthcare providers due to fears of a negative reaction. Notwithstanding these findings, participant resilience and strength of spirit was clearly present, engendered through the use of processes and strategies at individual and group level including reflexive work on themselves, developing pride in who they were and how they had navigated a difficult social context for LGBT people, as well as active engagement with peer and professional networks, not least LGBT politics and activism. In terms of getting older, participants expressed preferences for living in their own homes, many being reticent about living in nursing homes with fears about their LGBT identities not being respected being a key concern. Participants expressed concerns about isolation and loneliness as they aged and many did not feel part of their local or LGBT communities. Since the *Visible Lives* study (Higgins et al. 2011), there have been several significant legal and policy changes in Ireland, outlined below, that have positively impacted the civil rights of LGBTQI+ people. Given the pace of this change since the *Visible Lives* study was conducted, it is timely to focus once again on the older LGBTQI+ population. Hence, the core focus of this report is on the mental health and wellbeing of LGBTQI+ older people. Drawing on data from *the Being LGBTQI+ in Ireland* study, the five main objectives are to:

1. provide a descriptive analysis of older LGBTQI+ people's wellbeing and mental health
2. compare the wellbeing and mental health of this population stratified by gender identity, sexual orientation, marital status, employment status and where they live
3. provide a descriptive analysis of older LGBTQI+ people's experiences of healthcare, safety, harassment and community belonging

4. summarise commentary participants made in response to open questions in the survey regarding experiences and challenges in ageing; and
5. position findings in the context of wider national and international literature on older LGBTQI+ people.

Changing legal and policy landscape

The Republic of Ireland has undergone rapid social change over the last 35 years and this has had a positive impact on sexual and gender diverse people. While progress was slow a number of key legislative changes reflect Ireland's more inclusive society. *The Marriage Equality Act 2015*, *the Gender Recognition Act 2015*, *the Equality Act in 2015*, and *the Children and Family Relationships Act 2015* were some of the legislative changes that signalled a more welcoming environment for the LGBTQI+ community. The participants in the first comprehensive study of older LGBT people in Ireland '*Visible Lives'* (Higgins et al. 2011) grew up prior to these societal changes and while it was their tireless activism that brought about these changes, their experiences were very different to those who are growing up now. It is worth remembering that homosexuality was only decriminalised in Ireland in 1993.

A range of policies and strategies have also been published, not only those targeted at LGBTQI+ people such as the National LGBTI+ Inclusion Strategy 2019-2021 (DCEDIY, 2019), but also general population strategies that recognise LGBTQI+ people as a priority group requiring targeted action, including *Connecting for Life Suicide Strategy 2015- 2024* (DoH, 2015), *The National Sexual Health Strategy 2015-2020* (DoH, 2015), *The National Drug and Alcohol Strategy 2017-2025* (DoH, 2017), and *Sharing the Vision, 2020* (DoH, 2020) the mental health strategy.

While these are welcome steps, not least because of the positive impact that pro-LGBT+ state-level policies have on LGBT people's health (Nelson et al. 2023), there are gaps in policy and planning which perpetuate the problem of older LGBTQI+ people being a hidden population. In terms of the National Positive Ageing Strategy, *Positive Ageing Starts Now* (DoH, 2013), LGBT+ people are recognised as a vulnerable group, but their experiences are not captured by the national indicators to monitor the strategies' implementation (Roe et al. 2020). Similarly, while an estimate of older LGBT people is included in the recent report by Age Action Ireland, LGBTQI+ specific experiences of ageing are not explored (O'Connor and Murphy, 2022). In addition, LGBT+ people are not identified in the older person's organisation Alone's Strategic

Plan *Transform Ageing at Home in Ireland* (2021). Neither are older LGBTQI+ people referenced as a specific group in terms of housing in *Housing for all*, Ireland's housing plan to 2030 (GoI, 2021), although there is a recognition of the need for increased housing options for the growing ageing population in Ireland (GoI, 2020).

LGBT ageing and mental health

In the *Visible Lives* study (Higgins et al. 2011), the lifetime prevalence rate of having a mental health difficulty among participants was 33%, with the most frequently reported mental health issue being depression followed by anxiety problems. Among those reporting lifetime thoughts of suicide (11.4%), and acts of self-harm in the last year (4.5%), reasons participants gave were associated with struggles to come to terms with their LGBT identity or rejection having disclosed their identity to others. More recent international research suggests that rates of mental health issues within older LGBTQIA+ people continue to be very high when compared to the general population. For example, in Yarns et al.'s (2016) exploration of the topic of mental health of older LGBT adults, the authors point to a large-scale US study that identified current depression rates (31%) at two to three times higher than those in the general older population, while rates of positive screening for depression for older transgender individuals were even higher at 48%. On examining specific sub-groups in smaller scale studies, Yarns et al. (2016) identified even higher rates of mental health problems. For example, convenience sample research reported on in that study (Yarn's et al. 2016) found very high rates of lifetime depression (52.4%), suicidal ideation (53.5%), suicide planning (34.9%) and suicide attempts (28%) among New York based transgender women between 40-59 years old.

In their narrative review of the mental health needs and concerns of older LGBTQ+ people, McCann and Brown (2019) highlight how internalised homophobia, loneliness, depression, alcohol and drug use can be co-occurring overtime, and can be detrimental to LGBTQI+ people's mental well-being and overall quality of life (McCann and Brown, 2019). Older LGBTQI+ people can become disconnected from social networks, for example, due to rejection by family members, and so may be at increased risk of loneliness and social isolation, which has been linked to harmful effects on well-being for older people, including poor mental health, cognitive impairment, as well as risk factors for premature morbidity and mortality (Fredriksen-Goldsen et al. 2013). In addition, COVID-19 has been found to exacerbate already

challenging mental health related risks and conditions among the older LGBTQ+ population (Yu et al. 2022; Age UK, 2021; The Fenway Institute, 2020).

While in the general population, hazardous substance use tends to decline with age, older LGBT people have been found to have a less pronounced decline (Yarns et al. 2016). In their secondary analysis of 2015 to 2017 US National Survey data on drug use and health, Han et al. (2020) explored past-year prevalence rates for use of cannabis, alcohol, cocaine, methamphetamine, and misuse of prescription opioids, sedatives, stimulants, and tranquillizers by adults identifying as LGB and heterosexual. LGB middle aged and older adults had a significantly higher prevalence than heterosexuals for all substances examined except nicotine dependence. In the UK, a greater proportion of LGBTQI+ adults were found to consume alcohol when compared to the general population, and drinking alcohol every day was more prevalent among older LGBTQ+ people than their younger counterparts (IAS, 2021).

In the Higgins et al. (2011) study, older participants also reported experiencing multiple losses and grief due to loss of family networks, the death of a partner and the death of friends during the AIDS epidemic or by suicide. Older LGBTQI+ people may also face aggression and violence in their day-to-day lives, with participants in Higgins et al.'s study (2011) reporting experiencing verbal (47.3%), physical (19.1%), domestic (15.8%) and sexual (6.7%) violence.

LGBT ageing and physical health

In addition to typical physical health problems associated with ageing, LGBTQI+ older people can experience health problems that are associated with being LGBTQI+. Similar to mental health challenges the risks for poorer physical health may be rooted in the historical context of growing up in a hostile environment, one which may persist throughout the life course, and which can have an enduring negative effect on LGBTQI+ people's health. Correro and Nielson (2020), in their review, reported that lifetime victimisation and internalized stigma predict poor general health for older LGBT people, with internalised heterosexism associated with an increased number of chronic health conditions in LGBT adults aged 50 and older including angina, arthritis, congestive heart failure, diabetes, heart attack, high cholesterol, hypertension, osteoporosis and stroke. Contracting HIV/AIDS also remains a risk for gay and bisexual older men (Kneale et al. 2021), which is concerning given that older people living with HIV are at risk of poorer health outcomes (Age UK, 2021; Emlet, 2016). In

addition, global prevalence estimates indicate that transgender individuals are also disproportionately affected by HIV (Stutterheim et al. 2021).

Yarns et al. (2016) also point to differences in physical health outcomes at the sub-group level. For example, in comparison to their heterosexual counterparts older lesbian and bisexual women have higher rates of obesity and cardiovascular risk, older gay and bisexual men are more likely to live alone and experience poor physical health, and older lesbian women have been found to have more risk factors for breast cancer (Yarns et al. 2016). Many of the modifiable factors for Alzheimer's disease, such as depression, cardiovascular disease, smoking, obesity, and limited social or cognitive engagement, are experienced at higher rates among LGBT older adults, and people living with HIV (Fredriksen-Goldsen et al. 2018).

Disparities in health care access

Studies report that there are disparities in healthcare access both between LGBTQI+ older people and their non-LGBTQI+ counterparts, and among sub-groups within the LGBTQI+ population (Emlet, 2016). Access disparities are reported across many aspects of health and social care, including end-of-life care for older LGBTQI+ people (Kneale et al. 2021, Higgins and Hynes, 2019, The Fenway Institute, 2020; Age UK, 2021).

A recent study by Crenitte et al. (2023), found that being LGBT+ was an independent factor associated with worse access to health screening, with the rate of screening for cancer (breast, colon, and cervical cancer) being lower in the LGBT+ population aged 60+ in comparison to non-LGBT+ people (Crenitte et al. 2023). Kneale et al. (2021), noted in their systematic scoping review, that older gay men were less likely than younger gay men to take care of their sexual health, less likely to be tested for HIV/AIDS and less willing to take a test (Kneale et al. 2021), while Fredriksen et al. (2013) found that bisexual older men reported lower rates of being tested for HIV than older gay men.

Care homes can also present access challenges for all older people due to fear of loss of autonomy and independence. For older LGBT people not knowing if their sexual / gender identity will be properly respected, or if they will encounter homophobia, transphobia, heteronormativity or identity denial can be a key deterrent to accessing care home services (Kneale et al. 2021). Transgender people have been identified as a group that face unique stresses and challenges in terms of these and other care

settings in older age, for example, difficulties identifying care contexts that will not devalue or deny their gender identity but instead will facilitate them to live out their lives as their gender identity (Higgins and Hynes, 2019; Kneale et al. 2021).

Causes of health disparities

Crenitte et al. (2023) identified relational, organisational and contextual barriers to healthcare access among older LGBTQI+ people. Negative interactions with health and social care providers, for example, where one's LGBTQI+ identity or relationship is not acknowledged, whether intentionally or not, can result in identity loss and a sense of invisibility (Crenitte et al. 2023; Kneale et al. 2021). Studies show that older LGBTQ+ adults may opt to conceal their identities from health and social care providers, fearing that disclosing their sexual orientation or gender identity to care providers may result in identity-based discrimination (Benbow and Kingston, 2022, Burton et al., 2019, Putney et al. 2018, Hayman and Wilkes, 2016). This can result in receiving sub-optimal care. Services that are culturally heteronormative and cisnormative in nature can be experienced as exclusive, such as patient/client data forms that don't recognise a person's LGBTQI+ status, toilet access barriers, or absence of relevant educational material (Crenitte et al. 2023). Having prior negative healthcare experiences can result in older LGBTQI+ people delaying care access or avoiding it altogether. Health and social care providers' lack of knowledge and cultural competency in providing care to older LGBTQI+ people may also be a barrier to healthcare use for older LGBTQI+ people both in the community and in long-term health care settings (Millar, 2023; Villar et al. 2022; Jurček et al. 2020).

Concerns about a lack of understanding of sexual orientation and gender identity, and fear of harassment have been identified as deterrents to availing of drug and alcohol support services among transgender people in Scotland (Valentine and Maund, 2016). Other contextual barriers to health care access can include financial difficulties, social isolation, housing exclusion and homelessness, and wider societal discrimination and stigma (Fredriksen-Goldsen et al. 2013; Marshall and Cahill, 2022; Kneale et al. 2021). Insecure housing or homelessness can make accessing appointments difficult (CSH et al. 2021), while living rurally may also mean a lack of options for accessing LGBTQ+-affirming health care (The Fenway Institute, 2020). Finances, or lack of them, have also been identified as a deterrent to accessing care (Benbow and Kingston, 2022, The Fenway Institute, 2020), where LGBTQ+ older adults struggle to pay not only for health care, but also for day-to-day living costs. Studies also indicate that structural

barriers such as state policies / legislation can fail to meet older LGBTQI+ people's needs (Nelson et al. 2023; Roe et al. 2020). Research by Nelson et al. (2023) found that US states with enactment of fewer anti-discrimination policies were associated with higher risks of poor health among LGBTQI+ people.

Like all LGBTQI+ people, different sub-groups of older LGBTQI+ people may have to navigate different intersectional barriers such as race and sexuality (Kum, 2017; Crenitte et al. 2023). Older adults with HIV can experience an intersection of stigma between ageing and their sexuality, HIV status, and real or perceived drug use (Johnson Shen et al. 2019), or struggle to source healthcare (The Fenway Institute, 2020; Marshall and Cahill, 2022) which can negatively impact service access.

Concerns of older people as they age

While older LGBTQI+ people share similar concerns of older people in general, studies indicate that LGBTQI+ people also have specific concerns. While many older LGBTQI+ people have support from family members, there are others who have experienced becoming estranged or shunned by their families since their younger years during a time when being LGBTQI+ was criminalised or pathologized (The Fenway Institute, 2020). Indeed, older LGBTQI+ people continue to have fears about growing old alone, and fears regarding who would care for them in the event that care was needed (Cummings, 2021). In Lottmann and King's (2022) study, 'families of choice' were identified by lesbian and gay men as the people they saw themselves relying on for support in later life, but not necessarily support for personal care needs or full-time assistance, highlighting the probability of older LGBTQI+ people needing to seek formal assistance.

Like non-LGBTQI+ older people, LGBTQI+ people may be fearful about going into a long-term care home or nursing home, fears related to loss of autonomy and independence, fears of entering formal settings and of dying alone (Kneale et al. 2021). However, for LGBTQI+ people these fears may be exacerbated because of concerns about stigma and discrimination in these care contexts, and in turn being forced to go back into 'the closet' (Addis et al. 2009; Cummings et al. 2021; Age UK, 2021, Miller, 2023). Villar et al. (2022) reported on care facility staff accounts of heterosexist long term care settings which can present barriers for older LGBTQI+ people, fears also highlighted by older LGBT+ people themselves (The Fenway Institute, 2020). Cummings et al. (2021) found that some older LGBTQI+ people have aspirations for maintaining connection with other LGBT+ people as they age due to a

shared history, particularly in relation to experiences of coming out. In Miller (2023), ageing in place with others from the LGBTQI+ community, associated for some with prioritising quality of life over longevity, was a key theme identified.

Many older people have concerns about getting dementia and needing dementia related care. For older LGBQTI+ people these fears can be exacerbated by the additional fears that their advocacy and identity will be neglected when they receive care (Age UK, 2021). There is literature highlighting how this can be more challenging for transgender people, for example, should they forget they have transitioned, which contributes to a confusing context for both the person and service provider (Baril and Silverman, 2022). This is within a wider context of interlocking systems of oppression faced by transgender older adults, including ageism, ableism/sanism and cisgenderism (Baril and Silverman, 2022).

Wellbeing and resilience

Despite the issues and challenges outlined above, older LGBTQI+ people continue to be found to be a resilient population (Yu et al. 2022; The Fenway Institute, 2020; Higgins et al. 2016). Resilience among older LGBTQ+ people is often associated with the strengths gained through adaptation and the development of coping skills in response to previous experiences of stigma and discrimination (Higgins et al. 2016; McCann and Brown, 2019; Pereira and Banerjee, 2021). Qualitative and quantitative studies exploring pathways to resilience in older LGBT+ people have identified positive identity, and social resources (e.g. community, family, relationships) as being among the key factors associated with resilience building in this population (Higgins et al. 2016; Fredriksen-Goldsen et al. 2017; Yarns et al. 2016). In McCann & Brown's narrative review (2019) of the mental health needs and concerns of older LGBTQ+ people, social engagement was found to have a positive impact on health outcomes including depression, disability and overall general health. Additionally, community connectedness, community belonging, sexual identity disclosure, and a positive living environment have been identified as protective factors for mental health (Yarns et al. 2016; Nedeljiko et al. 2024). Spirituality and religion were also found to have a potential boost to resilience with a positive influence on older LGBTQI+ people (Kum et al. 2017), and being open and out to their religious communities about their sexual minority status was associated with older LGBTQI+ people's better mental health outcomes (Escher et al. 2018). Older lesbian and gay people have also reported having greater confidence and self-esteem in older age, when qualitatively reflecting

on life then and now (Waling et al. 2023) and report having arrived at a place of 'contentment', 'comfort' and 'happiness with the self' (Higgins et al. 2011).

Conclusion

In the context of what is described as a hidden population, this research presents an opportunity to undertake an updated exploration of the current status of older LGBTQI+ people's mental health and well-being in Ireland. Mental health, substance use and eating disorder status of the cohort will be examined, along with participants' experiences of healthcare use and their sense of connection and belonging to the LGBTQI+ community. In addition, older LGBTQI+ individuals' resilience will be measured, with well-being examined by measuring happiness, gender and sexual orientation consonance, and self-esteem. The report will also present qualitative feedback on a range of open text questions, which bring to life experiences of coming out, mental health challenges, experiences of ageing, healthcare concerns, support needs and the impact of COVID-19 on participants' lives. Views on how society has progressed in relation to LGBT lives and issues over their lifetime will also be presented. In the context of the more recent fast changing social and policy context in Ireland, this update since the *Visible Lives* (Higgins et al. 2011) study is timely. Prior to presenting the findings, the methodology used in the study will first be outlined.

Chapter 2 : Methodology

Objectives

The objectives of the study are to:

1. provide a descriptive analysis of older LGBTQI+ people's wellbeing and mental health.
2. compare the wellbeing and mental health of this population stratified by gender identity, sexual orientation, marital status, employment status and area living
3. provide a descriptive analysis of older LGBTQI+ people's experiences of healthcare, safety, harassment and community belonging
4. present some of the commentary people made in the survey regarding experiences and challenges in ageing and
5. position findings in context of wider national and international literature on older LGBTQI+ people.

Research Design

This report is based on data from the *Being LGBTQI+ in Ireland* study (n=2,806). The *Being LGBTQI+ in Ireland* study as a whole examines the mental health and well-being of the LGBTQI+ community in Ireland. It collected data using an anonymous online survey from individuals who identified as LGBTQI+, were 14 years of age or over and living in the Republic of Ireland. This study received ethical approval from the Research Ethics Committee of the Faculty of Health Sciences in Trinity College Dublin. A more detailed methodology for this study is published in the full report (Higgins et al. 2024). The results related to older people (those aged 60+) are outlined in this report.

Survey questions

Participants were asked socio-demographic questions that included their age, employment status, ethnicity, marital status, highest level of education, area living, gender identity and sexual orientation. They were also asked questions related to community belonging, safety in public, experiences of violence and harassment, health status and healthcare experiences and degree of 'outness' with family, friends and other groups in their lives.

Nebraska Outness Scale

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

Safety in public

Participants were asked how safe they feel as an LGBTQI+ person in Ireland in public doing the following: using public transport; checking an LGBTQI+ website on a public computer; reading an LGBTQI+ publication in a public space; being seen going to or leaving an LGBTQI+ venue; showing affection with a same-sex partner in public; holding hands with a same-sex partner in public; and expressing one's gender identity in public. This last question was omitted from the analysis due to the very small number of trans and non-binary older participants in this study. Three response categories were available: safe/very safe; unsafe/very unsafe; and would not do it.

Violence and harassment

Participants were asked how often they had experienced seven forms of violence and harassment due to being LGBTQI+ with three response options available: never; within the last year; more than one year ago. The forms of violence and harassment inquired about included physical assault, sexual assault, non-consensual sexual touching, verbal abuse, online harassment, being threatened with being outed and being purposefully misgendered. As the last statement was applicable to only a small number of participants, this was excluded from the analysis.

Connection or belonging to the LGBTQI+ communities

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

- I feel welcome in the LGBTQI+ communities
- I don't feel included in the LGBTQI+ communities

- I feel the LGBTQI+ organisations do a good job advocating for my rights & needs
- I don't feel that my identity is given equal recognition in the LGBTQI+ communities
- I feel my identity is visible in the LGBTQI+ communities
- I feel isolated and separate from other people who share my identity.

Healthcare experiences

Participants who used healthcare services within the previous five years were asked about how often (Response options: never, sometimes, most of the time, always) they experienced the following:

- Healthcare practitioners told me my LGBTQI+ identity could be changed
- I felt personally discriminated against by a healthcare practitioner because of my LGBTQI+ identity
- Healthcare practitioners asked me unnecessary/invasive questions about my LGBTQI+ identity that were not related to the reason for my visit
- I had to continually educate healthcare practitioners about LGBTQI+ identities
- Healthcare practitioners were knowledgeable about LGBTQI+ identities
- Healthcare practitioners made incorrect assumptions about my LGBTQI+ identity
- I felt comfortable to disclose my LGBTQI+ identity to the healthcare practitioner
- When I disclosed my LGBTQI+ identity to healthcare practitioners, it was acknowledged
- The healthcare service/practitioner had posters/leaflets/information that were relevant to LGBTQI+ healthcare.

Wellbeing and mental health indicators

The survey contained validated tools and one custom designed tool which measured indicators of wellbeing and mental health. The following measures have been included in the analysis.

Happiness

A frequently used one-item 11-point scale (0-10) was employed to measure happiness. ‘Taking all things together, how happy would you say you are?’ on a scale of 0-10, with ‘0’ meaning ‘extremely unhappy’ and ‘10’ meaning ‘extremely happy’.

This tool is considered as reliable and valid as multiple items scales (Veenhoven, 2017).

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.

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).

Comfort with Sexual Orientation and Gender Identity

To measure comfort (consonance) or discomfort (dissonance) around gender identity and sexual orientation, an eight question measure was generated, in the absence of an accepted validated measure for dissonance/consonance (Vaidis & Bran, 2019). The Comfort (Consonance)/Discomfort (Dissonance) Scale was constructed based on the comfort measure used in the *LGBTIreland* study (Higgins et al. 2016) and supplemented with themes based on the literature on the experiences of LGBTQI+ communities. Four questions focused on dissonance/consonance around gender identity (GI) and four were focused on sexual orientation (SO). Participants were asked to rate each item on an 11-point Likert scale ranging from 0 to 10. Total scores were computed for the Gender Identity scale and the Sexual Orientation scale, with higher scores on these scales indicating greater comfort/consonance with sexual orientation/gender identity.

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 (Table 2.1 for cut-off points).

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+

Self-harm and suicidality

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

Alcohol use

Participants were asked 10 questions to ascertain their alcohol use based on the Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 2001). Responses were scored from zero to four. Scores were totalled and fell into four categories: low risk level of alcohol consumption (1-7), 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

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

Eating disorders

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

Data analysis

Quantitative data

The quantitative data were analysed in SPSS Statistics Version 27 (IBM Corporation 2020). Data analysis includes descriptive (frequencies, percentages, means and standard deviations), and bivariate inferential statistics. The latter included a series of non-parametric tests to examine whether there were any differences in the wellbeing and mental health indicators based on one's sexual orientation, gender identity, marital status, employment status and area living. The valid percentage is reported for each question with missing data excluded from the calculations. Internal reliability analysis was conducted to assess the reliability of scales used in the survey. Most

scale measures achieved high Cronbach's Alpha values (> .70) indicating that they are reliable. SCOFF's Cronbach's Alpha was slightly lower at 0.58.

Qualitative data

While no open questions relating to older people or ageing specifically were included in the survey, all of the open-ended questions were analysed for themes relating to older people or ageing. Many of the older participants provided qualitative comments relating to their experiences of being older and ageing as well as reflecting on how society has changed over time. While relevant comments were found across nearly all open-ended questions, three questions in particular contained the most comments: What you like most about being LGBTQI+?; What do you find hardest about being LGBTQI+?; If you have any comments to make about your sense of connection or belonging to the LGBTQI+ communities, including suggestions for how connection might be improved, please tell us here.

Ten main themes emerged from the data. Participant quotes are used to illustrate these themes and these are accompanied by the participant's age, gender identity, sexual orientation and their unique study identification number.

Chapter 3 : Sample Profile

Age, gender and sexual orientation

There were 99 older LGBTQI+ participants ranging in age from 60 to 84 (M=64, SD=4.3). Most were in the 60-67 age bracket (n=87, 88%), with just 11 people aged over 70 and one person over 80 years of age (see figure 3.1 for age distribution).

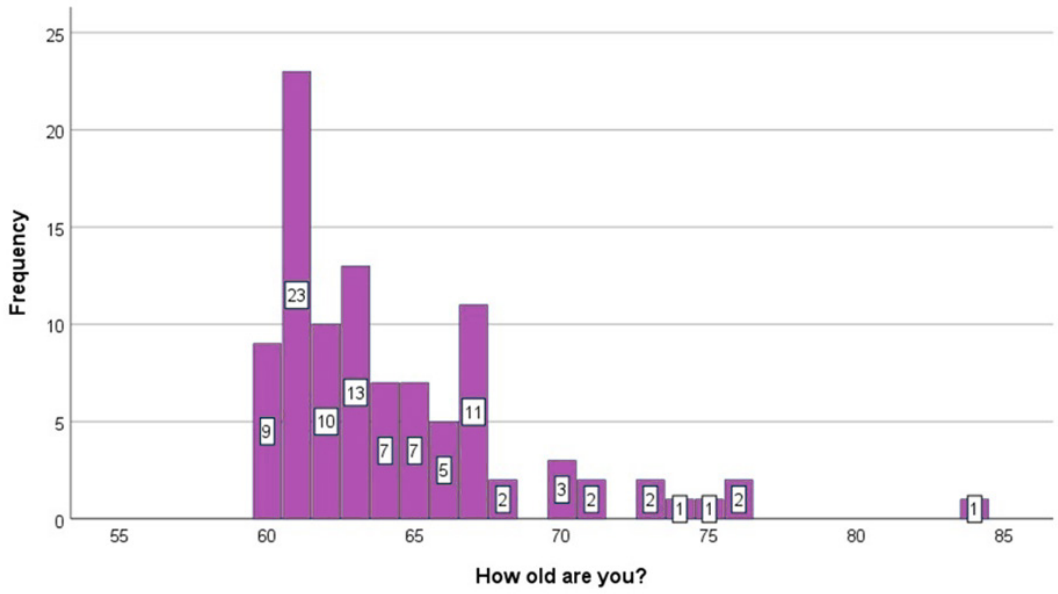

Figure 3.1: Age distribution of older LGBTQI+ participants

The gender and sexual orientation of the sample is shown in Table 3.1. In total, 57 (57.6%) participants identified as a man, 38 (38.4%) identified as a woman, two people as non-binary, one person as 'trans fem' and one person didn't answer. Eight of the participants identified as transgender, seven of whom identified as a trans woman while one person described themselves as 'epicene' which is a term used to indicate a lack of gender distinction. Six of the eight transgender participants lived openly as their gender full-time, one part-time and one person did not live openly as their gender, with the reason given was that it was "unacceptable within family and society in general". One person identified as intersex or as having an intersex variation. Two people selected that they "didn't know" and one person selected "prefer not to say" in response to this question.

Just over half of the sample identified as gay (50.5%), over one quarter as lesbian (28.3%), 8.1% as bisexual, 8.1% as queer and a small number identified with other sexual orientations. Most who identified as gay also identified as men, apart from one participant who identified as a gay woman. Four of the eight bisexual participants

identified as women, and two identified as women/trans women and two as men. Of the 28 who identified as lesbian, 24 identified as women, three identified as women/trans women, one person didn't answer the question on gender.

Table 3.1: Gender and sexual orientation of sample

Characteristic	Category	n	%
Gender (n=99)	Man	57	57.6%
	Woman	38	38.4%
	Non-binary	2	2.0
	Not listed: Please tell us	2	2.0
Sexual orientation (n=99)	Lesbian	28	28.3
	Gay	50	50.5
	Bisexual	8	8.1
	Queer	8	8.1
	Asexual	1	1.0
	Pansexual	2	2.0
	Other	2	2.0

Note: 'Other' sexual orientation includes one person who self-described as 'transvestite' and another who described themselves as both 'lesbian and queer'

Socio-demographic characteristics

The socio-demographic profile of the sample is shown in Table 3.2. Most of the sample had completed education to third level (86.5%). Nearly half were retired (46.5%) and nearly half were in employment (45.5%). Most were Irish (83.8%), just over one-tenth had another white background (13.1%), just three participants were of mixed background. There was no representation from other ethnic minorities, such as Roma, Irish Traveller, Black/Black Irish or Asian/Asian Irish. More than one quarter of participants were single (27.4%), one quarter were in their first marriage to a person of the same-sex (25.3%), 19% were separated/divorced and 9.5% were widowed. The majority of the sample were in a monogamous relationship (42.3%) or single (33%). Three in five had no religion (59.6%), and approximately one quarter were Roman Catholic (26.6%). Among those who had a religion (n=38), 45% practiced sometimes (n=17/38, 44.7%), over one-third (36.8%) practiced regularly (n=14/38), one-tenth practiced 'always' (n=4, 10.5%) and a small number never practiced (n= 3, 7.9%). Nearly two-fifths of participants (37/97, 38.1%) were parents (Cis men 39%; Cis women 44%; TGNC 17%). Just under one-fifth of the sample reported that they or their family were struggling with weekly expenses (n=17/96, 17.7%).

Table 3.2: Socio-demographic characteristics of sample

Characteristic	Category	n	%
Highest Education (n=96)	Some primary education or less	2	2.1
	Completed lower secondary level	6	6.3
	Completed upper secondary level	5	5.2
	Completed third level education	83	86.5
Employment Status (n=99)	Working for payment or profit	45	45.5
	Short-term unemployed (Less than 6 months)	1	1.0
	Long-term unemployed (More than 6 months)	2	2.0
	Retired from employment	46	46.5
	Unable to work due to permanent sickness or disability	3	3.0
	Other: Please tell us	2	2.0
Ethnic Background (n=99)	Irish	83	83.8
	Any other White background	13	13.1
	Other including mixed background	3	3.0
Marital Status (n=95)	Single	26	27.4
	First marriage to someone of the same-sex	24	25.3
	First marriage to someone of the opposite sex	5	5.3
	Re-married to someone of the same-sex	3	3.2
	Re-married to someone of the opposite sex	2	2.1
	In a registered same-sex civil partnership	8	8.4
	Separated/Divorced	18	19.0
	Widowed	9	9.5
Relationship status (n=97)	Single and not dating	32	33.0
	Single and dating	6	6.2
	In a monogamous relationship	41	42.3
	In a non-monogamous (open) relationship	11	11.3
	In polyamorous (multiple people) relationships	1	1.0
	Other: Please tell us	6	6.2
Religion (n=94)	No religion	56	59.6
	Roman Catholic	25	26.6
	Church of Ireland	2	2.1
	Other	11	11.7

Note: Other employment: Practising artist; Unpaid voluntary work. Other religions: Atheist; Christian; Deinstitutionalized Christian; I have a Christian outlook not practiced in organised religion; Lapsed Roman Catholic; Pagan (n=2); Buddhist (n=2); Spiritual to some extent. Other relationship: Widowed (n=2); Separated; Married (n=2); Married but came out…

Living situation

The living situation of participants is displayed in Table 3.3. The majority of participants lived alone (41.7%) or with their same-sex partner/spouse without children (37.5%). Most participants were resident in Leinster (60%), one quarter in Munster (26.3%), one tenth in Connacht (11.6%), and just two participants were from Ulster. Just over one quarter lived in a rural area (27.4%), nearly one quarter in a city (24.2%) while between 13 and 19 per cent lived in other areas, including a village, town and suburb of a city. Just over one fifth of participants (n=20/93, 21.5%) reported that they had experienced a housing difficulty for even one night, mostly couch surfing or staying somewhere temporarily. Five participants had to stay in emergency/temporary accommodation, and four had to sleep rough/in public place.

Table 3.3: Living situation of sample

Characteristic	Category	n	%
Province (n=95)	Leinster	57	60.0
	Munster	25	26.3
	Connacht	11	11.6
	Ulster	2	2.1
Area living (n=95)	Rural/country area	26	27.4
	Village	12	12.6
	Town	16	16.8
	Suburb of a city	18	18.9
	City	23	24.2
Living situation (n=96)	I live alone	40	41.7
	I live with family members (including my child/children) other than my parents/guardians	4	4.2
	I live with my same-sex partner, civil partner, or spouse with no child(ren)	36	37.5
	I live with my same-sex partner, civil partner, or spouse with child(ren)	3	3.1
	I live with my opposite sex partner/spouse with no child(ren)	4	4.2
	I live with my opposite sex partner/spouse with child(ren)	3	3.1
	I live with friends or housemates	5	5.2
	Other	1	1.0

Characteristic	Category	n	%
Type of housing difficulty experienced (n=20)	Yes, I had to stay with friends or relatives temporarily (e.g. couch surfing)	10	
	Yes, I had to stay in a place not intended as a permanent home	8	
	Yes, I had to sleep rough or sleep in a public space	5	
	Yes, I had to stay in emergency or temporary accommodation	4	

Note: Participants could select multiple categories in response to 'Have you experienced any of the following housing difficulties, even for one night?'

Coming out and openness

Most of the older LGBTQI+ participants had told someone about their LGBTQI+ identity (95.8%, n=92/96), with most doing so in their late teens and early 20s (Figure 3.2). The average age of coming out was 28 (N= 91, SD=12.7), with a range of 6-61. Reasons for not telling anyone about their LGBTQI+ identity included feeling 'ashamed', wanting to be 'discrete', and not feeling the need 'to declare my sexuality to the whole world'.

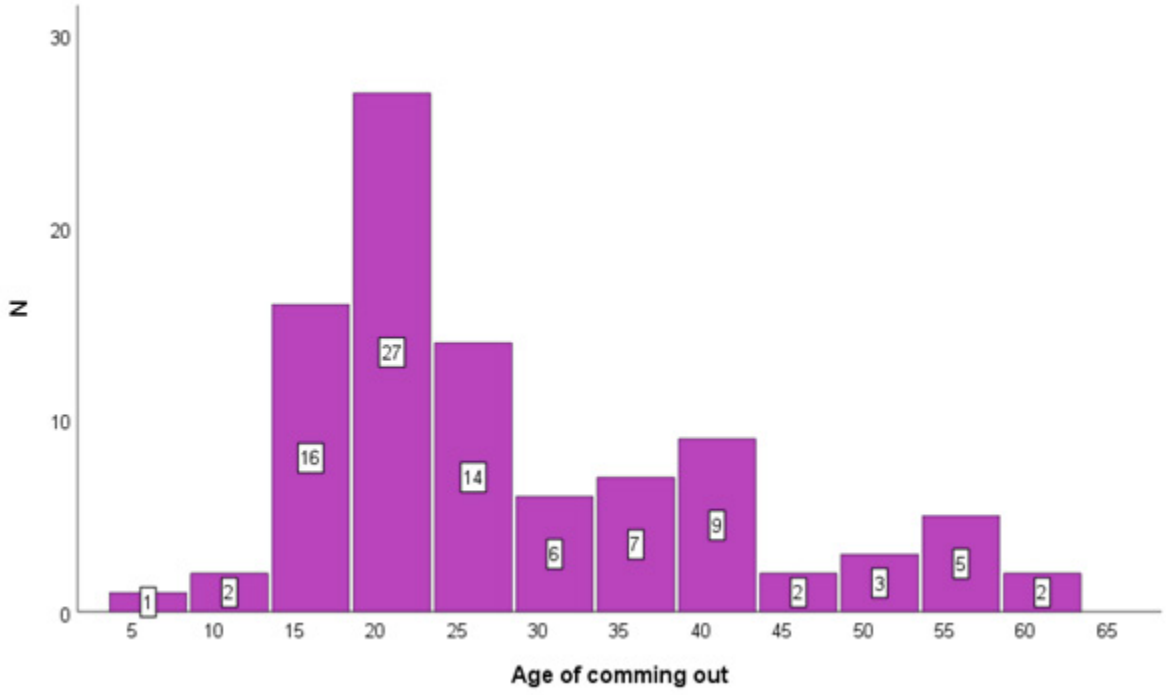

Figure 3.2: Distribution of age of coming out to someone

Apart from strangers, most older people reported that the various groups of people in their lives were aware of their LGBTQI+ identity, with ≥77% levels of awareness (Figure 3.3). Participants were asked how often they avoid talking about topics that

might indicate their LGBTQI+ identity when interacting with various groups on a 0-10 scale with '0' representing 'never' and '10' representing 'always'. Participants avoided this less than half the time with all groups. They were most open in discussing topics with the people they socialise with, members of their immediate family and healthcare providers. With the remaining groups, there was a greater avoidance of discussing topics (Figure 3.4).

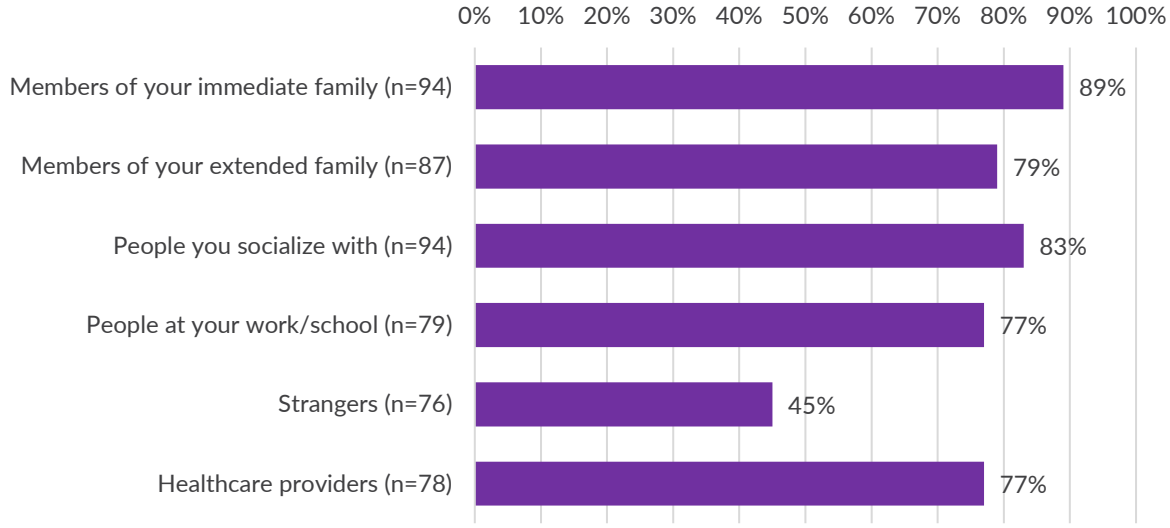

Figure 3.3: What percentage of people in this group do you think are aware of your LGBTQI+ identity?

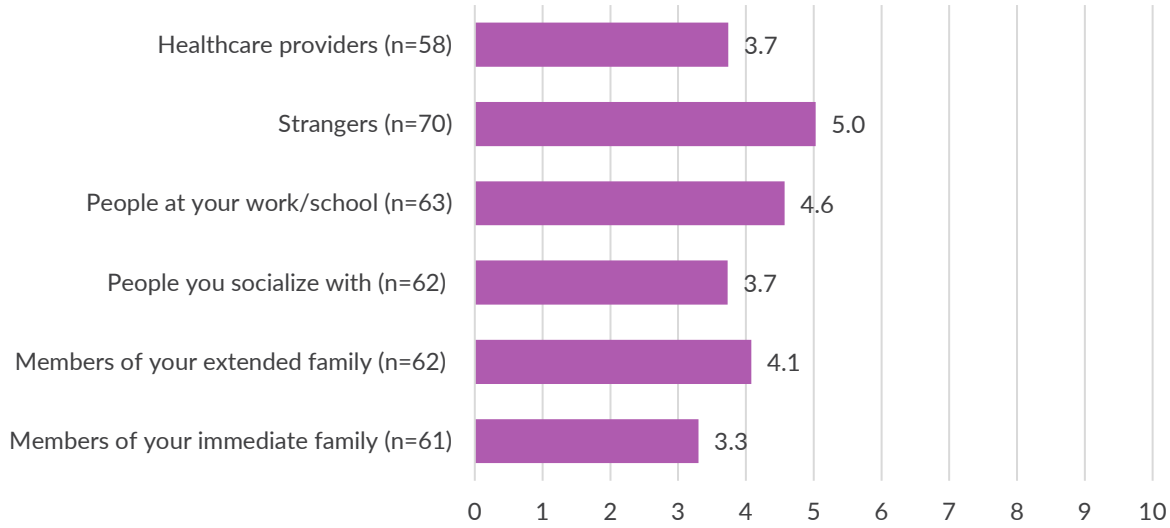

Figure 3.4: How often do you avoid talking about topics that might indicate your LGBTQI+ identity when interacting with these groups?

Chapter 4 : Findings

Objective 1: To provide a descriptive analysis of older LGBTQI+ people's wellbeing and mental health

Wellbeing

Participants' mean score for happiness was 7.69 (N=89, SD=1.54, Range 4-10) on a 0-10 scale. None rated it below 4.

The mean scores for Comfort with Gender Identity (GI consonance) and Comfort with Sexual Orientation (SO consonance) were 8.66 (N=99, SD=2.12) and 9.00 (N=99, SD=1.59) respectively, indicating a high degree of consonance or self-acceptance in the sample around one's gender identity and sexual orientation (Figure 4.1).

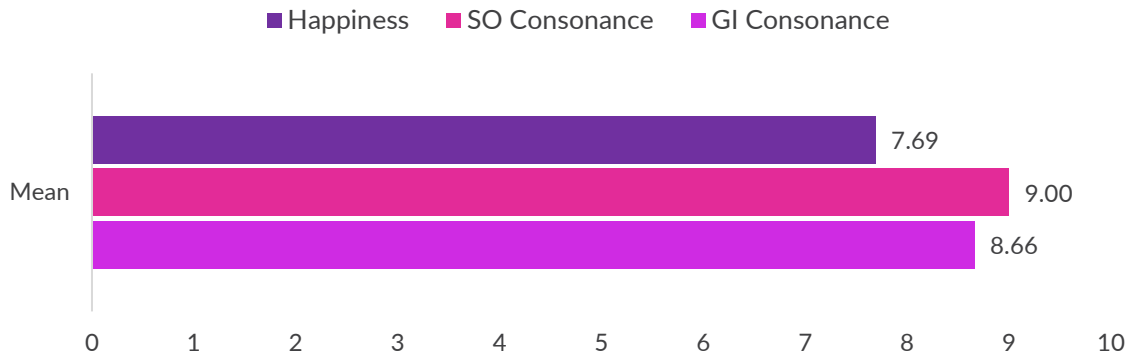

Figure 4.1: Happiness among sample and consonance with gender identity and sexual orientation

Self-esteem was assessed using a scale developed by Rosenberg et al. (Rosenberg et al. 1989). In that scale, scores for self-esteem are categorised as follows: 10-25 (low); 26-35 (normal/medium); and 36-40 (high) (Rosenberg et al. 1989). The mean score for self-esteem was 32.81 (N=97, SD=5.44, Range= 17-40). Over half of the sample (n=53, 54.6%) had scores within the medium category, one third (n=32, 33%) had scores which fell within the high category, and just over one tenth (n=12, 12.4%) had scores which fell within the low category (Figure 4.2).

The mean Brief Resilience Scale (BRS) (Smith et al. 2008) score was 3.53 (N=99, SD=0.79, Range=1.83-5.00), which is above the midpoint of 3 on the scale. Scores can be categorised as follows: Low (1.00-2.99); Normal/medium (3.00-4.30); High (4.31-5.00 = high) (Smith et al. 2013). Accordingly, around one quarter (n=22, 22.2%) fell within the low resilience category, just over half (n=58, 58.6%) scored within the medium category and one fifth (n=19, 19.2%) scored within the high category (Figure 4.2).

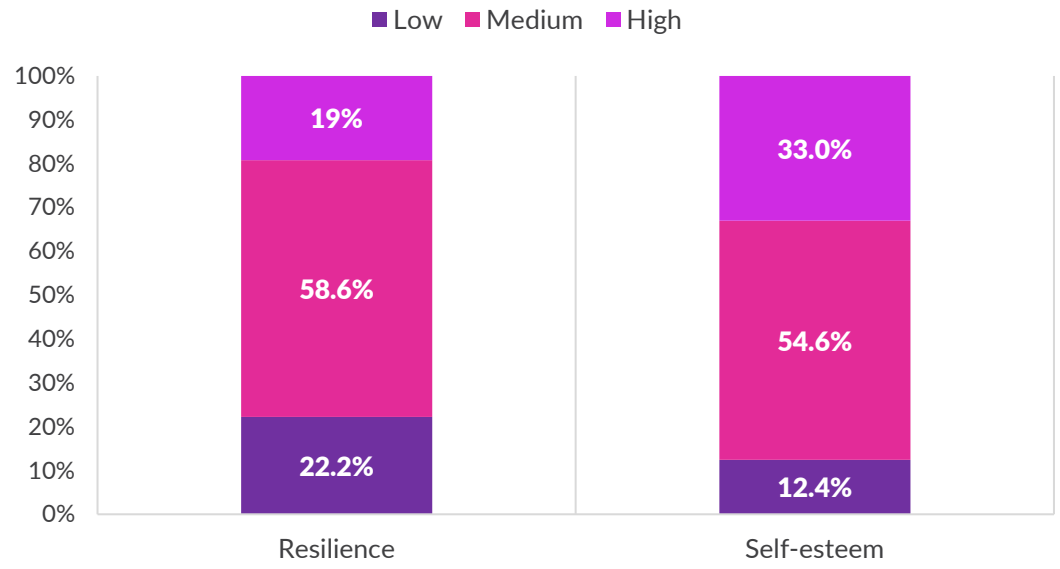

Figure 4.2: Level of resilience and self-esteem among sample

Mental health challenges

DASS-42 (Lovibond &Lovibond, 1995) was used to measure symptoms of depression, anxiety and stress. The mean scores for depression, anxiety and stress were 6.45 (N=88, SD=7.2, Range 0-34), 4.20 (N=88, SD=5.6, Range=0-26), and 8.52 (N=88, SD=7.5, Range=0-36) respectively. Figure 4.3 shows that the vast majority of participants didn't display any symptoms indicative of depression, anxiety or stress.

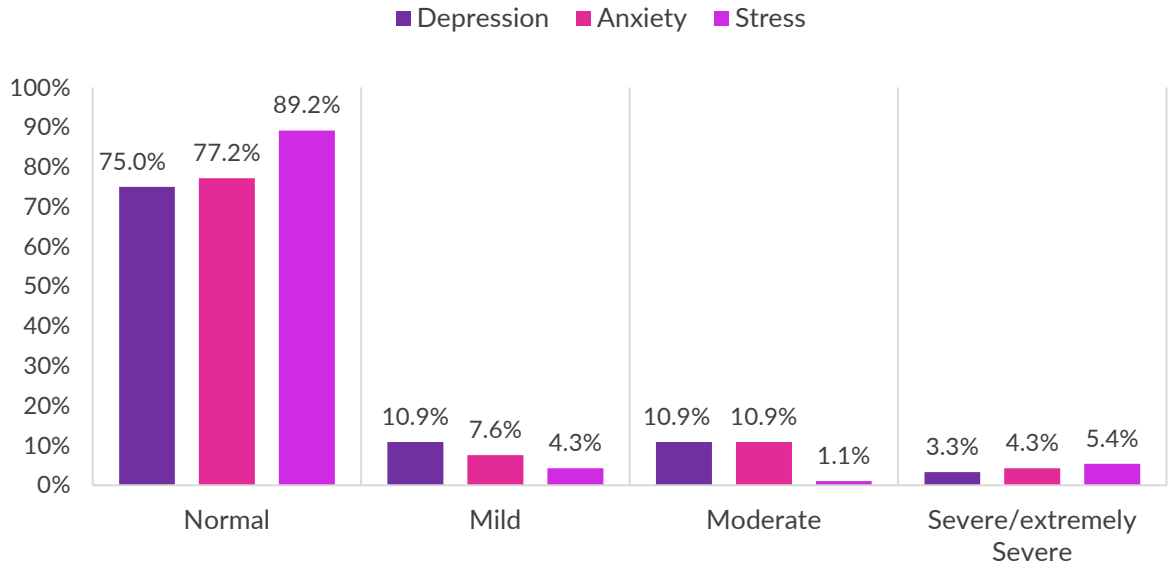

Figure 4.3: DASS-42 categories

Regarding the presence of multiple comorbidities of depression, anxiety and stress, figure 4.4 shows that of the five people who had symptoms of severe or extremely

severe stress, only one person had symptoms of severe/extremely severe stress alone, with the remaining four also having symptoms of severe/extremely severe depression and/or anxiety. Similarly, of the four people who had symptoms of severe or extremely severe anxiety, only one person had symptoms of severe/extremely severe anxiety alone, with the remaining three also having symptoms of severe/extremely severe depression and/or stress. All three who had symptoms of severe or extremely severe depression also had symptoms severe/extremely severe anxiety and/or stress.

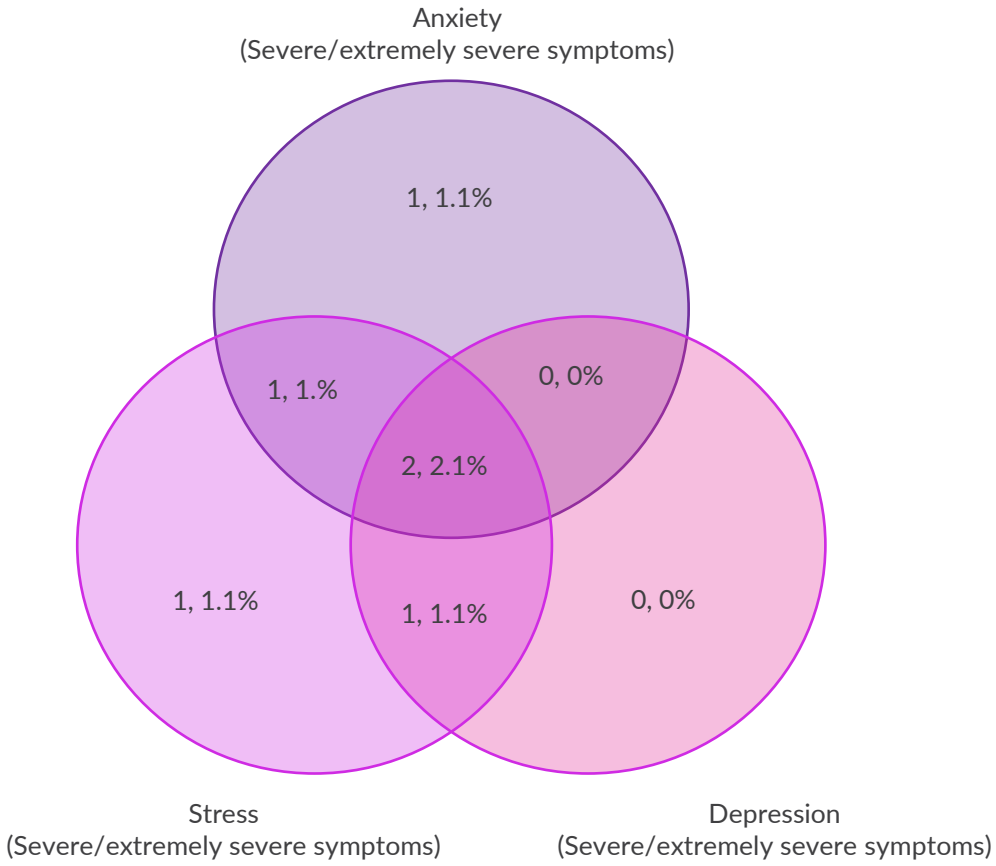

Figure 4.4: Presence of mental health comorbidities – symptoms of severe/extremely severe depression, anxiety and stress

Figure 4.5 shows the rates of self-harm and suicidality among older LGBTQI+ participants. Over one tenth (n=12/90, 13.3%) of the sample reported that they had deliberately harmed themselves in a way that was not intended as a means to take their own life. Most self-harmed for the first time in their teens (13-19 years) (n=9/11). A total of 9/11 reported that they had last self-harmed more than one year ago, with 10/12 reporting that their self-harm was somewhat/very/very much

related to their LGBTQI+ identity, including non-acceptance by community and family.

Around two fifths (n=38/91, 41.8%) of the sample reported having seriously thought of ending their own life, with most (32/38) last having thoughts more than one year ago. The age at which older participants first thought of ending their own life ranged from 15 to 59, with 15 being the most common age and 29 (M=28.9, SD=12.5) being the average age. 26/38 reported that their suicidal thoughts were somewhat/very/very much related to their LGBTQI+ identity.

Almost seventeen percent (16.9%, n=15/89) of participants reported that they had made a suicide attempt, with most (13/15) having done so more than one year ago. The age of (first) suicide attempt ranged from 15 to 48, with the most common age being 15, and the average age being 29 (M=29.1, SD=11.3). 10/15 reported that their suicidal attempt was somewhat/very/very much related to their LGBTQI+ identity.

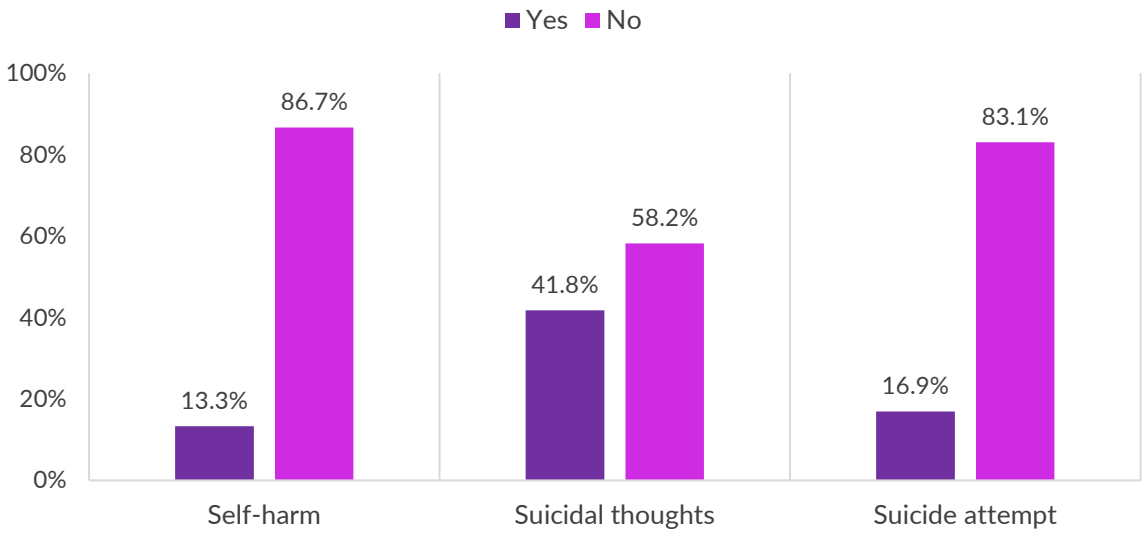

Figure 4.5: Self-harm and suicidality among older LGBTQI+ sample

Substance use

Alcohol use

Alcohol use was measured using the Alcohol Use Disorders Identification Test (AUDIT) (Babor et al. 2001). Approximately one fifth of older participants never drank alcohol (22.2%, n=22). Around one third reported drinking alcohol a few times a week (34.3%, n=34), 15% reported drinking alcohol monthly or less (n=15), 14% reported drinking a few times a month (n=14) while 14% reported drinking 4 or more times a week (n=14) (Figure 4.6).

The average AUDIT score was 6.23, with a range of 1-25 (N=74, SD=4.8). In terms of AUDIT categories (Figure 4.6), 68.9% (n=51) of those who drank alcohol scored as low risk. Approximately one quarter scored within the moderate category (n=19, 25.7%), 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. Three participants had scores indicative of a high-risk level of alcohol consumption, with recommended treatment at this level being brief counselling and continued assessment while one participant scored within the very high risk level category, for which further diagnostic assessment for alcohol dependence by a healthcare provider is recommended.

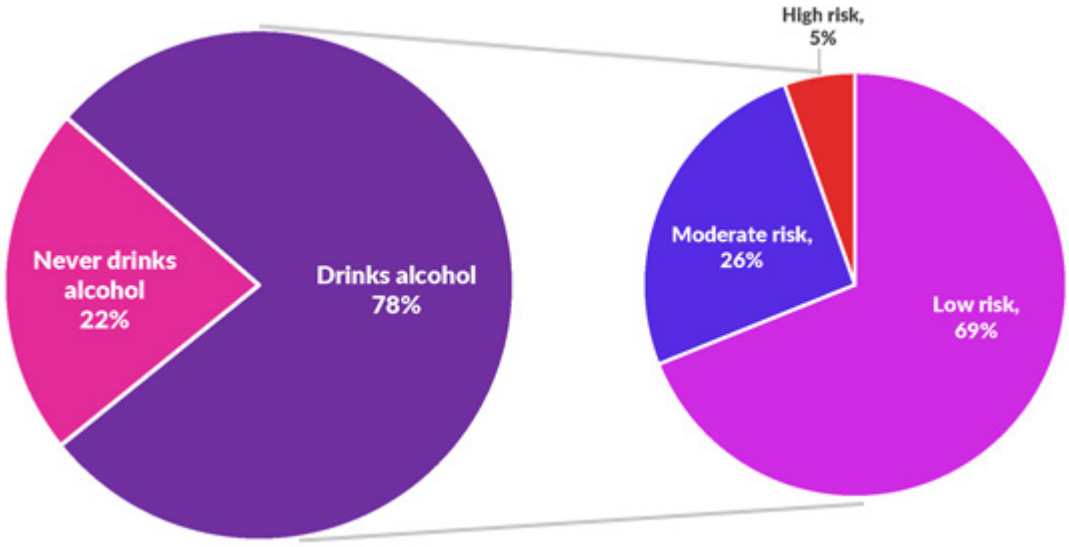

Figure 4.6: Alcohol consumption and risk

Drug use

Nearly half of older participants (47.5%, n=47) reported ever having taken drugs (other than those required for medical reasons). Of these, over two-thirds had taken drugs more than one year ago (68.1%, n=32). Nearly one fifth reported taking drugs within the last month (19.1%, n=9) and just over one tenth had taken drugs within the last year (12.8%, n=6).

DAST-10 (Skinner, 1982) was administered to the 15 who answered 'yes' to having taken drugs within the previous year. One participant was subsequently excluded as they scored as being at no risk with regard to their drug use as they indicated that they had not taken drugs within the last year. Most of the older participants screened

were in the low-risk category (76.9%, n=10), with the suggested action by the authors (Skinner, 1982) being to monitor and re-assess at a later date while three (23.1%) scored at a moderate level, with further investigation recommended at this level. None of the participants' drug use scored at either a substantial or severe risk level.

Of the 14 who took drugs within the last year, the most common reasons were to enhance sexual pleasure (n=8), to get high (n=8), to reduce stress/relax (n=4), and to reduce psychological barriers to sexual performance (n=4). The most common venue for drug taking was at home (n=14).

Eating disorders

The SCOFF Questionnaire is a 5-item measure used to raise awareness of the possible existence of an eating disorder (Morgan et al. 1999). A 'yes' to two or more items (Q1-Q5) (Table 4.1) indicates the possibility of an eating disorder and warrants further questioning and more comprehensive assessment by a healthcare professional. A further two questions (Q6 & Q7) (Table 4.1) have been shown to indicate a high sensitivity and specificity for bulimia nervosa and would indicate further questioning and discussion is required. 14.6% (n=13/89) of participants reached the risk threshold indicative of having a potential eating disorder. In relation to the two additional questions, 10.6% (n=10/94) of the sample indicated that they were dissatisfied with their eating patterns and ate in secret, answers which would indicate a need for further assessment.

Table 4.1: SCOFF items (Q1-Q5) and additional questions (Q6-Q7)

Questions	No		Yes	
	n	%	n	%
Q1. Do you make yourself sick because you feel uncomfortably full?	94	100.0	-	-
Q2. Do you worry you have lost control over how much you eat?	68	73.1	25	26.9
Q3. Have you recently lost more than one stone in a 3 month period?	83	89.2	10	10.8
Q4. Do you believe yourself to be fat when others say you are too thin?	81	89.0	10	11.0
Q5. Would you say that food dominates your life?	86	91.5	8	8.5
Q6. Are you satisfied with your eating patterns?	43	45.7	51	54.3
Q7. Do you ever eat in secret?	83	88.3	11	11.7

Help-seeking

Around one-third of participants (n=32/98, 32.7%) reported that they had sought help for a mental health problem in the last five years, with counsellor/therapist and GP being accessed most by participants (n=27 and n=11 respectively).

Physical health and disabilities

Participants were asked 'how is your general health?'. Over half the sample rated it as good (n=54, 54.5%), just over one fifth rated it as fair (n=21, 21.5%), just under one fifth rated it as very good (n=19, 19.2%), with very few rating it as bad (n=4, 4%) or very bad (n=1, 1%). One of the Census 2022 (CSO, 2022) questions on disability was administered to participants, which asked if they had any of seven long-standing conditions or difficulties, and if yes, to what extent. As Table 4.2 shows, the most prevalent disability experienced by the older sample was 'A difficulty with pain, breathing or any chronic illness or condition' which 22.9% (n=22) reported. Most reported having it 'to some extent' and a few to a 'great extent'. On the other disabilities/conditions, between 86% and 98% of the sample had no experience of them. None or very few of the older participants reported having any of the disabilities to a great extent.

Compared to the prevalence of disability in the general population of older people aged 60+ recorded in Census 2022, older LGBTQI+ people in this study had a lower prevalence of a difficulty with basic physical activities (13.9% vs 21%). Most of the older LGBTQI+ sample were aged in their early to mid-60s which may account for this difference. The level of psychological or emotional condition was almost two times higher in the older LGBTQI+ sample (9.7% vs. 4.8%). On the other conditions, the prevalence among the two samples were on par or within a few percentage points of each other.

Table 4.2: Long-lasting conditions or disabilities

	Being LGBTQI+ in Ireland 60+			Census 2022 60+	
Do you have any of the following long-lasting conditions or disabilities?	Yes, to a great extent	Yes, to some extent	Yes, to any extent	No	Yes, to any extent
Blindness or a vision impairment	1 (1.1%)	8 (8.4%)	9 (9.5%)	86 (90.5%)	11.0%
Deafness or a hearing impairment	1 (1.1%)	12 (12.8%)	13 (13.9%)	81 (86.2%)	15.6%
A difficulty with basic physical activities such as walking, climbing stairs, reaching, lifting or carrying	1 (1.1%)	12 (12.8%)	13 (13.9%)	81 (86.2%)	21.0%
An intellectual disability	0 (0.0%)	2 (2.1%)	2 (2.1%)	94 (97.9%)	2.1%
A difficulty with learning, remembering or concentrating	1 (1.1%)	5 (5.3%)	6 (6.4%)	88 (93.6%)	8.3%
A psychological or emotional condition or a mental health issue	2 (2.2%)	7 (7.5%)	9 (9.7%)	84 (90.3%)	4.8%
A difficulty with pain, breathing or any chronic illness or condition	3 (3.1%)	19 (19.8%)	22 (22.9%)	74 (77.1%)	19.6%

Objective 2: To compare experiences of this population stratified by socio-demographic characteristics

Gender and sexual identity subgroups

Given the small sample size and the fact that there were six sexual orientation subgroups, sexual orientation was regrouped into three categories: Lesbian (n=28), Gay (n=50) and Other (included Bi, queer, pan, asexual) (n=19). Non-parametric tests were conducted to determine if any of the wellbeing and mental health indicators differed depending on one's sexual orientation. Statistically significant higher gender identity comfort was found among lesbian and gay participants compared to the 'other' sexual orientation group at the $p<.05$ level. On all other measures, no statistically significant differences were found. The mean scores for all measures across sexual orientation subgroups are shown in Table 4.3.

Table 4.3: Wellbeing and mental health indicators among sexual orientation subgroups

Measure	Category	N	Mean	SD
Self-rated happiness (N=87)	Lesbian	28	8.11	1.52
	Gay	43	7.56	1.65
	Other	16	7.44	1.21
GI consonance (N=97)	Lesbian	28	8.95	2.06
	Gay	50	8.99	1.66
	Other	19	7.42	2.87
SO consonance (N=97)	Lesbian	28	9.21	1.12
	Gay	50	9.06	1.48
	Other	19	8.41	2.31
Depression (DASS-42) (N=90)	Lesbian	26	4.4	4.70
	Gay	48	7.4	8.39
	Other	16	5.8	6.23
Anxiety (DASS-42) (N=90)	Lesbian	26	3.4	3.57
	Gay	48	4.4	6.22
	Other	16	4.1	6.59
Stress (DASS-42) (N=91)	Lesbian	26	7.5	5.53
	Gay	49	9.1	9.23
	Other	16	8.0	3.35
Alcohol use (AUDIT) (N=73)	Lesbian	22	5.18	3.63
	Gay	37	7.19	5.59
	Other	14	5.57	4.20
Self-esteem (RSES) (N=95)	Lesbian	27	33.85	5.75
	Gay	49	31.76	5.37
	Other	19	34.26	5.09
Resilience (BRS) (N=97)	Lesbian	28	3.52	.80
	Gay	50	3.45	.82
	Other	19	3.71	.75

For the purpose of analysis, gender was regrouped into three categories: Cisgender man (n=57), Cisgender woman (n=31), and Transgender and Gender Non-Conforming (TGNC) (n=9). Non-parametric tests were conducted to determine if any of the wellbeing and mental health indicators differed depending on this classification. No

statistically significant differences were detected. The mean scores across gender identity subgroups are shown in Table 4.4.

Table 4.4: Wellbeing and mental health indicators among gender identity subgroups

Measure	Category	N	Mean	SD
Self-rated happiness (N=87)	Cis man	49	7.49	1.54
	Cis woman	30	7.80	1.49
	TGNC	8	7.88	1.55
GI consonance (N=97)	Cis man	57	8.81	1.78
	Cis woman	31	8.70	2.04
	TGNC	9	8.32	3.05
SO consonance (N=97)	Cis man	57	8.93	1.60
	Cis woman	31	8.93	1.74
	TGNC	9	9.42	1.00
Depression (DASS-42) (N=90)	Cis man	55	7.35	8.12
	Cis woman	27	5.41	5.32
	TGNC	8	3.50	5.10
Anxiety (DASS-42) (N=90)	Cis man	55	4.47	6.01
	Cis woman	27	2.89	3.34
	TGNC	8	6.00	8.42
Stress (DASS-42) (N=91)	Cis man	56	9.04	8.63
	Cis woman	27	8.00	5.23
	TGNC	8	7.25	4.53
Alcohol use (AUDIT) (N=73)	Cis man	41	7.24	5.63
	Cis woman	26	4.85	3.18
	TGNC	6	5.67	4.08
Self-esteem (RSES) (N=95)	Cis man	56	32.11	5.18
	Cis woman	30	33.77	5.67
	TGNC	9	32.44	5.83
Resilience (BRS) (N=97)	Cis man	57	3.51	.83
	Cis woman	31	3.41	.67
	TGNC	9	3.85	.84

Employment status

Non-parametric tests were conducted to determine if any of the wellbeing and mental health indicators differed depending on whether one was employed or retired

(note: other groups had only 1-3 people in it so excluded from analysis). No statistically significant differences were detected.

Marital status

Given the small sample size and the fact that there were eight marital status subgroups, marital status was regrouped into three categories: Single (n=26), Married/In civil partnership (n=42) and Separated/divorced/widowed (n=27). Non-parametric tests were conducted to determine if any of the wellbeing and mental health indicators differed depending on one's marital status. No statistically significant differences were detected.

Area living

Given the small sample size and the fact that there were five area subgroups, area living was regrouped into two categories: Rural (Rural/country area or village) (n=38) and Urban (City, suburb of city or town) (n=57). Non-parametric tests were conducted to determine if any of the wellbeing and mental health indicators differed depending on living in a rural or urban location. No statistically significant differences were detected.

Living situation

Given the small sample size and the fact that there were eight living situation categories selected by participants, living situation was regrouped into two categories: Living alone (n=40) and Other living circumstances (i.e. Living with partner with/without children, living with family members, living with friends/housemates, other) (n=56). Non-parametric tests were conducted to determine if any of the wellbeing and mental health indicators differed depending on living situation. No statistically significant differences were detected.

Self-harm and suicidality

Fisher's exact tests were conducted to examine if there were any differences in self-harm, suicidal thoughts, and suicide attempts depending on one's sexual orientation, gender identity, employment status, marital status, area living and living situation. On self-harm and suicide attempts, the numbers in some cells were very few, and no statistically significant differences were detected. On suicidal thoughts, while the numbers in the cells were comparatively bigger, no statistically significant differences were detected also.

Objective 3: To provide a descriptive analysis of older LGBTQI+ people's experiences of healthcare, safety, harassment and community belonging

Healthcare use and experiences

In total, 91% (n=90) of the sample reported that they had used healthcare services/practitioners in the last five years. Their healthcare experiences are detailed in Figure 4.7. The majority reported never having had a practitioner tell them that their LGBTQI+ identity could be changed (98%), were never asked invasive questions about their identity which were unrelated to their reason for visiting (92%) and were never discriminated against because of their LGBTQI+ identity (84%). Views on how knowledgeable healthcare practitioners were about LGBTQI+ identities varied, with around two-fifths (43%) reporting that they were 'sometimes' knowledgeable, around one-third considering that they were knowledgeable 'most of the time' and a further one-tenth (12%) reporting that they 'always' demonstrated knowledge. In total, 36% reported educating practitioners about LGBTQI+ identities sometimes/most of the time/always and two fifths (40%) reported that healthcare practitioners made incorrect assumptions about their LGBTQI+ identity sometimes/most of the time/always. More older people were always comfortable disclosing their LGBTQI+ identity than not (Always: 43%, Never: 18%) and more agreed that disclosure of one's identity was acknowledged by healthcare practitioners (Always: 43%, Never: 14%). Approximately two-fifths reported (44%) that there were never materials relevant to LGBTQI+ healthcare in their healthcare service.

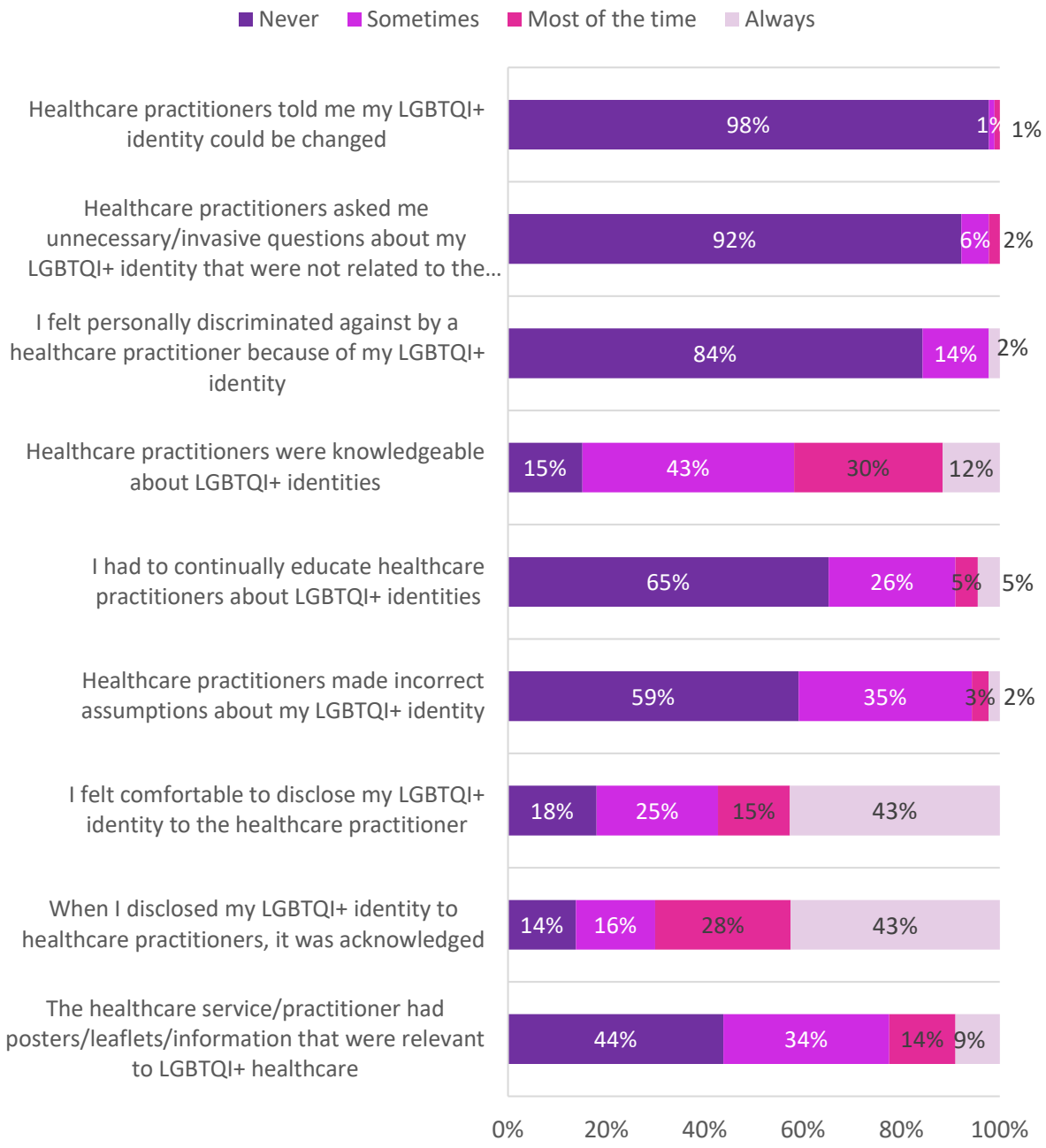

Figure 4.7: Healthcare experiences

Safety and harassment

The majority of the older LGBTQI+ sample reported feeling safe/very safe using public transport (82%), checking an LGBTQI+ website on a public computer (82%), reading an LGBTQI+ publication in a public space (81%) and being seen going to or leaving an LGBTQI+ venue (76%) (Figure 4.8). Participants felt least safe showing affection or holding hands with a same-sex partner in public, with approximately half reporting feeling unsafe/very unsafe, and around one-tenth reporting that they would not do it.

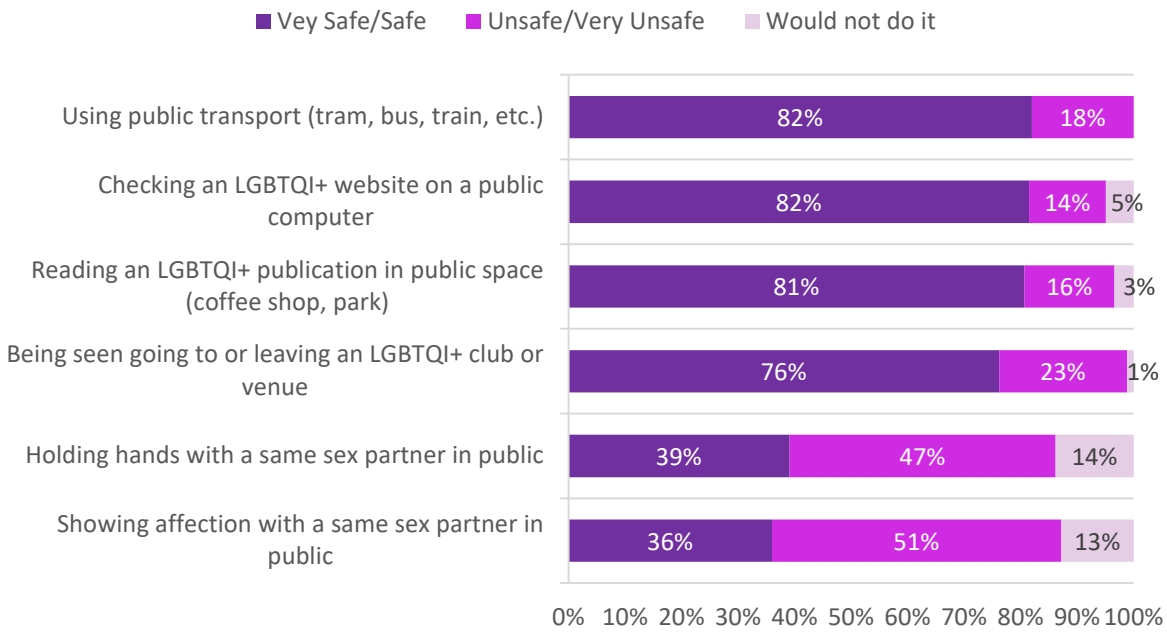

Figure 4.8: Sense of safety in public places

Low levels of harassment within the previous year were reported by older LGBTQI+ participants (Figure 4.9). Less than 1 in 20 reported experiencing physical assault, sexual assault, non-consensual sexual touching, or a threat of being outed due to being LGBTQI+. Over two thirds had never experienced any of these forms of violence and harassment in their lifetime either, with as many as 87% having no experience of online social media harassment. However, the majority (65%) experienced verbal harassment due to being LGBTQI+ at some point in their lives, with most having experienced it more than one year ago (55%) and one tenth reporting that it occurred within the last year. One third of participants reported being threatened with being outed (32%) which occurred more than one year ago, while just over one quarter experienced physical assault which again occurred more than one year ago.

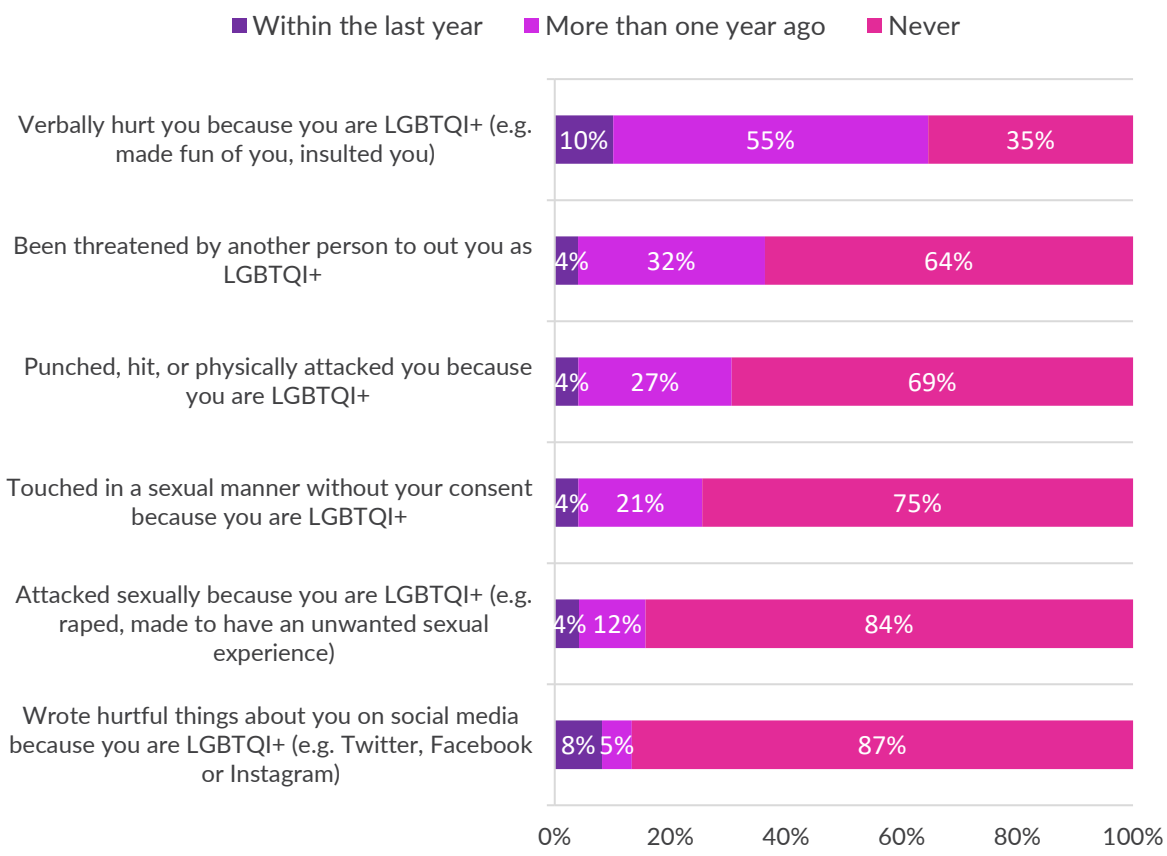

Figure 4.9: Experiences of harassment and violence

Connection and belonging to the LGBTQI+ communities

Participants were asked to rate (strongly agree to strongly disagree) six statements regarding belonging, inclusion and representation in the LGBTQI+ communities (Figure 4.10). Around one-fifth to one-third had no strong opinions on the items either way. Around two-thirds felt advocated for by LGBTQI+ organisations, and around half felt welcome and visible in the LGBTQI+ communities. However, nearly half reported feeling isolated and separate from others who share their identity, around one third reported that their identity was not given equal recognition in the LGBTQI+ communities and nearly one quarter did not feel included in the LGBTQI+ communities.

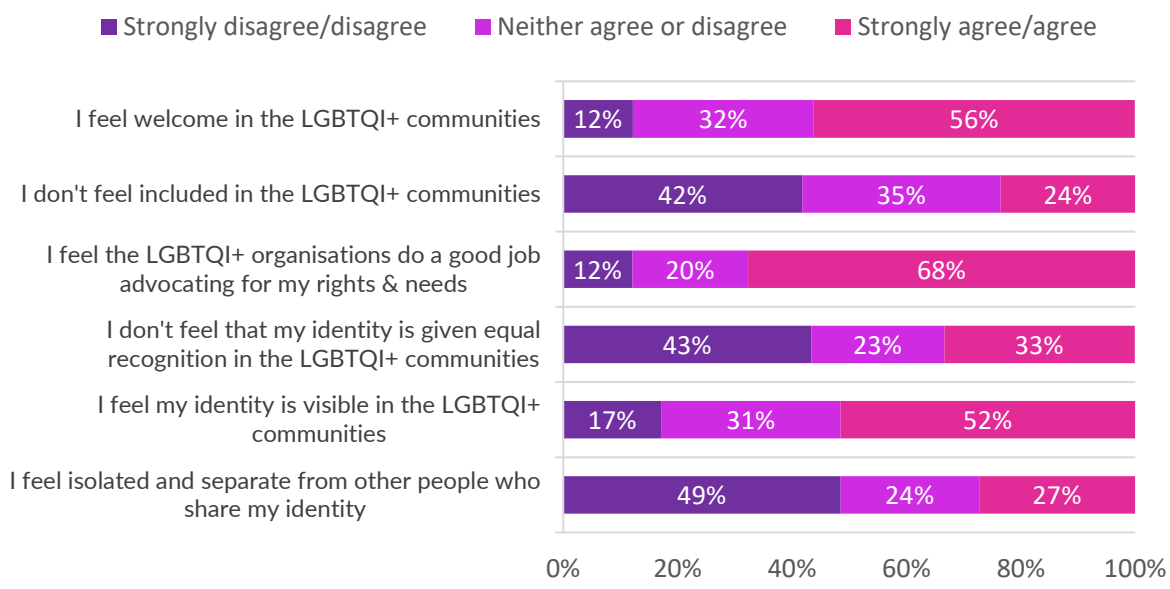

Figure 4.10: Views on connection or belonging to the LGBTQI+ communities

Objective 4: To summarise commentary participants made in response to open questions in the survey regarding experiences and challenges in ageing

The following ten themes emerged from the qualitative data analysis of all of the open-ended questions (Figure 4.11).

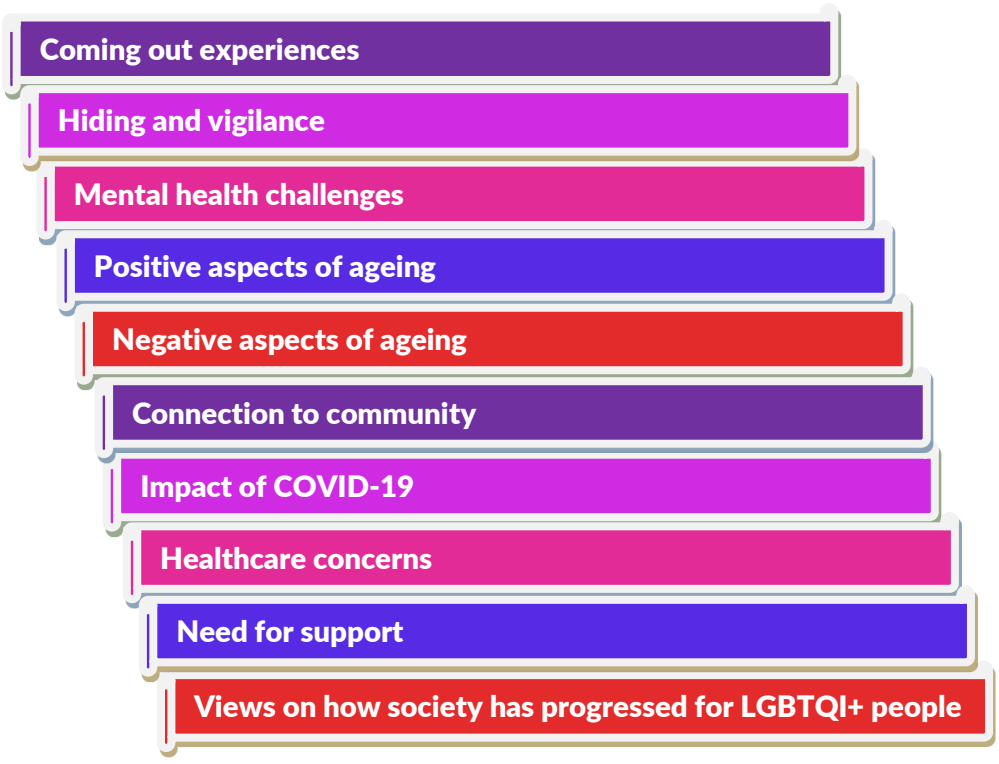

Figure 4.11: Qualitative themes

Coming out experiences

Many participants reflected on the experience of coming out. Within this theme, coming out was a hugely positive experience, with one participant expressing "*regret*" for not having done so earlier.

> *"Feelings of regret for not coming out and coming to terms with my sexuality when I was younger. Not having come out to my family".* (68, man, gay, ID1916)

The experience of coming out, in some cases after years of concealing and denying one's identity, was freeing in the sense of being able to be one's true self, not having to be vigilant, and opening up opportunities to meet people. It's contribution to positive mental health was cited by several participants.

> *"After many years of hiding myself it is such a pleasure to be myself without apology. Straight people will never understand the importance of being truly yourself as they take that for granted".* (67, man, gay, ID2476)

> *"I just love being myself (a woman, albeit one who's pretty non-conforming in self-presentation). And when I came out as a lesbian post-operative transsexual (the term I still use) it felt like finally coming home. And the long term relationship I'm now in (married to another woman and as happy as anything) just completes and fulfils me as never before (even though as a man I was in a very long term relationship/marriage of 45 years, though never comfortable with myself and definitely uncomfortable with performing as a man). Now I'm comfortable with myself, the only 'bother' for me being that my physical size, etc, means that I'll always look...different. But I knew that would be the case as I went through the change, and I accepted that, as I accept it now".* (76, woman, trans woman, lesbian, ID2099)

Some participants wrote about how they themselves felt different or were viewed differently by others in their younger years because of their identity and about how realising their identity and their shared identity with others brought a sense of relief and allowed them to "*make peace with their own life*" and "*embrace*" their identity.

> *"I'm of an age group, where it was a relief to discover I was a lesbian, up until this enlightenment, I just thought I was weird. It's not nice not to be a full part of society but I've made my peace with my own life, I don't really care what others think about me - as I've learned to sort out whose opinions count to me and whose do not".* (61, woman, lesbian, ID2470)

> *"When I was young I had a real hard time because of my sexuality, I was always being told I was different I did not fit in. Today at 65, I embrace my difference, I do not care about fitting in, I strive to change societies views about being Queer, not change my views, I no longer feel the need for societal approval. I love being different. I love being Queer".* (65, man, queer, ID2029)

Coming out over thirty years ago was not experienced in a positive way by this participant who felt that the *'lesbian scene'* at that time was no less limiting than heterosexual society.

> *"Having missed out on some possibly rich experiences; at the time of 'coming out'--30+ years ago, I felt the lesbian scene was nearly as prescriptive and constrained as heterosexual society".* (84, woman, bisexual, ID866)

Hiding and vigilance

In the context of what was hardest about being LGBTQI+, a few participants mentioned concealing their identity or practising vigilance over their words and actions out of habit or out of concern over possible rejection in some settings, with one participant ascribing this practice to the existence of entrenched homophobia in Irish society despite all the advances that had been made as well as their own lingering sense of internalised stigma.

> *"Having been out for forty years I still find it hard to know that I censor myself in some settings where I fear rejection, that I can still tap into internalised shame about being lesbian, that to be Queer is still to be on the edge, or at risk of ridicule in certain settings…".* (61, woman, lesbian, ID2231)

Mental health challenges

While coming out was ultimately positive, participants who had engaged in self-harm, had suicidal thoughts and attempted suicide recounted the difficulties they encountered related to their LGBTQI+ identity, particularly in their youth. These difficulties included society's negative perceptions and treatment of LGBTQI+ people, trying to deny one's LGBTQI+ identity and to conform to societal expectations and 'norms' of the time, feeling *"wrong"* for feeling same-sex attraction and being LGBTQI+, and having no-one to talk to or no resources to draw information from. Self-acceptance, coming out and realising that society was at fault for its views on LGBTQI+ identities were identified by participants as helping them to move past their self-harm or suicidal thoughts/behaviour.

> *"As a young man growing up in the 1960s in Ireland I did not even know what being LBGT+ identity meant. When I did begin to find out all I heard from society, religion, medical and legal groups was totally negative. So my attempts to end it all harm myself all stemmed from society's views on LBGT+ identity, being LBGT+ was not the problem it was society's views that caused me to think it was. So I felt I was something wrong, I did not fit in and I tried to get out… I am happy to say that at the age of 65 I am a very happy queer man"*. (65, man, queer, ID2029)

> *"I wanted to be "normal". I did not want to spend my life being gay/lesbian. I wanted to be like everyone else. I tried and tried to be straight but I was dying inside. Finally crawled out of that rabbit hole at around 40 and am good since"*. (63, woman, lesbian, ID2049)

Positive aspects of ageing

One of the themes which emerged was positive aspects to ageing and the shifting of time, with some participants singling out their age or stage of life as being a factor in not really engaging with any "*issues*", not being as "*affected*" by them, a sense of having moved on from the past, feeling safer, gaining more perspective and self-acceptance, and feeling buoyed by society being a comparatively better place for young LGBTQI+ people today.

> *"As I am quite elderly now, I am not as affected as I used to be"*. (84, woman, bisexual, ID866)

> *"If there ever ever was anything hard about being gay, the memories of this, is lost in the midst of time. Sorry"*. (67, man, gay, ID2139)

> *"I feel pretty safe now. Perhaps it's due to my age"*. (64, woman, gay, ID249)

Retirement was also mentioned in a positive context in terms of becoming involved in other activities, not having the stress associated with work and enjoying financial security. One person, however, highlighted how the late extension of equal marriage rights to same-sex couples had disadvantaged them in relation to their pension.

> *"Being financially secure, retiring from a stressful job"*. (65, woman, lesbian, ID2370)

> *"Being involved in a mental health reform group since my retirement as a related professional"*. (84, woman, bisexual, ID866)

> *"Retiring from work/ Becoming involved with other people in a parish context"*. (66, man, gay, ID2335)

> *"Having been unable to be legally married and have children until my 50s impacts severely now. Just retired, I have no refund of pension contributions compulsorily collected for spouses and dependents during the time that this was legally impossible"*. (61, man, gay, ID755).

Negative aspects of ageing

Negative aspects of ageing mainly related to feelings of being invisible and marginalised within wider society and LGBTQI+ communities/organisations. Similar to older heterosexual people, many participants expressed feeling invisible due to one's age within the media and in public life in general.

> *"Being an older man, can make you feel invisible"*. (70, man, gay, ID892)

> *"Older generations are marginalised"*. (61, man, gay, ID2151)

> *"I rarely see anything at all in the media about older lesbians! We might as well not exist at all"*. (76, woman, lesbian/queer, ID63)

> *"There are challenges being over 70 in terms of lesbian visibility in all areas of public life"*. (70, woman, lesbian, ID543)

This feeling of invisibility, exclusion and isolation was also experienced within the LGBTQI+ communities

> *"Again, I think in part I feel isolated from "my own community" because of my age"*. (61, woman, lesbian, ID2470)

> *"I use gay community venues regularly (pubs and centres) and enjoy them. I feel my age sometimes means I'm not fully included"*. (64, man, gay, ID282)

The spaces and activities within LGBTQI+ communities were deemed to be geared more towards younger people, transgender people and drag artists.

> *"There is definitely age discrimination in the LGBT community. Most social spaces and activities are aimed at the young. I rarely feel welcome"*. (61, man, gay, ID416)

> *"Most gay communities are ageist and dominated by drag, trans and shallow people"*. (64, man, gay, ID954)

Another participant expressed the view that their identity and their experience was not reflected in LGBTQI+ advocacy organisations, and felt that they were "*patronised*" at best.

> *"I am an older man living in rural Ireland. My type of identity is not reflected in LGBTQ media and by LGBTQ organisations, with the exception of some gay/bi/msm health organisations. At best I am patronised as being brave for living as I do. I was very involved in the past, I now regard myself as having survived 'the scene'".* (61, man, queer, ID1932)

Two participants felt that there needed to be greater understanding and emphasis placed on *"gay history in Ireland"* and the difficulties that older LGBTQI+ people faced at that time in order to bridge the generational gap between younger and older LGBTQI+ people.

> *"As an older LGBT in Ireland I often feel caught between different worlds. There needs to be better understanding of how difficult it was to be gay and out in the past so a connection can be made between different generations".* (65, man, gay, ID932)

> *"I know this is probably crass however so be it. I now consider myself a stately homo of Ireland. And I have many friends who identify similarly. So there. Maybe it is not politically correct these days. But to us you are trying to silence an important part of gay history in Ireland".* (67, man, gay, ID2139)

Connection to community

While many participants felt excluded from LGBTQI+ communities due to ageism, some participants noted that they were not involved/very involved in LGBTQI+ communities and highlighted their greater sense of connection and commonality to other communities based on parenting, neighbourhood, and other interests.

> *"Now aged 60 and in a loving relationship with a very caring and understanding woman I am generally much happier in my own skin. We are both introverts and do not connect with groups much. We live a quiet life with a few friends but little connection to LGBTQI+ communities. It is great, though, to be able to go to occasional events, such as Gaze film festival, etc. and I am hugely thankful for and appreciative of the great work done by LGBTQI+ activists and event organisers".* (60, woman, lesbian, ID1628)

> *"Being part of 'the scene' was very important to me in my 20s, but now I have more in common with straight neighbours and other straight parents".* (61, man, queer, ID2718)

> *"I am 61 and live in a rural community with my wife so I am not involved in LGBTQI+ communities specifically. However I do have a sense of belonging in the*

> *communities as well as in other wider communities. It has always been important to me to feel part of multiple communities according to the interests and priorities at different times in my life".* (61, woman, lesbian, ID2231)

Healthcare concerns

Participants expressed concerns about healthcare options and services available to them should they require care as they grow older. Many noted a lack of LGBTQI+ inclusive or specific healthcare services for older LGBTQI+ people, with one participant voicing concern about having to *"go back into the closet"*.

> *"Concerns about aging and potential issues should residential care ever be required".* (61, man, gay, ID2151)

> *"Health services for older LGBTIQs are very poor - totally inadequate. Recognition of the health issues facing older LGBTIQs is very rare, and I know of no specific services for us. This is worrying and stressful. I do think about what will happen to me if and when i can't take care of myself appropriately".* (76, woman, lesbian/queer, ID63)

> *"I am increasingly aware of anxieties being expressed by older members of the LGBTI+ community about care options for us as we age".* (63, man, gay, ID748)

> *"The grey gays have been out when young. Do we have to go back into closet when old because health and social care services including old people's homes are neither gay inclusive or gay specific".* (61, man, gay, ID944)

> *"I worry about ever ending in a nursing home without other LGBQTI people".* (66, man, gay, ID1592)

Older LGBTQI+ participants also noted that the option of care being provided by children or families may not be available to older LGBTQI+ people who don't have children or close relationships with their family of origin, and highlighted how this made the provision of services specific to their needs all the more important.

> *"I help look after my parents & mother-in-law. I wonder how many childless gay people my age will cope with getting older?"* (65, woman, lesbian, ID2370)

> *"It's very challenging to grow old in a community that's so focussed on youth - in so many different ways. We haven't really learned how to see - and what to do about - ageing generations of LGBTIQs. We do need to address this challenge now because, quite simply, LGBTIQs grow old, just like everyone else, and we need*

services, and care and social activities! Especially since so many of us are estranged or at least distant from our birth families". (76, woman, lesbian/queer, ID63)

Impact of COVID-19

The majority reported that since the COVID-19 pandemic their mental health had 'stayed the same' (61%, n=60), one quarter reported that it had worsened (26%, n=25) and a smaller proportion reported that it had improved (13%, n=13). The qualitative comments highlighted how the COVID-19 lockdowns significantly impacted older LGBTQI+ people who lived alone, with participants highlighting the isolation they experienced and its negative impact on their physical and mental health.

"Covid! 'Cocooning' was dreadful - very isolating for older LGBTIQs living alone, like me.....Incarceration i.e. very lengthy and total lockdowns for older people was very tough and definitely impacted my mental health and also my physical fitness". (76, woman, lesbian/queer, ID63)

"Living alone was very tough and emphasised isolation as I age. Most messages were for families and households. Single people were ignored". (61, man, gay, ID755).

"My physical health has deteriorated considerably, and I now feel like an old person. Inevitably that has a negative effect on my mental outlook". (76, woman, trans woman, lesbian, ID2099)

Need for support

Many participants called for organisations to address the specific needs of older people and for the provision of more services, supports and spaces for older people. Particular support for older LGBTQI+ people living in rural areas or in isolated circumstances was called for.

"I think LGBTI plus organisations need to address needs of older people". (61, man, gay, ID944)

"More support for older LGBTQI+ people especially those who may be housebound or isolated". (68, man, gay, ID1916)

"Probably more space for older gay & lesbians". (63, man, gay, ID964)

"Support for older people and those in very rural areas". (63, man, gay, ID1925)

Views on how society has progressed for LGBTQI+ people

Many of the older LGBTQI+ participants reflected on how Irish society has changed for LGBTQI+ people over the years, and compared to their youth, noting that much progress has been made.

> *"My partner, friends, very happy career wise. Things are much better than the 1970s when I was a teenager".* (63, man, gay, ID964)

> *"The general change in social attitudes towards LGBT+ people has helped. In the small village I live in everyone knows I'm gay and no-one is bothered".* (67, man, gay, ID2476)

> *"….seeing younger people more comfortable and happy has been hugely uplifting and gives me strength that their world is better than the horrible one I grew up in".* (70, man, gay , ID960)

While many participants expressed the view that societal attitudes towards LGBTQI+ people have generally improved and that much progress has been made, they also identified ongoing challenges for LGBTQI+ people. These participants noted that the legacies of homophobia, and of religious and political fundamentalism continued to be felt at a personal or societal level while heterosexism was identified as being deeply entrenched in Irish society. They also expressed empathy towards young people who identify as gay or gender dysphoric due to the difficulties and challenges that they still encounter in today's society.

> *"But all in all - even though some things have changed, a lot has not - and there are days when I wish I were a straight woman".* (61, woman, lesbian, ID 1551)

> *"… even though Irish society has progressed so much over the years since I first came out. Homophobia and internalised homophobia are very strongly rooted in the national and individual psyches".* (61, woman, lesbian, ID2231)

> *"To feel equally valued but at 70 years of age I am still affected by the oppressive and controlling country I grew up in - we are still emerging from a Religious and Political Fundamentalism working hand in hand".* (70, man, gay, ID960)

> *"The continuing stigma and embedded heterosexism. It is the cultural air we breathe".* (61, man, gay, ID944)

> *"Still surprised by the idiocy of people. I feel very bad for younger gay people and gender conflicted young people who still have a hard time".* (63, man, gay, ID964)

Chapter 5 : Discussion

The focus of this sub report was to describe older LGBTQI+ people's wellbeing and mental health, and identify any differences stratified by gender identity, sexual orientation and demographic factors. Additionally, the sub report aimed to describe older LGBTQI+ people's experiences of healthcare, safety, harassment and community belonging, and present commentary participants made regarding experiences and challenges in ageing. This final chapter provides a summary of the main findings and positions them in the context of the main *Being LGBTQI+ in Ireland* report (Higgins et al. 2024) as well as in the context of wider national and international literature on older LGBTQI+ people.

The findings on the mental health and wellbeing of the older sample of LGBTQI+ participants indicates that the majority are in good health. Nearly three quarters rated their general health as either good or very good (74%), just over three quarters didn't display any symptoms indicative of depression, anxiety or stress (75%-89%), the majority hadn't sought help for a mental health problem in the past five years (67%) and more than half (53%) had never taken drugs within their lifetime. Lifetime rates of self-harm and suicide attempt were relatively low at 13% and 17% respectively in comparison to the younger cohorts *in Being LGBTQI+ in Ireland* (Higgins et al. 2024). Suicidal thoughts, while again comparatively lower than the younger cohorts, were higher at 42%. However, the majority had engaged in self-harm and suicidality over a year ago, and the commentary on their experiences suggest that much of it was historical and related to a lack of acceptance for one's identity growing up in a heteronormative and homophobic society. Resilience and self-esteem were comparatively better than younger cohorts in *Being LGBTQI+ in Ireland* (Higgins et al. 2024), suggesting that well-being and mental health may improve with age in the LGBTQI+ communities. However, the results also suggest that there is a cohort of older LGBTQI+ people who may have mental health challenges. Of those who drank alcohol (78% of the sample), 31% screened as being at risk for harmful alcohol use. A total of 15% reached the threshold indicative of having a potential eating disorder, while moderate/severe/extremely severe symptoms of depression and anxiety were experienced by 14% and 15% of the sample respectively.

Many of the older LGBTQI+ participants recounted growing up in an environment dominated by heterosexism, homophobia and stigmatisation, and where they struggled alone with feeling '*wrong*' and '*weird*'. For some participants, this feeling of

being '*wrong*' precipitated mental health challenges in their youth, including self-harm, suicide attempts and disordered eating. Other studies show that many older LGBTQI+ people experienced this sense of being 'wrong' in their early life due to the absence of language, role models and positive frameworks with which to make sense of, and understand, one's sexual and gender identity (Higgins et al. 2011; Hurd et al. 2022). Suicide also features in the narrative histories of other older LGBTQI+ people who were subjected to hostility in their communities growing up and experienced internalised homophobia as a result (Kneale et al. 2021). Coming out for older LGBTQI+ participants in this study was recounted as a liberating experience, freeing them of being closeted and in denial of one's identity, enabling them to fully accept and embrace their identity, and presenting them with opportunities to connect with others with a shared identity. Similar experiences and feelings were recalled by older LGBTQI+ participants in other studies in which they spoke about a sense of relief, peace and self-acceptance with coming out, and the validation and affirmation of their identity through connecting with others with a shared identity and through relationships (Neville et al. 2015; Hurd et al. 2022).

While many older LGBTQI+ participants in this study acknowledged that society has progressed for LGBTQI+ people, heterosexism and homophobia were identified as being deeply embedded in Irish society, with some participants continuing to feel internalised stigma and practicing self-censorship at times. Fear of being '*rejected*' and '*ridiculed*', out of '*habit*' were some of the reasons participants gave for self-censoring themselves in some situations. Self-regulatory practices also occur for reasons of self-protection against hate crime, and concern for other people's feelings, such as causing them discomfort (Formby, 2020). Hypervigilance in terms of monitoring oneself and others over anticipation of rejection or discrimination from others and adjusting one's behaviour is stress inducing for LGBTQI+ individuals and undermines their wellbeing and mental health (Stoneman et al. 2020; Hollinsaid et al. 2023).

While recognising that older LGBTQI+ people experience greater inequality than their peers in respect of physical and mental health, housing and their financial situation (Redden et al. 2023; Kneale et al. 2021), resilience is mentioned often in the literature as a key feature of the older LGBTQI+ population (Higgins et al. 2016, McParland & Camic, 2016; Turesky, 2022, Yu et al. 2022). It is suggested that older LGBTQI+ people have cultivated resilience through the challenges they have navigated in coming and being out which in turn helps them to be prepared for and cope with any challenges they encounter as they age (McParland & Camic, 2016). This seems to be

borne out by research which shows that resilience (as measured by the Brief Resilience Scale (BRS)) increased with age in gay and lesbian participants (Lyons, 2015). Notwithstanding the challenges that this cohort of older LGBTQI+ participants described experiencing over their lifetime, more than three quarters scored as having a medium or a high level of resilience on the BRS and their level of resilience was comparably higher than the younger LGBTQI+ participants in the main *Being LGBTQI+ in Ireland* report (Higgins et al. 2024). In terms of comparing older LGBTQI+ participants' resilience to a general population of older people, only one other study was found which used the BRS (da Silva-Sauer et al. 2021). That study which consisted of 1,251 older adults (60+) from different Brazilian regions found slightly lower levels of resilience compared to this study.[1] Cultural, economic and social differences between the countries may affect levels of resilience which could affect the reliability of the comparison. Therefore, in the absence of a more suitable comparison, it is difficult to gauge in quantitative terms how resilient this older LGBTQI+ cohort are.

Similar to resilience, the level of self-esteem among older LGTBQI+ participants was comparably higher than the younger LGBTQI+ participants in the main *Being LGBTQI+ in Ireland* report (Higgins et al. 2024). Koziara et al. (2022) found that self-esteem, as measured by the Rosenberg Self Esteem Scale (RSES), increased with age among a sample of LGBT persons, while resilience, although measured by a different tool than the one we used, also increased with age among most of the LGBT sample. Like resilience therefore, self-esteem appears to increase with age among LGBTQI+ people, and this may buffer older LGBTQI+ adults from the adverse impacts of minority stress and contribute to positive mental health and wellbeing. The higher levels of happiness and consonance (or comfort) with their sexual orientation and gender identity among older LGBTQI+ participants in comparison with younger LGBTQI+ participants in *Being LGBTQI+ in Ireland* supports this perspective.

Notwithstanding, the higher levels of happiness, consonance (comfort) and resilience, nearly half of older participants in this study reported feeling isolated and separate from others who share their LGBTQI+ identity. This sentiment of feeling isolated and separate was expressed in participants' comments about how they felt about the perceived presence of ageism within LGBTQI+ communities, and spaces and activities catering primarily to other audiences, such as young LGBTQI+ people. Some of these

[1] Being LGTBQI+ in Ireland: BRS sum score=21.18. Brazilian study: BRS sum scores of 19.93 among 60-69 year-olds, 19.43 among 70-79 year-olds, 20.19 among 80+.

issues, such as perceived ageism and the youth-focussed nature of activities, were cited in the *Visible Lives* study of older Irish LGBT adults published in 2011 (Higgins et al. 2011), suggesting that, more than a decade on, the needs of older adults have not been addressed in a way which makes them feel seen and included. Other research has found that the youth orientation culture of LGBTQI+ spaces can marginalise older people (Turesky, 2022), and concluded that given the important role that social interaction plays in the formation and development of one's LGBTQI+ identity and building support systems, the lack of connection with LGBTQI+ communities in some older people's lives may put them at risk of social isolation and loneliness, and adversely affect their sense of self (Kneale et al. 2021; Turesky, 2022). Indeed, social isolation is one of a range of factors identified as playing a role in health care access disparities, when compared to the non-LGBTQI+ population (Marshall and Cahill, 2022). With both self-acceptance and connection to peers recognised as positive mediating influences on adjustment to ageing (McParland & Camic, 2016), it is important to facilitate opportunities for older LGBTQI+ people to be meaningfully involved in LGBTQI+ communities. Participants in this study expressed varying preferences for engagement with the LGBTQI+ community with some wishing to feel more inclusion, and others happy to dip in and out of community events or pursue connections within non-LGBTQI+ communities based on other interests and commonalities. These varying preferences need to be fully explored and taken into account in future planning around community engagement with older LGBTQI+ people.

A few of the participants alluded to the work that needs to be done in order to give recognition and value to older LGTBQI+ people's experiences. For these participants, it was important to acknowledge their struggles and to preserve this history in the hope of bridging the intergenerational gap that divides young and older LGBTQI+ people. These findings highlight the importance of making LGBTQI+ histories visible in order to preserve them, prevent erasure into the future and as a way of restoring justice (Turesky, 2022; Freeman 2023). Freeman (2023) notes how archives often exclude the voices and experiences of LGBTQI+ people due in part to their own self-erasure as a means of protecting themselves but also due to the way in which archives record a history of "criminalisation, marginalisation, and oppression—generally from the perspective of the oppressor." (P448). The findings also beg the question of whether there are or could be some initiatives which could target the intergenerational divide in the LGBTQI+ community based around sharing narratives

and experiences through dialogue and interaction. Indeed, stories of older LGBTQI+ people having greater confidence and self-esteem, developed despite, or perhaps because of prior challenging experiences (Waling et al. 2023), as well as accounts of having arrived at a place of happiness and contentment (Higgins et al. 2011) are examples of the wealth of knowledge and insight that could greatly benefit younger LGBTQI+ people.

Compared to their heterosexual and cisgender peers, older LGBTQI+ people have more friendship-based relationships than those that are based on family ties and therefore may be more reliant on informal help provided by 'families of choice' as well as having to access formal care supports as they age (Higgins & Hynes, 2019). A common concern expressed by older LGBTQI+ participants in this study and others is the lack of LGBTQI+ specific or inclusive care options available to them (Johnson et al. 2005; Hughes, 2009; Waling et al. 2018), and fears around disclosure and having to go back in the closet in residential homes (Espinoza, 2014; Gardner et al. 2014; Löfaand & Olaison, 2020; Cummings et al. 2021; Miller et al. 2023). Just one fifth of respondents to a 2015 survey on policy priorities for the LGBT+ community in Ireland agreed that 'Health, social and care services for older people in Ireland are fully inclusive of LGBT people and respectful of their relationships' (NFX, 2015). In addition, fears around being discriminated against and receiving sub-optimal care, fears that one's sexuality will be erased within heteronormative environments, fears of being socially isolated and fears that one's partner will not be recognised and included have been reported elsewhere (McIntyre & McDonald 2012; Almack et al. 2014; Waling et al. 2018; Turesky, 2022; Skeldon & Jenkins, 2023). Research shows that while most staff working in residential settings often exhibit goodwill and good attitudes towards LGBTQI+ people, they lack knowledge and awareness of LGBTQ+ issues and policies, are misguided in their approach of 'treating everyone the same' and do not have an awareness of the presence of, or record the number of, LGBTQI+ residents in their care (Almack et al. 2014; Simpson et al. 2018; Skeldon & Jenkins, 2023). Another issue requiring attention is that of prejudice and rejection from older heterosexual residents towards residents who identify as LGBTQI+ (Villar et al. 2015; Leyerzapf et al. 2018). Finally, the issue of the broader environment needs to be looked at. A review of the experiences of older gender and sexually diverse women in accessing health, social and aged care services found a lack of inclusiveness in forms and other materials, no recognition of sexual diversity or the needs of same-sex couples who wish to stay together, and predominantly heteronormative

environments in which heteronormative assumptions were commonplace (Dune et al. 2020). In order to build on staff's goodwill, more training and strategic planning is recommended (Almack et al. 2014), such as the Champions Training Programme offered by LGBT Ireland to support health and social care professionals to become proficient in the provision of care to LGBTQI+ people (lgbt.ie/advocacy/campaigns).

This sample of older people seem to possess many of the elements which facilitate successful ageing, being in good physical health, having psychological resources in terms of happiness, resilience, self-esteem and consonance with their sexual and gender identity, and few having severe or very severe symptoms of psychological distress. However, there are potential challenges among this older cohort of LGBTQI+ people. Those older people who live alone can experience social isolation (Fredriksen-Goldsen et al. 2013) as was the experience for many participants during the COVID-19 pandemic. A lack of connection to the wider LGBTQI+ community and the lack of service provision for older LGBTQI+ people therein highlighted the vulnerability of this cohort to social isolation and exclusion based on ageism, as well as reduced access to social support. The lack of healthcare options for LGBTQI+ people as well as fears around the inclusiveness of residential settings for older LGBTQI+ people leaves older people vulnerable to not accessing the care that they may need, having their identity/relationships erased or not acknowledged within residential settings and not having their needs and wishes met (Baril and Silverman, 2022).

Limitations

The findings of this sub report must be considered with some limitations in mind. The self-selected and homogeneous sample consisted of well educated, and 'out' LGBTQI+ older individuals. It is unknown if these findings would extend to more diverse, disadvantaged or hidden older LGBTQI+ populations. Furthermore, the online hosting of the survey together with its promotion through social media may have limited participation in the survey by some older LGBTQI+ people. It is of particular importance to note that due to the virtual absence of octogenarians in our study it is not possible to identify in more detail how ageing at that stage in life relates to LGBTQI+ identities. The small sample size limits analyses of differences in mental health and wellbeing indicators between subgroups. In addition, the small numbers of non-binary and transgender older adults and older adults who identified with emerging sexual identities means that there is little or no focus on their experiences. In the *Being LGBTQI+ in Ireland* study, no focussed questions were

developed for the older LGBTQI+ cohort specifically and this may have limited the scope and richness of the data gathered.

Recommendations

Recommendations for Policy

In some policy documents LGBTQI+ older people are identified as a priority group but exploration about how this groups' needs and aspirations might be addressed is missing, while in other policy documents older people are a priority group without any specific focus on older LGBQTI+ people. Therefore, it is recommended that:

- Older LGBTQI+ people should be included in all health and wellbeing policies, government and non-government, not only as a specific target group, but with data on their experiences to inform policy and regulatory standards. This should not only relate to policies about older people, but also other topics that also affect older LGBTQI+ people such as housing or healthcare policy.
- Government should ensure that there is LGBTQI+ representation, based on co-production principles, on policy and strategy advisory groups across all of government so that older LGBTQI+ people's challenges, needs and experiences are included in planning and evaluation processes in the work of government. In terms of the current study, this is particularly important in the areas of health and housing.
- Funding should be allocated to LGBTQI+ organisations for the continued development of older LGBTQI+ people's initiatives. These initiatives should be co-produced with LGBTQI+ older people, with a view to being valuable not only for older LGBTQI+ people, but the entire LGBTQI+ community, and indeed society more generally.
- Health educators should conduct a review of current curricula to ensure that they are more inclusive and are not reinforcing heteronormative, cisgender, or ageist biases.
- Professional bodies which accredit health professional education, (for example, the Nursing and Midwifery Board of Ireland, Medical Council) should include competencies related to providing culturally sensitive care for older LGBTQI+ people.

Recommendations for Research

There were gaps in terms of the participation of some older LGBTQI+ sub-groups in this study. In addition, research undertaken with older people is not always inclusive of older LGBTQI+ people's voices. We recommend that:

- Research into the experiences of older LGBTQI+ people should be undertaken again with a view to actively including transgender and non-binary people, and people who identify with emerging sexualities. LGBTQI+ people that come out at an older age should also be targeted for research as they may have unique experiences.

- Research into the experiences of LGBTQI+ people who are not out or are disconnected from the LGBTQI+ community should also be undertaken in order to capture and address their needs.
- Research being undertaken with older people should include LGBTQI+ identifiers to ensure that the voices of LGBTQI+ people are heard and that their experiences, needs and aspirations go towards informing policy and practice, particularly in terms of health, wellbeing, housing, and health care.
- Research focused on a comparison of the LGBTQI+ community with the general population in terms of psychological, social and economic factors in ageing is needed to identify where patterns converge or diverge. This will identify in more detail how needs of older LGBTQI+ people relate to those of the general population.
- A longitudinal study of older LGBTQI+ people should be conducted to learn about how ageing affects this population overtime. All future research on ageing should include sexual orientation and gender identity in demographics in order to provide data on health and other outcomes for the older LGBTQI+ population.

Recommendations for Service Provision

While participants' health and healthcare use experiences were positive on many levels, the findings indicate that there are still some areas that require attention. These include participants' discomfort disclosing LGBTQI+ identities and having their identity acknowledged by health care professionals. In addition, some indicators of poorer mental health were identified. Based on these findings we recommend that:

- The HSE and other healthcare providers should continue to work with LGBTQI+ organisations to build capacity among all healthcare and support staff through training and ongoing continuing professional development on the provision of inclusive and affirmative approaches to the provision of care to older LGBTQI+ people. This is with a view to providing culturally competent health and social care across state and NGO services.
- All existing health and social care services for older LGBTQI+ people need to be proofed to ensure that their policies and practices are LGBTQI+ inclusive, for example, ensuring patient/resident forms are inclusive of sexual and gender minority identities and reviewing visitation policy to include 'family of choice'.
- In particular, the HSE dementia services should be proofed to ensure that they are inclusive of older LGBTQI+ people and their families in general, and transgender and non-binary people in particular; this includes having health care providers who are knowledgeable on LGBTQI+ issues and are equipped to provide an affirmative service to the individual.
- To ensure the quality of and access to mental healthcare for the older LGBTQI+ community, specific emphasis on exploring indicators of mental

health challenges should be explored such as alcohol and drug use, and symptoms of depression and anxiety. This will go towards creating accessible, safe, high-quality mental health services with improved access with tailored and specific supports for older LGBTQI+ people.

- In terms of planning for the housing needs of older LGBTQI+ individuals, housing policies should consider ways to support and develop options for secure housing which meets the needs and wishes of older LGBTQI+ people.

Recommendations for the LGBTQI+ community

Despite the work focused on older LGBTQI+ people that is already ongoing within the LGBTQI+ community, the study findings indicate that a degree of isolation exists among this population (more so than among younger LGBTQI+ people). Consequently, it is recommended that:

- LGBTQI+ organisations review policies, strategies, systems, infrastructure and processes to ensure they facilitate connection for older LGBTQI+ people to the wider LGBTQI+ community. These should be proofed not only from an age perspective, but also from an accessibility perspective to ensure that the community, events, activities and spaces are user-friendly and relevant. This proofing work should be done with older LGBTQI+ people using co-production principles.
- More emphasis should be placed on developing initiatives that aim to strengthen intergenerational links within the LGBTQI+ community, that draw on the knowledge and experiences of older LGBTQI+ people and younger LGBTQI+ people, and should be designed and developed with LGBTQI+ people from across the life course.

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